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WOMEN ON THE SCENE: HUMANIZED CHILDBIRTH AND GENDER VIOLENCE

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ABSTRACT

For centuries, childbirth was considered a private care of the female gender and was performed by midwives, women who transmitted their practical knowledge from each generation. With the advent of traditional medicine, childbirth became institutionalized as medical, male, safe and scientific knowledge, resulting in the marginalization of social practices. In this scenario, the woman is no longer considered an active and conscious subject, capable of gestating and giving birth according to her wishes, but subject to medical scrutiny and formal institutions of care. The submission of women to medical-hospital control at birth is part of a patriarchal view of the female body, as a nature to be "domesticated" by the biomedical culture, which deprives women of autonomy over their bodies.In this way, obstetric violence is characterized as another form of violation of women's human rights. This article aims to promote reflections on the importance of women's knowledge and the dispute with obstetric violence in the processes that involve the moment of parturition.Research on the subject allows one to observe that the gradual disappearance of midwives and their empirical knowledge about childbirth, combined with the consequent recognition of the technical approach to the detriment of the humanization of care for pregnant women, has been feeding this type of violation still silenced by society.

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INTRODUCTION

We believe that changing the world requires a change in the manner how we are born, since, according to Odent (1981), birth is the first great perceptual-emotive-sensory experience in one's being and, for that reason, the way this person is welcomed will influence their understanding of the world. This influence also falls on the mother and family, once the event of childbirth can either be a profound and transforming experience, rich in livingness, or a moment that does not deserve to be remembered. Before modern medicine, childbirth was considered an eminently feminine event, closed in the private home environment, where women were assisted by other women who had the experience of knowing how to "hold children".

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It is noteworthy that all the care and assistance provided to the woman and her child during pregnancy, childbirth and postpartum were empirically constituted knowledge, characterizing an essentially feminine culture. Women known as traditional birth attendants or "midwives" used to perform rituals with prayers and blessings and used instruments from the domestic environment, such as the basin, scissors to cut the umbilical cord, brandy to clean the scissors, as well as oil or lard for massages –according to Del Priore (1993), childbirth was, in a sense, a moment of solidarity among women. In the end of the nineteenth century, the process of medicalization of childbirth began. During this period, a transition took place not only in who provided care and assistance to women, but also in where it was administered. In this important period of life, women began to be assisted by local professionals, who worked in maternity wards, more specifically, by doctors. As

for the place for women to give birth[1], for being safer, homes were replaced by hospital spaces. Hereby, the people who accompanied women changed, as well as the process of labor, from the physical position assumed by the women to the introduction of medicine and other interventions capable of stimulating the birth of the child (THÉBAUD, 2002; MOTT, 2005). From this perspective, women are seen only from a biological approach, and there is even a disregard for the cultural and psychological aspects involved in childbirth, since the uterus and pathological processes are the focus of medical professionals. Therefore, women cease to be protagonists in the scene of childbirth, being relegated to them the role of coadjuvants, with a small participation in the process of parturition, resulting in a culture of silence. Their intuitions, beliefs, values, wisdom and culture are being erased little by little (SILVA; CHRISTOFFEL; SOUZA, 2005). These changes did not occur by chance, since historically the oldest system of domination-exploration is patriarchy. For Hartmann (1979, p.232), patriarchy refers to "a set of social relations between men, which have a material base, and which, though hierarchical, establish or create interdependence or solidarity among men that enable them to dominate women." Patriarchy is therefore the male system of oppression of women. Cantuário (1998) also mentions a typical patriarchal vision in which a woman is raised to obey her parents and, when she marries, to obey her husband, bearing this yoke to represent her role as daughter-wife-mother, thus keeping "harmony" in the family.

