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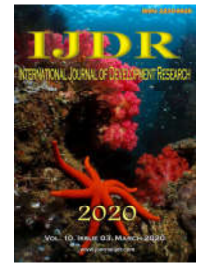

RESEARCH ARTICLE OPEN ACCESS

# MANIFESTATIONS FORMS OF VIOLENCE IN CHILDBIRTH CULTURALLY IMPOSED

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## ABSTRACT

A qualitative study carried out in a teaching hospital in a basic health unit in Rio Grande do Sul, Brazil, which aimed to know the representations of obstetric violence with a group of women of childbearing age, with a previous history of vaginal or cesarean delivery. The results show that the majority of the interviewees wanted the normal delivery, but they did not obtain enough information about this form of birth by the health professionals who, in general, directed them to have a caesarean section. Women were identified as forms of obstetric violence, which removes their autonomy in the process of parturition, such as: attendant's confinement in labor and delivery, invasion of privacy with the entry of strangers to attend the birth, without The parturient's due leave, and the power of choice for normal childbirth.

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## INTRODUCTION

This article analyzes the representations of obstetric violence among a group of women of childbearing age, with a previous history of vaginal or cesarean delivery. Violence in the puerperal pregnancy period is addressed by different authors as institutional violence, violence against women or gender, symbolic violence and obstetric violence (AGUIAR, 2013; PEREIRA, 2000; FIGUEIRÊDO, 2004; WOLFF, 2008; ZBIKOWSKI, 2012 and FANEITE, 2012). The Venezuelan legislation whose government created in November 2006 an Organic Law that deals with the right of women to have a life free of violence, including obstetric violence (GUERRA, 2015). The concept of obstetric violence refers to a procedure or act of omission caused by a health professional, in both supplementary and public health. It is expressed in the abuse of medicalization in the processes of childbirth and birth. According to some scholars, this excessive medicalization can lead to the loss of the woman's autonomy and ability to decide freely about her body and sexuality, negatively impacting her life quality (FANEITE, 2012 DINIZ; 2005). A study in the last decades of research carried out in universities, government agencies and non-governmental organizations in developing countries, finds that frequent and repeated abuses of women by health service personnel have been documented. Four types of violence were identified in the childbirth / obstetric 1) neglect, 2) verbal violence, including harsh treatment, threats, scolding, shouting, and intentional humiliation; 3) physical violence, characterized as mistreatment in childbirth care, including denial of pain relief when technically indicated; 4) and the sexual violence that manifests itself through rape, harassment ('OLIVEIRA, 2002). In this panorama, physical violence (17%) and neglect (14%) are reported more intensely by women with a high level of education, a segment that tends to have higher expectations regarding the information that professionals should provide them in relation to procedures performed ('OLIVEIRA, 2002). A survey by the Perseu Abramo Foundation, conducted in 2010, in 25 units of the federation, covering urban and rural areas of all Brazilian

macro-regions, interviewed 2365 women about childbirth assistance. The study showed that 25% said they had suffered some form of violence in childbirth care, such as having a painful examination or denying pain relief (10%), or having heard a humiliating phrase during labor such as " don't cry that next year you're here again "(15%) or 'when it was time to do it, you didn't cry, you didn't call mommy, why are you crying now" (14%) (FUNDAÇÃO PERSEU ABRAMO, 2010). In the same direction, the National Nascer no Brasil survey identified procedures considered abusive used in childbirth and birth. This survey carried out by the Oswaldo Cruz Foundation, between February 2011 and October 2012, in 266 public, private and mixed maternity hospitals throughout Brazil, involving a total of 23894 women. Among the procedures considered abusive, he found the indiscriminate use of the practice of episiotomy (cut in the perineum between the anus and the vagina) in 56% of women, as well as the use of oxytocin in 40% (LEAL, 2014). Contractions caused by oxytocin, when compared to spontaneous childbirth, tend to be longer lasting, more intense and frequent. The constriction periods are, therefore, longer than usual, with the total oxygen supply to the baby reduced and, therefore, the probability of fetal distress is increased (BALASKAS, 2012).

