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Obstetric violence experienced by women from an educational center in the city of São José – SC

Violencia obstétrica vivida por mujeres de un centro educativo de la ciudad de São José - SC

A violência obstétrica vivenciada por mulheres de um centro educacional no município de São José - SC

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Abstract

Objective: To identify the prevalence and the main types of Obstetric Violence suffered by a group of women; in addition to investigating the level of knowledge of these women on the subject and instructing them. Methods: In this study, qualitative, observational and cross-sectional analytical research was used, through interviews and surveys conducted with women linked to the Centro de Educação Alegria e Cia. Results: Through the analysis and reading of the questionnaires answered by women, 65 , 9% confirmed having suffered obstetric violence, even though 87.2% of them stated that they had knowledge about the topic. Most of these women (70%) report having higher education and age between 20- and 29-years during pregnancies. The most frequent obstetric violence was routine serum, direction of pulls, vaginal examination, and routine cesarean delivery. Conclusion: According to the research, despite the high level of education and knowledge on the subject, many women still suffer obstetric violence, even though it is currently being commented on more. Most women were unaware of Obstetric Violence.

Descriptors: Obstetric Violence; Puerperium; Nursing; Childbirth; Birth Plan; Humanization; Maternity.

Resumén

Objetivo: Identificar la prevalencia y los principales tipos de Violencia Obstétrica que padece un grupo de mujeres; además de investigar el nivel de conocimiento de estas mujeres sobre el tema e instruirlas. Métodos: En este estudio se utilizó investigación cualitativa, de tipo observacional y analítico transversal, a través de entrevistas y encuestas realizadas a mujeres vinculadas al Centro de Educação Alegria e Cia. Resultados: A través del análisis y lectura de los cuestionarios respondidos por mujeres, 65 El 9% confirmó haber sufrido violencia obstétrica, aunque el 87,2% de ellas manifestó tener conocimientos sobre el tema. La mayoría de estas mujeres (70%) informan tener educación superior y una edad entre 20 y 29 años durante el embarazo. La violencia obstétrica más frecuente fue el suero de rutina, la dirección de los tirones, el examen vaginal y la cesárea de rutina. Conclusión: De acuerdo con la investigación, a pesar del alto nivel de educación y conocimiento sobre el tema, muchas mujeres aún sufren violencia obstétrica, aunque actualmente se está comentando más. La gran mayoría de las mujeres desconocía la violencia obstétrica.

Descriptores: Violencia Obstétrica; Puerperio; Enfermería; Parto; Plan de Nacimiento; Humanización; Maternidad.

Resumo

Objetivo: Identificar a prevalência e os principais tipos de Violência Obstétrica sofrido por um grupo de mulheres; além de investigar o nível de conhecimento destas mulheres a respeito do tema e instruí-las. Métodos: Neste estudo foi utilizada a pesquisa qualitativa, do tipo analítico observacional e transversal, através de entrevistas e pesquisas realizadas com as mulheres vinculadas ao Centro de Educação Alegria e Cia. Resultados: Por meio da análise e leitura dos questionários respondidos pelas mulheres, 65,9% confirmaram terem sofrido violência obstétrica, mesmo 87,2% delas terem afirmado que tinham conhecimento sobre o tema. A maioria dessas mulheres (70%) relata ter escolaridade a nível superior e idade entre 20 e 29 anos durante as gestações. As violências obstétricas mais incidentes foram soro de rotina, direcionamento de puxos, exame de toque vaginal e parto cesáreo de rotina. Conclusão: De acordo com a pesquisa, apesar do alto nível de escolaridade e conhecimento acerca do assunto, muitas mulheres ainda sofrem violência obstétrica, mesmo esta sendo mais comentada atualmente. A grande maioria das mulheres se mostrou desconhecedora da Violência Obstétrica.

Descritores: Violência Obstétrica; Puerpério; Enfermagem; Parto; Plano de Parto; Humanização; Maternidade.

Introduction

Childbirth is a very striking and special episode, a period of many changes in the woman's life, when health professionals should make her the protagonist of this unique event, making her as human and natural as possible. Although the birth process is a physiological and natural event of the female body, in some events hospital interventions are necessary. However, many times what is needed is the simple welcoming and support in a humanized way to the parturients[1].