According to Saffioti (2001, own translation) "Gender violence is the broadest concept, encompassing victims such as women, children and adolescents of both sexes." Gender violence, therefore, is an important mechanism of power, in which women arethe main target, being diverse the way they are affected in their daily lives. In this way, gender violence has reproduced power relations in which gender, class and race/ethnicity are interwoven. For Phillip (2010), women are victims for the mere fact of being women, of belonging to the female gender and for their social condition of gender and, in this process of domination-exploitation, the two poles of the relation have power, however, unequal.In this same sense, Cunha (2007, p.36) writes: "Dealing with violence against women means trying to cover a set of facts and situations related to the feminine condition in the world today", adding that this type of violence is one of the most practiced and least recognized forms of violation of human rights in the world. Therefore, it refers to a phenomenon secularly perceived in society, whose consequences remain current. In the case of traditional midwives, for example, their contributions were important in the process of migration from home deliveries to hospital units, since, according to Rodhen (2001), at the beginning of the 20th century, midwives, specially European newcomers to Brazil, contributed to increase the knowledge of Brazilian doctors in relation to women's health and also in how to gain the confidence of pregnant women. According to Diniz (1996), the way to legitimize obstetrics was to transform pregnancy and childbirth into pathological events, thus requiring the direct and essential intervention of obstetricians with their surgical instruments and techniques. Hence, medical knowledge, specifically in the field of obstetrics, has been ratified in society and has gained adherents. However, a considerable number of women continued to give birth at home, supported by other women, and when they appealed to a doctor, they were also guided by the lay practice of midwives, making room to the existence of a hybrid of erudite medicine and healing knowledge. Thus, the history of childbirth reveals not only the great recognition of scientific knowledge, but also the marginalization of social practices whose bases were not scientific, as women healers and midwives. Such path reveals serious gender issues when relating the knowledge of women as natural and biomedical knowledge as cultural. The opposition between nature and culture demonstrates the human intention to dominate nature, natural laws, implying that culture is greater than nature, transcending it, controlling it, as through technology. History presents women as closer to nature, in view of their bodies and their reproductive functions, while men are related to culture and therefore control what is natural (DINIZ, 1996). Contrary to scientific advance, the process of building knowledge that guides the action of midwives is beyond the limits of scientific rationality, since, as Martins (2004, p. 61, own translation) states, "Their knowledge derives from the sharing of the same method of production of meanings ". Moreover, based on Heller's (2004) thesis, daily life is not outside history, but at the center of historical events, and it is in this space that the method of producing meanings of midwives becomes alive, material. Thus, it is ratified the permanence of a contradictory dynamic that involves tradition and modernity in the processes of childbirth.

DISCUSSION

The function of midwifery is considered to be one of the oldest tasks that is recorded in the history of humanity. Records of this activity can be found in almost all civilizations (LARGURA, 1998). For the World Health Organization - WHO (1997), the person who provides care for women during parturition is called a midwife, that is, the term means one who attends childbirth regardless of their academic training. According to DelPriore (1993), for many centuries, childbirth was considered an exclusively feminine care, performed by midwives. Those women who performed the deliveries used empirical, practical knowledge, transmitted from each generation, from experiences with other women who also practiced this duty and who attended the pregnant women in their homes throughout the pregnancy cycle, including the newborn. Since ancient times, women acted as the popular healers, and with their own knowledge acquiredalong generations, they were responsible for cultivating and healing through herbs. According to Muraro (2000), these women went from house to house, from village to village, to provide assistance to other women. In spite of all the importance that the midwives had to the communities, their activities continued to reflect the image of inferior work, without a scientific knowledge, acquired by daily practice, therefore applied clandestinely and marginally. According to Rezende (1974), medical historians disqualified the assistance given by educated or lay women to childbirth, as opposed to medical, male, safe, and scientific care. Pernoud (1996) highlights that, in the twelfth century, Hildegard of Bingenwas a woman of compelling importance, a writer, composer, physician, abbess, mystic, and prophetess. In an ecclesial context, in which women's participation was usually marked by withdrawal and silence, their preaching was heard and celebrated by laymen and clerics, having traveled through various cities of Germany to minister.

[1]When a woman or female animal gives birth, she produces a baby or young animal from her body.(Cambridge Dictionary).

She wrote two books that guided healing practices in general, and her fame was such that many people made long journeys to seek treatment for their illnesses and infirmities with her. That is why her work, from a medical point of view, was respectable, so much that she was the first woman to be recognized as a doctor by the church, as can be seen in this quotation from the Apostolic Letter of Benedict XVI about this Benedictine nun, in which she states that "[...] the title of Doctor of the Universal Church to Hildegard of Bingen has great significance for today's world and an extraordinary importance for women."[2] At the end of the Middle Ages, when society already lived under the aegis of Catholic thought and was in the process of Inquisition, midwives were regarded as witches, being defamed and slandered, considered even as persons who could harm the health of both women and children, and such arguments were used so that many of them were burned and decimated (MURARO, 2000). Consequently, women were deprived of the assistance of the midwife, who is a figure of ancient tradition for the necessary care and support during this important event for the sexual and reproductive life (DIAS, 2007). Between the sixteenth and seventeenth centuries, the professional figure of the surgeon begins to emerge in the scenario of health and healing process. Foucault (1980) reports that in Europe, up to the sixteenth century, surgery was the job of rude and ignorant men, and for that very reason, obstetrics was left to women. Only in the most serious cases were the assistance of the surgeon or the doctor sought and he emphasizes that the request for the presence of a physician at the time of childbirth was very rare, due to the excess of decorum in relation to the male professional. Nevertheless, gradually, childbirth ceases to be a "women's issue", and becomes an increasingly complex medical assignment.