Data from the National Nascer no Brasil survey show that use is greater in the public sector and in women with less education.[11] According to this study, dehumanized care during childbirth has contributed to the increase in the number of cesareans and, consequently, to the reduction of normal births in the public system in Brazil, revealing that the rate of cesarean sections in the public sector in Brazil was 52% and in the private sector 88% (LEAL, 2014). The rate of cesarean sections, which in 2005 was 28.70%, increased to 36.10% in 2010. The number of normal births, which in 2005 was 71.30%, decreased to 63.20% in 2010 (BRASIL, 2010). Since 2002, the Brazilian Medical Association (AMB) and the Federal Council of Medicine (CFM), in a joint initiative, have developed a protocol on the topic Cesarean Indications, entitled Project Guidelines (PD) that stimulates the practice of evidence-based medicine, this that is, individually analyze cesarean section indications based on scientific evidence in the literature and promote a decrease in cesarean section rates (PROJETO DIRETRIZES, 2002). However, as these guidelines are verified, they have not represented a reduction in cesarean procedures in the country. The percentages of cesarean deliveries place Brazil on the same level as underdeveloped countries where the prevalence is 11.8%. In developing countries the percentage is 9.4%, according to the report "Born too Soon", released by the World Health Organization in 2012 (WORLD HEALTH ORGANIZATION, 2012). A nonsense is that the data from the World Health Organization, reveal that from 70% to 80% of pregnancies that occur in the world are considered to be of low risk and, in addition, the gestation and delivery of many high-risk pregnant women have a normal course (ORGANIZACÃO MUNDIAL DA SAÚDE, 2010). In Brazil, since 1998, policies for assistance in childbirth and birth have been created, among them, Ordinance MS / GM 2,815, of May 29, 1998, considered a milestone in the care of childbirth and birth, as it took the focus only on doctor, instituting in the Unified Health System payment for delivery performed by an obstetric nurse legally qualified to provide childbirth care without dystocia or physiological where there is no need for medical intervention during labor and delivery (BRASIL, 1998). Since 2002, the Brazilian Medical Association (AMB) and the Federal Council of Medicine (CFM), in a joint initiative, have developed a protocol on the topic Cesarean Indications, entitled Project Guidelines (PD) that stimulates the practice of evidence-based medicine, this that is, individually analyze cesarean section indications based on scientific evidence in the literature and promote a decrease in cesarean section rates.14 However, as these guidelines are verified, they have not represented a reduction in cesarean procedures in the country. The percentages of cesarean deliveries place Brazil on the same level as underdeveloped countries where the prevalence is 11.8%. In developing countries the percentage is 9.4%, according to the report "Born too Soon", released by the World Health Organization in 2012 (WORLD HEALTH ORGANIZATION, 2012). A nonsense is that the data from the World Health Organization, reveal that from 70% to 80% of pregnancies that occur in the world are considered to be of low risk and, in addition, the gestation and delivery of many high-risk pregnant women have a normal course (ORGANIZACÃO MUNDIAL DA SAÚDE, 2009).

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pelvis) and also the practice of separating the mother binomial and baby. This study then seeks to reflect and explore the mismatches between policies and guidelines related to childbirth and birth and care practices, from the perspective of women in relation to this event.

## METHODOLOGICAL TRAJECTORY

It is a qualitative research under the interpretative focus, in the light of some issues of gender and power brought by the anthropologist Emily Martin.20 Based on the Marxist framework of analysis of social relations, the author proposes an analysis of the phenomenon of childbirth and biomedicine as a force that imposes itself on the female body. The ethnographic study carried out by the author with women of childbearing age in the city of Baltimore-USA was useful to think about the experiences of Brazilian women with the same profile who went through the birth process. The focus on objectifying the female body through obstetric medical practice centered on the control, standardization and technologization of the parturition process allowed us to understand what comes to be described as the "alienation" of the female body. The use of metaphors that make an analogy between childbirth and a factory production process makes it possible to draw parallels between medical interventions on childbirth and industrial labor control processes. Through this analogy, Martin problematizes the relations of power and gender relations between doctors and women. Therefore, the data in this article were obtained from the interview with eight women, of childbearing age, with a previous history of vaginal or cesarean delivery, who were not in the pregnancy-puerperal period, and whose births occurred in 2004. The study was carried out in a teaching hospital and in a basic health unit in a municipality in the south of Brazil that serve as an internship field for undergraduate students in the health area of a Federal University. The University HU is a teaching hospital, founded in 1970, which serves as a primary care base for the neighborhoods that surround it; secondary care for the population of Santa Maria and tertiary care for the center and border region of Rio Grande do Sul.