For mothers, childbirth, which should be a special milestone and would bring good memories, unfortunately ends up being remembered as a negative impact, in which they feel violated and devalued, precisely by the people who should give them confidence and especially emotional support. . The woman's feelings of helplessness and incapacity in relation to her body were reinforced by inadequate care by health professionals and institutional practices. In Brazil, the pain of childbirth is often expressed as the pain of humiliation, aggression and loneliness[2].

The woman's body can be considered a mechanical tool, in which the doctor fits as his manipulator for having knowledge about her. This, in turn, has neglected information, and going against the National Humanization Policy taking away the autonomy of the pregnant woman during childbirth, where she is prevented from choosing the position she wants to give birth to, having the presence of a companion, and showing feelings and opinions about how you want to give birth. In this way, they end up silencing their voices and having a certain vulnerability due to the way they are treated by the professionals who provide care. However, the terrible memory and traumatic shock accompany the woman for the rest of her life[1].

"Obstetric Violence" (VO) is an expression that describes various forms of violence, that is, damage during professional care in the parturition process. It covers physical, psychological, and verbal violence, as well as unnecessary and traumatic procedures. Among them, the excess of routine cesarean sections stands out, despite the efforts of the Brazilian government to take initiatives regarding the exaggerated growth of cesarean sections, in the last decades the records indicate that the numbers have been growing in Brazil[3].

There are two ways to bring a baby into the world, one of them is through cesarean section. The need to perform this should only occur in the face of a medical indication, in which there is a risk of life for the mother and / or the baby, and that should only be done when there is really a need. In recent years, the Brazilian government has been campaigning to decrease rates of cesarean delivery. Another way of giving birth would be through vaginal delivery[4].

What matters at the moment of childbirth is that it is humanized, that women are the protagonists, since they are in control of their bodies and know the best way to give birth, with the health team having the role of instructing them. Thus, they must not only fight for the right not to undergo cesarean section, if they do not want to do so, but also claim to be able to give birth at the place and in the way they choose: home or hospital, with a trusted companion and without medical interventions considered expendable[4].

Before directing obstetric care to the period before childbirth, during and after childbirth, the woman's legal rights must be known, such as: receiving humanized treatment, obtaining information and the informed consent form with the possibility of refusal and guarantee respect for your preferences, including a companion throughout the hospital stay, receive treatment free from discrimination, receive quality professional care and have access to health with freedom, autonomy, secrecy, privacy and not be coerced in your choices[5].

Given the above and considering the relevance of the topic, interest arose in investigating, through reports of women who had their children by vaginal delivery and cesarean delivery, what types and how obstetric violence occurred. The study aimed to portray the obstetric violence suffered by women before, during and after childbirth, from the report of their experiences. Therefore: What is the prevalence of Obstetric Violence experienced by the group of women at the Alegria e Cia Education Center? The objective was to identify the prevalence of Obstetric Violence experienced by women from the Alegria e Cia Education Center and the types of obstetric violence suffered by them.

Methodology

In this study, qualitative, observational, and transversal analytical research was used. Qualitative research is defined as a type of research focused on the qualitative aspects of a given question.

The contact with the women who took part in the research was carried out at the Centro de Educação Alegria e Cia. This private school network serves around 50 children from 0 to 6 years of age, located in the Kobrasol neighborhood, municipality of São José, State of Santa Catarina. The staff of this Education Center has 15 employees, including a director, assistant director, teachers, room assistants and general services, psychologist, nutritionist, speech therapist, and the Music Education teacher.

The initial contact with these people was made by phone call and the virtual agenda application used by the school. After the first contact, we decided together the day so that they could carry out the interviews. The interviews were conducted at the school office, where it was more feasible so that all women could participate and answer the questionnaire.

The study subjects were women linked to the Centro de Educação Alegria e Cia. These people were recruited through the virtual agenda application and were invited to participate in this research. We initially proposed to interview up to 50 people, as long as they met the inclusion criteria. The choice of this number was based

on the average number of students attended by the school. In this sense, we managed to obtain a minimal amount of people. If necessary, we would include more women in the study, as we were aware that there could be dropouts during the survey. The sample was intentional to meet the following inclusion and exclusion criteria.