According to Rezende (1974), the care provided by the first midwives was guided by ignorance and little discernment. Their knowledge was passed on from each generation, as it was the responsibility of older, multiparous women to initiate beginners. As being a practice apart from logic or reason, the use of spells and creeds, bitter drinks, and sufferings were more likely to complicate than assist in labor. In this sense, the only positive aspectof these practices recorded by the author is related to the psychological support provided by midwives to women at the time of childbirth.The disrepute in the work of the traditional midwives had a direct connection with the transformations that took place in society from the eighteenth century, all due to an alleged modernizing project. Midwives, as well as many other social actors, had their knowledge treated as of lower value, inferior to knowledge considered legitimate, that is, inferior to the formal knowledge. The process of parturition became institutionalized as medical knowledge, becoming the only legitimate knowledge to the detriment of other types. In this way, the matter of gender is present in the very constitution of obstetrics as the "science of childbirth" from the production of specialized knowledge about the pregnant female body between the nineteenth and twentieth centuries. Following this path, in Brazil, it can be understood that the search for this modernity influenced the consolidation of ideas linked to the care of the female body, specifically in big cities.

[2] Available on: <http://w2.vatican.va/content/benedict-xvi/en/apost_letters/documents/hf_ben-xvi_apl_20121007_ildegarda-bingen.html> Access in: December 2017.

In a society called modern, the knowledge related to obstetrics and gynecology is presented within a masculine logic in which the anatomical and physiological aspects are the main characteristics at delivery, rather thanissues related to the psychological and cultural aspects. The submission of the female body is seen by biomedicine as a defective machine (taking Cartesian thinking that conceptualizes the body as a machine, and the male body as the parameter of normality) and a hospital is needed as a space of high technology for the production of "perfect babies". The female body under medical-hospital control at the time of parturition is part of a historical construction that relegates women to a subject without dominance, taking power over their bodies and their decisions. It was from the twentieth century that childbirth took on a more intense form in hospital units, becoming a surgical procedure performed by physicians specialized in obstetrics, with a role and power over the puerperal pregnancy period of women. This process was later called medicalization of labor, sometimes tainted by abusive use of medications to induce labor, routine procedures, several times unnecessary, such as trichotomy, enema, episiotomy and amniotomy, among others. In addition, medical practices have taken on the power to turn some physiological events into illness, nourishing the idea of childbirth as a traumatic event, crammed with pain, loneliness and constraints, and going further, some of the routine institutional protocols reinforce the feeling of incapacity and impotence of the parturient over her own body (WEISSHEIMER, 2002).

This new model of assistance is known as technocratic and is clearly characterized by the primacy of technology over human relations, which is neutral in relation to values, but in fact masks a discourse purely of scientific knowledge. This model of attention to childbirth is widely criticized, mainly to the detriment of the impersonality, a narrow view of childbirth, which regards this event as exclusively physiological, not seeing the cultural and social amplitude that parturitioninvolves. In this context of silence in the processes of parturition as a human event of the feminine gender, discussions and claims begin, whose scope is a change in the form of birth, recovering its roots. This movement, known as the Humanization of Childbirth, claims the recognition of women as capable of gestation and birth and, consequently, the recovery of their autonomy as to the choices regarding pregnancy and childbirth.

Proposed Changes: Humanization of Childbirth

The term humanization of assistance, which is still consolidated as a concept, is generally used to designate a way of care that is attentive both to citizenship rights and to inter subjective issues between patients and professionals, addressing a change in the culture of assistance. This concern for women's rights in reproductive issues was elevated in September 1995, when the United Nations convened the Fourth World Conference on Women in Beijing, China. This conference inserted four platforms for population and development programs, with a focus on gender equality, empowerment of women, protection of sexual and reproductive rights and elimination of all violence against women. This conference approved the Beijing Declaration and Platform for Action to advance the goals of equality, development and peace for all women. According to Cavalcanti (2012, p.108), the importance of this event is because"[...] for the first time, reproductive and sexual health