The hospital is a teaching, research and extension center within the scope of Health Sciences, as well as a center for programming and maintaining actions aimed at the health of local and regional communities. It also provides assistance services in all medical specialties. Women who they participated in family planning groups and attended the pre-established days for dispensing contraceptive methods at the UBS. At the university hospital, the search for subjects was extended to different gynecological obstetric care units, accompanying women and women who work in these units and who met the inclusion criteria. All were aged between 22 and 35 years. Regarding marital status, six are married, one divorced and one single, but in a stable relationship at the time of the interview. Therefore, the data in this article were obtained from the interview with eight women, of childbearing age, with a previous history of vaginal or cesarean delivery, who were not in the pregnancy-puerperal period, and whose births occurred in 2004. The study was carried out in a teaching hospital and in a basic health unit in a municipality in the south of Brazil that serve as an internship field for undergraduate students in the health area of a Federal University. The University HU is a teaching hospital, founded in 1970, which serves as a primary care base for the neighborhoods that surround it; secondary care for the population of Santa Maria and tertiary care for the center and border region of Rio Grande do Sul. The hospital is a teaching, research and extension center within the scope of Health Sciences, as well as a center for programming and maintaining actions aimed at the health of local and regional communities. It also provides assistance services in all medical specialties. Women who they participated in family planning groups and attended the pre-established days for dispensing contraceptive methods at the UBS. At the university hospital, the search for subjects was extended to different gynecological obstetric care units, accompanying women and women who work in these units and who met the inclusion criteria.

All were aged between 22 and 35 years. Regarding marital status, six are married, one divorced and one single, but in a stable relationship at the time of the interview. Data collection took place in the months of January and March 2011, by one of the authors of this article who works as an obstetric nurse at the teaching hospital where the research was conducted. As this is a research with a focus on social representations, women from different socioeconomic and age contexts were interviewed. A semi-structured interview was used as instruments, containing questions that investigated the themes of prenatal, childbirth and postpartum, with observations of the appointments and informal conversations with the women and professionals of the analyzed services. As the research subjects were women outside the puerperal pregnancy period, women who were accompanying pregnant women and puerperal women in prenatal and / or hospitalization consultations and also health service workers were invited. This brought some disadvantages due to the inhibition in the first moment of the interviewees to expose the researcher's service, for this reason some interviews were scheduled at the interviewee's home. The analysis of the data was based on the thematic analysis of Bardin21 adapted by Minayo (MINAYO, 2013). His operative proposal consists of two operational moments: exploratory and interpretive. The interpretative phase is divided into: Ordering of data and Classification of data and subdivided into: horizontal and exhaustive reading of texts, transversal reading, final analysis and report. The research was approved by the Ethics Committee of the Federal University of Santa Maria under number CAAE nº 0317.0.243.000-10, according to Resolution nº 466 / 2012.23.

## RESULTS AND DISCUSSIONS

In the data analysis process, two categories stood out, namely: “The idealized delivery”, and the lack of autonomy under your body ".

**“The idealized childbirth”:** Most of the interviewees reported that information about normal childbirth, since prenatal care, was not sufficiently provided to them to help them in the process of choosing the type of procedure to be followed. In a way, the statements indicate that medical health professionals influence the choice of the type of delivery with a greater tendency to perform cesarean section.

I wanted vaginal delivery, so it was cesarean; and on the other, it was cesarean, too. It had to be programmed. By the doctor's influence. (M6)

I had in mind that my first child was going to be normal. Normal childbirth, the mother wins and already walks with the

child on her lap and not a cesarean (...). But the doctor induced me to cesarean. (M8)

I always wanted a cesarean, because I was afraid of feeling pain right there. I did not receive guidance on normal childbirth from the doctor, he influenced me to have a cesarean. (M4)

Another fact that left me frustrated was when I started prenatal care. I said I wanted a normal birth for the doctor. He was angry and was very rude and asked what I was doing there (...) I changed the doctor. (M3)

The understanding that childbirth has a faster recovery and does not interfere with the routine and autonomy of women punctuated most of the reports. However, as it was possible to verify, the woman's voice is, in general, suppressed in the decision process on the desired mode of delivery. It can be said that the ascendancy of medical power over their bodies is such a naturalized procedure that the various forms of obstetric and gender-based violence remain institutionally invisible.