Inclusion criteria: women over 16 years old; women who are linked to the Alegria e Cia Education Center; reside in Greater Florianópolis. As for the scope of the Greater Florianópolis region, it corresponds to the following municipalities: Florianópolis, São José, Biguaçu, Barreiros, Palhoça and Santo Amaro da Imperatriz. The choice of the region is due to the possibility of conducting interviews at the school located in the Kobrasol neighborhood. Exclusion criteria: women who are not linked to the Centro de Educação Alegria e Cia; people with cognitive impairment; people with communication problems. Through the initial contact will be evaluated how they perform their verbal communication, excluding people who have difficulty communicating, formulating sentences, telling the story.

In-depth interviews and questionnaires were carried out focusing on whether the women interviewed have knowledge about the subject addressed by the research, whether they suffered any type of obstetric violence and which one. Each interview was conducted considering the information contained in the responses to the questionnaires answered by them. The interviews were conducted with a preliminary script. After approval by the FASC Ethics Committee, we started the data collection period on 10/22/2018 until 11/9/2018. A partnership was made with the Centro de Educação Alegria e Cia, with telephone contact and a virtual calendar application to check the availability of women to participate in the interview and questionnaire. With the positive answer, the day of the interview at the school office was questioned.

People were contacted, being informed about the research objectives and procedures, and asked about the inclusion and exclusion criteria. Those that met these criteria were formally invited to participate in the research. The Free and Informed Consent Term (ICF) was offered and after reading and signing, the interview was scheduled at another time, with the person making the most practical day and time. After the women signed the informed consent form and answered the questionnaires, informative folders on the topic addressed in this research were made available through the school's virtual agenda application.

The interviews and questionnaires answered were analyzed by the nursing students who conducted this research. As a way of organizing the data, Excel software was used.

The research was presented to the Human Research Ethics Committee of the Faculty of Santa Catarina, and met all requirements established in Resolution No. 466/12 of the National Health Council, positive opinion under No. 2,962,326.

With respect to human dignity, the research was carried out after necessary clarification to the research participants and signing the Informed Consent Form. Throughout the research process, the data was kept confidential and handled only by those involved in the project, preserving the image of the participants, confidentiality, guaranteeing the non-use of the data to the detriment of people or communities, also guaranteeing respect for the values cultural, moral and religious aspects of the participants.

Results and Discussion

From the questionnaires applied to women interested in participating in the research, the results were organized using Excel spreadsheets and the results, as shown below, were organized in the form of graphs and tables. The analyzes allowed the tracing of topics related to the questions asked through a questionnaire and these were used to divide the results obtained.

Characterization of the school profile about pregnancies and births experienced by women participating in the research

A total of 47 women participating in the Centro Educacional Alegria and Cia participated in this research. According to the results obtained, the age range of the women interviewed ranged from 16 to 82 years of age in the period of the interviews. To draw a profile of these women, the level of education and age of these women at the time of their births was asked.

Figure 1. Characteristics regarding education (1A) and age during the gestational period (1B) of women linked to the Centro de Educação Alegria e Cia. São José, SC, Brazil, 2018