and women's rights have become central elements of an international agreement regarding population and development." According to Diniz (1996), there are different versions of humanization of childbirth. The first one, referring to the Catholic Church, described the suffering of childbirth as a divine will, a penalty for original sin, making it difficult or even illegal any help to ease pains of childbirth. In a second version, medical obstetrics claims its role in the rescue of women, bringing a "humanitarian" concern to solve the problem of painless parturition as a way to revoke the sentence of Paradise (Magalhães, 1916), erasing through drugs the experience of parturition, or unconscious childbirth. These drugs did not eliminate the pain of giving birth, since they allowed the woman to remember not only the pain she felt, but also all the sensations experienced in the process of parturition. In this second version it is well established that women are no longer treated as guilty, one who must atone for their sins, but rather as victims of their own nature (RODHEN, 2001).

In the second half of the twentieth century, another version for the humanization of childbirth appeared: women would begin to give birth consciously. According to Diniz (2005), women were assisted by unknown people, kept in a specific bed, with legs raised and open while their uterus were stimulated. Women in labor were kept separate from their relatives, belongings, and clothing, and underwent various procedures which became routine. These changes in the way of giving birth were not contributing to the reduction of maternal and child morbidity and mortality, and it was evident that this type of care provided at birth discouraged forms of human relations, and increased the physical and emotional suffering of the woman and her family . There was also an evident increase in the number of cesarean deliveries worldwide, reaching 50% of deliveries in Brazil. In order to change this reality, Brazil undertakes the goal to reduce maternal mortality to at least one-third of its value in 1990, within the framework of the Millennium Development Goals (UN, 2015) and the National Pact for Reducing Maternal and Neonatal Mortality (BRAZIL, 2012). In order to do so, a number of actions were taken in favor of valuing normal childbirth. Among these measures, the public investment for the training of obstetrical nurses at the end of the 1990s and the beginning of 2000stands out, as well as the creation of the Model Birth CentersProject and Normal Delivery Centers under the Unified Health System (BRASIL, 1999a; 1999b). Another strategy used by the Ministry of Health in Brazil was the articulation between the traditional knowledge of midwives and biomedical knowledge through the Working with Traditional Midwives Program, initiated in 2000 (BRAZIL, 2012). This articulation did not occur in fact, since the midwives were trained and received the kit midwives to use in their labor, but their knowledge was not socialized to enrich medical knowledge.

The Federal Government has adopted as a public policy strategy the recommendation for vaginal birth, recognizing and starting to remunerate obstetric midwives for childbirths, and stimulating support for the action of lay midwives in places where health services do not provide care for childbirth. However, in relation to the supposed appreciation given to the traditional midwives mentioned above, we emphasize that midwives' care remained as care provided to poor women residing in places of difficult access. There are limitations in the acknowledgement of the work of traditional midwives, since, according to Pinto (2002), if on the one hand their life courses reveal that they are respected and valued women, on the other they point to the lack of recognition as care providers, especially for health authorities. For Escobar (2005), the knowledge is plural, incomplete and finite. That is, knowledge must be respected and valued. The incorporation of the knowledge of traditional midwifery into health services is intrinsically related to female knowledge and, according to Borges (2008), it legitimates and anchors the value of care and solidarity present in their knowledge and practices. Respect and consideration of different knowledge would then be a way to broaden the epistemological basis of the integral health paradigm.

Conclusion

Pregnancy is a unique event in the lives of women and it demands assistance in all its phases. For this reason, processes that involve the humanization of childbirth need to value, in addition to the biomedical dimension, traditional health knowledge, especially those aimed at caring for women. In this sense, knowledge of midwives materializes in the interrelated mediations of knowing and doing, which makes it relevant to share this trade with other professionals. This knowledge is organized from a totality that involves not only the rational, but also the affective, the senses, the corporal, the touch, the soul. The process of producing their knowledge is not necessarily subjected to the dichotomous logic that separates the objective and the subjective, and which divides the traditional and the modern.

In the various versions and attempts of humanization of childbirth, what is perceived is a patriarchal logic that is embodied through the assistance modalities intended for them. The patriarchal order of gender conceives the domination-exploitation of women by men, configuring in female oppression, in a context in which medical obstetrics represents the image of the masculine, who claims its superiority on the matter of parturition. Thus, the place of exercise of traditional midwives, obstetric nurses, and, of course, those who are on the scene to give birth is marked by asymmetry and inequality. This situation results from a policy of humanization that requires advances that effect the importance of the birth of the human being, of a whole memory of knowledge that involves childbirth and, especially, the appreciation of the female figure in society.

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