It is noteworthy that one of the interviewees mentioned having performed the cesarean section out of her own desire, justifying her choice because of the fear of the pain of childbirth. This factor is pointed out as one of the causes of cesarean intervention, required by women and, it can be considered one of the aspects related to increased rates of this surgery in the country (BRASIL, 2012 and D'OLIVEIRA, 2002). A study on the pain of normal childbirth with women seen at the public health service, found mechanisms that favor the perpetuation of cesarean delivery, in order to avoid the pain of normal childbirth (FAÚNDES, 1991). It is also understood that pain in childbirth is, in largely, amplified by the care model that institutes routines such as immobilization, the abusive use of artificial oxytocin, the Kristeller maneuver, episiotomy and episiorraphy. These practices are considered harmful or ineffective in normal birth. According to the recommendations of WHO (ALMEIDA, 2009) and the Ministry of Health (ORGANIZACÃO MUNDIAL DA SAÚDE, 1996), based on scientific evidence, they should be eliminated. According to Hugo Sabatino (BRASIL, 2001), an obstetrician with a historic role in defending the humanization of childbirth, ending a pregnancy through a cesarean section, without a medical reason that justifies it, even if this is at the request of the pregnant woman, is a medical conduct that does not respect the physiological processes of labor, childbirth and birth. For this reason, the surgical procedure performed without indications is no longer a natural procedure with regard to the physiology of the human being, becoming a risky procedure for the mother and the newborn. Although some professionals and women choose the type of delivery in advance, this fact cannot be seen as a simple matter of preference, since cesarean section is not a "consumer good" (SABATINO, 2013).

Responsibility for the role of the doctor as master of childbirth is not questioned, quite thecontrary, it is legitimized by the society that values scientific power. This position stands out from the 19th century onwards, changing the status of the physician as a mere practitioner of the art of taking care of the body and associating it with the image of legitimizing the power of science (ODENT, 2004). Until then, medicine functioned through doctrines, but with the revolution caused by Pasteur the patient stops following only advice and starts to obey orders due to the legitimacy of this science. In this scenario, then, the physician increases his prestige and power and starts to advocate on various topics in society and believes that he is able to enunciate the rules to be followed by society as a whole (VIEIRA, 2002). In the same vein, Pereira observes that this mandate of medical power operates a reinforcement of roles that legitimize the power and relationship of medicine with the family (PEREIRA, 2000). In this dynamic, the subordination of women to the process of birth is perpetuated. Women's health is no different with the development of obstetrics in the sec. XIX, interventional practices in childbirth, began to stand out through the symphysiotomy or pubiotomy techniques used to facilitate the passage of the baby during normal birth (VIEIRA, 2002).

Thus, the woman, in most cases, loses her autonomy as a protagonist in the birth process. In the present study, the feeling of frustration and loss of control of those who wanted normal births and had to undergo cesarean section was recurrent in the statements. I had talked to my husband at home and we wanted a normal birth, but it didn't work, I lost control (M2). My preference was always for normal delivery, I thought I would have a normal childbirth, but it didn't work, I was frustrated. (M5) Another factor that shows an excessive power of doctors under the woman's body, would be the indication for cesarean section, to perform tubal ligation, discouraging normal delivery in women with a previous history of this way of delivery. This constitutes a disregard for Law n°. 9.263, which deals with family planning, which prohibits surgical sterilization in women during childbirth or abortion, except in cases of proven need, by previous successive cesarean sections (BRASIL, 2002). This fact was perceived by an interviewee who reported her frustrated desire regarding the option of delivery, since she wanted to have a normal delivery, due to the need for ligation, but her wish was not met by the medical team. Normal childbirth was desired. If I had a cesarean, it would be the end of the world because it took me a long time to accept the idea that I would have to have a cesarean section. I always gave preference to normal birth because of comments and about having an infection. (M7)

Other reports demonstrate routines and behaviors in maternity hospitals that discourage the bonds between mother and baby, prioritizing procedures that could be postponed:

"First, the baby was taken care of and they showed me already wrapped in clothes" (M6).
"They stayed there taking care of the baby and showed me much later" (M8).

These procedures, in addition to interfering with the mother-baby relationship, ignore the implementation of simple practices such as immediate skin contact between them and the beginning of exclusive breastfeeding, which has a long-term impact on the mother's nutrition and health and of the baby, as they affect the child's development far beyond the neonatal period and the puerperium (BRASIL, 2002). The systematic practice of routines that discourage the bond between mother and baby can constitute institutional violence and is similar to the metaphor of factory production at birth, proposed by Emily Martin (BARDIN, 2009), where the author compares the figure of the doctor in the role of supervisor or even factory owner and woman in the role of worker, whose machine (womb) produces the product (baby). It also reveals a perspective that presents pregnant women as "raw material"