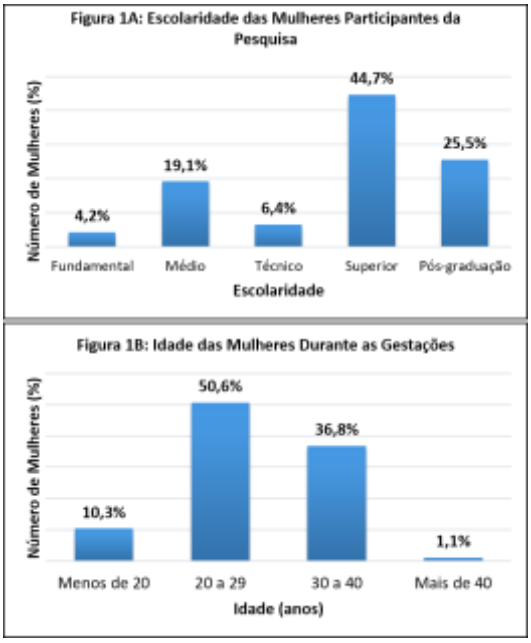


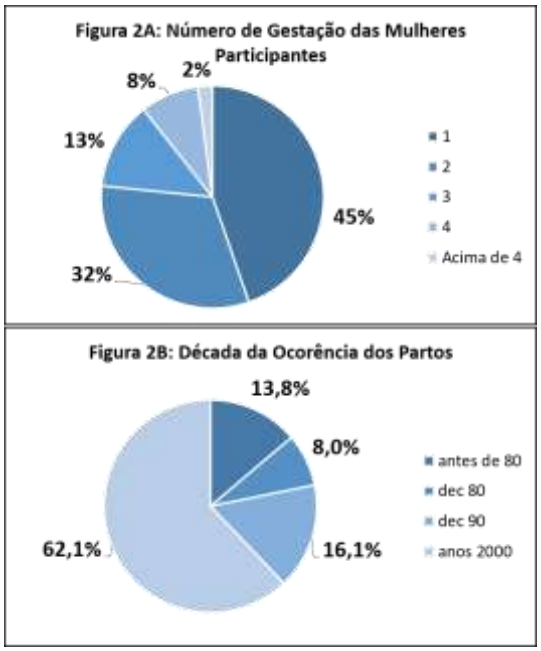
Figure 1 shows the results as a percentage of these two pieces of information. We can see that most women interviewed have undergraduate (44.7%) or even

postgraduate (25.5%), while a minority only completed elementary school (4.2%). The second important characteristic was in relation to the age of women at the time of delivery (s). More than half said they were between 20 and 30 years old during their pregnancies (50.6%), which already characterizes a greater maturity on the part of these women and, consequently, greater clarification about the experiences and practices related to pregnancy when compared with women with lower age during pregnancy.

Nowadays, women have as their focus their professional career, leaving in the background the desire to be a mother and build a family. With the education level ever higher, they have left to become pregnant at an older age, thus managing to complete other plans before motherhood.

Figure 2 shows a profile of the number of pregnancies per woman (Fig. 2A) and the decade of birth (Fig. 2B).

Figure 2. Number of pregnancies per woman (A) and decade of birth and pregnancy (B) in women participating in the survey conducted at the Centro de Educação Alegria e Cia. São José, SC, Brazil, 2018

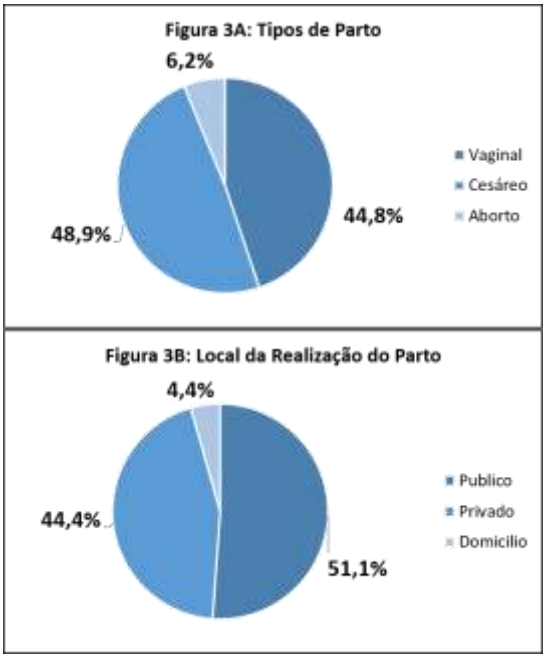


According to the results obtained, most women (45%) are currently opting for a single pregnancy, followed by two children per couple (32%) of the total. This is a current reality in several countries around the world, which is already changing the demographic profile of families. In Brazil, these data are no different. In recent years, the fertility rate has remained stable, but with a downward trend. According to IBGE data (2016), in all regions of the country, families have decreased: from 4.3 people per family in 1981, it reached 3.3 people in 2001. Also, according to IBGE (2018), in 2018 it reached 1.77 children for each woman. The trend is that, in 2060, the average number of children per woman should fall to 1.66[6].

Regarding the decade of births occurrence (Figure 2B), most occurred in the 21st century (62.1%), which corroborates even more with the changes in the profile of families. Many factors can influence this change, such as the couple's employment and income, especially women, who were previously seen as caregivers for families and the home and who today, many of them, recommend their jobs and financial stability.

Another profile that has been changing over the years is the choice of the type of delivery (Figure 3A).

Figure 3. Type of delivery (A) and place of delivery (s) (B) of women linked to the Centro de Educação Alegria e Cia. São José, SC, Brazil, 2018



In this research it was found that most deliveries were cesarean (48.9%), followed by 44.8% of vaginal deliveries. However, these results go against what the World Health Organization recommends. According to the WHO, it is indicated that only 15% of births are cesarean type, while the numbers show that in Brazil, there is a percentage of 53.7% of cesarean sections and, only in private networks, this number reaches an estimate of 84%. Brazil is considered a country with extremely high rates of cesarean deliveries, being a justification for such delivery, medical induction since a scheduled delivery does not imply the unpredictability of so much as a normal delivery. Higher income would also be another justification, since, in a single day, several cesarean deliveries can be performed, while in a single normal delivery, it can take hours[7].