for the production of a “product”. In this direction, it is essential, for the production of perfect babies, the intervention of cesarean section, requiring a minimum of work of the uterus and the woman, attributing to this procedure the image of the baby's “only saving grace” (BARDIN, 2009). It can be added that the experience of the birth process through a cesarean section interrupts the emotional bonds between mother and baby, due to the control over the female body exercised by the removal of the protagonism of the woman from the birth scene that the cesarean section abstracts. Often, when interfering with the birth of a baby, with its surgical extraction, the mother feels disconnected from the child after birth because she does not feel that she was supporting this process.[21] Furthermore, the lack of contact that can occur between the mother and the baby after the surgery can bring serious physiological damage to the baby as shown in a study conducted at the University of Cape Town, South Africa, with 16 babies in the first two days of life. This study showed that the separation between mother and baby has negative impacts, influencing the baby's sleep duration and heart rate (BRASIL, 2013). This fact was corroborated in another survey conducted on the internet, via social network with an invitation to participate published in October 2011. Twenty women were interviewed regarding their experience of unwanted cesarean section, feelings associated with the experience of childbirth and birth and the postpartum period -birth. The research was guided by the perspective of social gender relations. The results show that the majority could not count on a companion of their choice in the immediate postpartum period and could not remain with their baby due to the postpartum care routines (BARAK, 2011).

A survey of ten nursing professionals from an obstetric center in a teaching hospital in the interior of Rio Grande do Sul, found that they recognize the importance of humanized practices in childbirth care. However, they debate about aspects related to the work process in the hospital's daily life that interferes with the achievement of the objectives recommended by public policies, such as the valuation of technical skills, which, many times, are restricted to the domain of cognitive- instrumental rationality (SALGADO, 2013). Thus, women's care services, especially obstetric care services, need to invest in their facilitating role for a humanized practice, mediated by scientific knowledge (SALGADO, 2013). In Brazil, the movement for the humanization of childbirth has driven this experience in several states. In 1994, the first public self-defined “humanized” maternity hospital appeared in Rio de Janeiro, which was named Leila Diniz.8 Another milestone, in terms of public policies on childbirth and birth, was the creation of the Galba Araújo Award for Humanized Maternities instituted by Ordinance 2,883, of June 4, 1998 (PIESZAK, 2013). The criteria for granting this award are based on adherence to WHO recommendations, such as the presence of companions in the prepartum, delivery and postpartum periods, assistance to low-risk births by obstetric nurses and the control of cesarean rates (BRASIL, 2000). The Centro de Parto Normal-CPN was another initiative created by Ordinance No. 985, of August 1999, which aims to care for women during pregnancy and childbirth, having as one of its attributions, providing humanized and quality care exclusively to normal delivery without dystocia, assisted by an obstetric nurse carrying out educational and humanization activities during prenatal care, aiming at preparing pregnant women for childbirth at the CPN (BRASIL, 1998). However, these establishments are not available in all Brazilian states and are slowly being implemented with resistance to this new model of childbirth assistance by some professionals (BRASIL, 1999).

**The non-autonomy under your body:** The women's reports reveal the scenario of technicality and aridity of obstetric care and how far their bodies are separated from their feelings and their most basic rights. Their testimonies show that their wishes and expectations are not accepted by health professionals, such as not being able to choose their companion at the time of delivery, opt for comfort positions and methods during labor and on the routine use of oxytocin.

I wish my husband ‘had’ along. (...) to be more oriented. So the more natural it could be for me the better, choosing whether to shower or not, whether to stay in the water, sit in the ball. And they put the serum with oxytocin in it and I said “but why use it, if I'm almost winning?” (...) (M1)

I think everything was very forced. Students (7 to 8 people) attended my delivery, nobody asked me if I wanted to. I felt invaded. (M3)

Interviewees M1 and M3 adopt a strict stance in relation to the assistance model based on the biomedicine framework. This model is based on a reasoning where solutions are often merely palliative because they do not focus on the causes themselves, precisely because they act in the 'parts' of a system or process that, in essence, are much more complex, above all, omitting psychological or subjective components that accompany, to a greater or lesser degree, any problem (NICARETTA, 2015).

The biomedical or mechanistic model, which still bases all medical reasoning today, has its origins in the Renaissance with one of its precursors the philosopher and mathematician René Descartes (1596-1650). In his book Discourse on Method, Descartes formulates four rules that constitute the hegemonic basis of knowledge that persists to the present day. They are the primacy for reason as opposed to empiricism, the separation in as many parts as possible of a problem to solve it; linear thinking from the easiest to the most complex and the complete exhaustion of an argument in such a way that it is possible to make sure that nothing has been omitted (BARROS, 2002; NICARETTA, 2015). The mechanistic view was introduced by Isaac Newton where it was up to the creation of mathematical theories that confirmed the Cartesian view of the body and the world as a great machine to be explored, with the mechanical model in analogy to the functioning of the body: the clock and its gears. This way of thinking introduces a gradual reorientation in the principles and explanatory models that will shape current medical practices (NICARETTA, 2015). The biomedical model has been the target of protest among users of health services. One of the interviewees in this study who wished to have a normal delivery and was not attended to in her preferences protested this model by changing her doctor. Another interviewee questioned the lack of a companion during childbirth, even though her wishes were not met. It is also noteworthy that, from 2005, the right of parturients to the presence of a companion of their choice is guaranteed by law during labor, delivery and postpartum (DESCARTES, 1960). This means that women are not passive and question the situations imposed according to the biomedical model. Their statements also call attention to the importance of women having more

freedom and being able to exercise active participation, with the right to choices. The use of oxytocin was questioned as a routine procedure by M1. This interviewee also pointed out that she felt disrespected in her privacy, due to the fact that “strange” people, without previous authorization request, attended her birth in the teaching hospital. As part of the academic trajectory, students in the training process are, as it were, allowed to be in all places and moments without the prior consent of women. In other words, the obstetric reality of teaching hospitals demands the presence of students in all consultations because it is a training school. However, little is reflected on the excessive exposure of the user (a) who can promote embarrassing situations. Prior authorization and clarification to the user of the need for the presence of students in this process could circumvent the problems arising from the lack of privacy in the referred hospitals. As pointed out by Schraiber (BRASIL, 1990), the ideal of good assistance is no longer guided by ethical quality and trust in the interaction between professionals and women, to be based on greater access to technology, which represents a good in itself. This crisis of confidence fragility in relationships and, consequently, wear on care, opening spaces for the manifestation of violence. This attitude of the professional is called by the anthropologist Robbie Davis Floyd as “ethnocentric thinking” or “closed cognition system”[44] The biomedical assistance model is based on this form of thinking, also called the technocratic assistance model.[44] Several decades, this has been the dominant and guiding current in the practice of obstetric care in which the health professional separates mind and body, understood as a machine. This form of assistance then facilitates the distance between the user (a) and the health professional. Perhaps as a way to protect yourself from emotional reactions to the anxieties of interaction with users.

**Final considerations**

The naturalization of obstetric violence present in childbirth care practices, involves social issues such as gender, race, class and institutional. This violence is manifested by the use of the imposition of interventions that can damage the physical and psychological integrity of women in maternity hospitals, as well as disrespecting their autonomy. These interventions provoke iatrogenic practices, that is, those that are practiced without criterion by health professionals (FLOYD, 2009). This type of violence has its origins in several problems, among them is the educational training of health professionals and also through the way in which health care is offered, denied or neglected, through its rules, operating rules, bureaucratic and political relations, there also called institutional violence (MUNIZ, 2012). Authors who approach obstetric violence as a form of institutional violence claim that this type of treatment in assisting women, throughout the parturition process, such as the use of pejorative jargon hidden under a language of humor, threats, reprimands and negligence in handling of pain are configured as discriminatory and disrespectful practices.1 These practices reveal a service based on veiled violence and out of step with the Humanization of Birth policies (MINAYO, 2013; PEREIRA, 2000 and TEIXEIRA, 2006). The meaning of childbirth as mentioned by some women in the study, includes questioning and resistance to the cultural assumptions underlying the current biomedical model, disagreeing with practices that they experienced during childbirth, considered disrespectful. Women express their displeasure with behaviors that deprive them of their autonomy in the parturition process, such as the prohibition of the companion in labor and delivery, invasion of privacy with the entry of strangers to attend childbirth without a license from the parturient and the lack of autonomy in choosing the normal delivery route.

These behaviors can be forms of manifestation of obstetric violence, which is reflected in the fragility of bonds and the erosion of the ethical quality of the relationships between professionals and women within obstetric care services,

Thus, the present study brings reflections that may have an impact on the assistance provided to women during the period of parturition, since it helps in understanding the need for care with parturients, based on their perception of childbirth and birth. We highlight the importance of teaching hospitals to serve as models in the implementation of these policies, as they are training spaces that project future professionals for the job market that will naturally reproduce the behaviors they have learned.

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