Regarding the place of delivery (Figure 3B), this study registered a total of 51.1% of deliveries performed in the public health system; 44.4% performed in the private health network and only 4.4% of deliveries

performed at home.

In 2017, 2.7 million births were performed in the country. The Ministry of Health, aiming to reduce cesarean sections performed unnecessarily, created an online monitoring system, to monitor the number of cesarean deliveries that happen in SUS. Considering only deliveries performed in public health services, the number of vaginal deliveries is higher (58.1%) than those for cesarean sections (41.9%)[8].

Knowledge and experience of experiences related to obstetric violence

To measure the knowledge of the women participating in the research on what they have addressed (Obstetric Violence), these women were asked if they had knowledge about the research topic and if they considered themselves to have suffered some type of obstetric violence. It is important to highlight that in the question sheet delivered to the participants, there was a short text with little clarification on the topic, since the initial objective was not to instruct them before the interview.

A significant number of women said they already knew about obstetric violence - 41 women out of 47 - which corresponds to a significant 87.2%. When asked if they had already suffered some type of obstetric violence, 65.9% of them indicated the affirmative answer. However, during the analysis of the questionnaires, it was noticed that 22 women who claimed to have knowledge of the topic and who reported not having suffered any type of obstetric violence ended up also highlighting the issues where there were some of the procedures listed as unnecessary / violence, thus characterizing , the lack of knowledge on the subject.

In Brazil, between the 1980s and 1990s, violent events during childbirth care had already come under discussion, but it was only between the years 2007 and 2010 that the word “obstetric violence” came to be recognized and used in the country . The real meaning of this word is not well understood, as pregnant women and health professionals have in mind that everything they have been through or the assistance they provide would be just a natural process and not violence itself, and they would be exposed to interventions. Women, users of health services, ask professionals and researchers what the meaning of the expression “obstetric violence” means”[9].

As a correlation between two findings, a comparison was made between the level of education of the women participating in the research and the statement by these women about having suffered some type of obstetric violence during the delivery (s). Table 1 shows these data.

Maternal schooling is strongly associated with the type of delivery. Mothers, with a higher level of education, are more likely to give birth to their children through cesarean delivery. They have chosen cesarean section for fear of pain and suffering at the time of vaginal delivery, which is the most related to the incidence of various types of obstetric violence. This is associated both with the mother's option, as well as with the medical part, because cesarean sections usually have a higher financial cost and mothers with a higher level of education, who tend to have better financial conditions, can choose to do it[10].

Table 1. Relationship between obstetric violence and the educational level of participants in the research on Obstetric Violence conducted at the Centro de Educação Alegria e Cia. São José, SC, Brazil, 2018

Education	Absolute Frequency (number of Women)	Relative Frequency (%)
Elementary School	0	0
High school	10	28,6
Technical education	3	8,6
University graduate	14	40
Postgraduate studies	8	22,8

Women were also asked to report the types of obstetric violence suffered. Table 2 compiles the types of Obstetric Violence that the participants claimed to have experienced during childbirth, be it cesarean or vaginal.

Table 2. Main types of obstetric violence suffered by women participating in the research that occurred in different types of delivery: vaginal and cesarean. São José, SC, Brazil, 2018

Types of Obstetric Violence	Number of Women	
	Vaginal Delivery	Cesarean Delivery
Routine trichotomy (shaving of pubic hair)	8	5
Intestinal wash	8	2
Immobilization	0	3
Direction of pulls (professionals ask for strength)	12	1
Mother-baby separation	2	4
Companion restrictions	5	6
Vaginal touch examination (several times and by different professionals)	13	6
Lithotomy (horizontal position during labor)	9	1
Use of serum for the purpose of puncture the vein to facilitate medication administration	13	12
Routine oxytocin administration	8	2
Routine episiotomy (surgical incision in the vulva)	7	0
Kristeller maneuver (pressure on the upper part of the uterus)	6	4

Verbal aggression, threats, and humiliation	3	2
Neglect during assistance	2	6
Routine cesarean delivery	0	10

It is interesting to note in the table that the main types of obstetric violence suffered during cesarean delivery are different from those suffered during vaginal delivery. For example, the three main types of obstetric violence suffered during vaginal delivery are: vaginal examination (13), use of the serum in order to puncture the vein to facilitate medication administration (13) and directing pulls (12) . In the case of cesarean delivery: use of the serum in order to puncture the vein to facilitate the administration of medications (12), routine cesarean delivery (10), followed by negligence during care (6), vaginal examination and restriction of companion (6).

Despite not being among the main ones, episiotomy was mentioned seven times in this study as being an obstetric violence suffered by the study participants. According to an organization in the USA known as the American College of Obstetricians and Gynecology (ACOG), in 2006 it was agreed that the use of episiotomy should be restricted and that doctors should only do it when indicated and necessary, using all their knowledge for such an act . However, there is a routine use of this practice in the country, in some cases, against the will of women[7].

Still regarding obstetric violence, the participants were asked which health professionals were responsible for the obstetric violence they suffered (Figure 5B). 34.4% stated that the doctor was the professional who caused the obstetric violence, followed by the nursing team (31.2%) and nurses (28.1%). It is important to note that often the team's own professional does not identify himself correctly and that these data may not be as reliable with reality, since the woman does not know how to separate a nurse, a nursing technician or assistant.

> "*I believe I suffered verbal violence while breastfeeding, just at the time when I most needed peace and tranquility. By doctors and nurses. I had difficulties in breastfeeding, because my chest is inverted and at times I saw the looks of the nurses and technicians, as if it were my ill will to breastfeed and the doctor went at one point and pulled the nipple of my chest so hard that I feel sensitive to this day*" (ALCS).

The parturition process provides moments of vast vulnerability and loneliness, and health professionals often, due to their professional training, do not offer support to these women, expressing insensitivity instead of empathy. Between health professionals and patients, the relationship is sometimes marked by distrust, disrespect, and conflict. During the period of pre-delivery and childbirth, women have complained of disrespect from professionals who aid, in which the moralistic reading that blames women for having pleasure in exercising their sexuality is evident[11].

It was also asked if the participant knew more people who could have already suffered some type of obstetric violence. The majority (61.7%) said they knew more people who had already gone through this situation. This data was important for the research in the sense that currently obstetric violence is a subject more discussed among women from the same family or among friends. A theme that has become less "taboo" among women and that has been gaining strength. The relevance of this is made in the knowledge acquired by more women to reduce the number of cases of obstetric violence.

Knowledge about the birth plan

Research participants were asked if they were aware of the Delivery Plan and if at any point during delivery it was offered to them as an option. It is emphasized that 68.1% of the interviews stated that they had knowledge about the Delivery Plan and that 76.6% had received the proposed Delivery Plan.

These data are very contradictory, since having knowledge about a beneficial and recommended tool by the Ministry of Health and even allowing obstetric violence to occur is a fact for reflection: either women do not have real knowledge about birth plans and obstetric violence; or despite the knowledge they still allow the OV be a reality in their lives.

Every woman should have access to the informed choice of each procedure and a clear explanation of its risks and benefits to her health. The birth plan is a document where women include information about their choices and desires for the moment of delivery, which must be respected by professionals and institutions. To make their choices autonomously, women must have clear information about the procedures that are part of childbirth care, during prenatal care with professionals[12].

Influence of childbirth on the development of possible traumas: reports

According to the reports made by the women interviewed, there were some that drew a lot of attention, mainly due to the seriousness of the acts that caused psychological, emotional, and physical damage.

> *"What happened to me was almost 24 years ago, I went to have my second daughter, and when I arrived at the operating room, I underwent a cesarean section, I arrived at the operating room and the anesthesiologist when he saw me smiled and was friendly. At the time I thought it was just that, it was just sympathy, it was like a psychology to deal with because I was very nervous, very nervous. And he anesthetized me, and when I was already immobilized, you know, to have the baby, before the doctor arrived he started to caress me, to rub my breast and say that [...] he said some horrible things there. And it was just me and him, I started to get desperate, then it was happening for a few minutes that to me, seemed like hours! And it was very bad, it was very boring, and talking about it now brings me all that memory, that agony I felt at the time, it was very horrible. It was in the maternity ward of the Regional Hospital, and talking about it now was difficult, starting to write about it, brings me that feeling from that time"* (MACA).

Both the parturient and her family have a chance to acquire psychological disorders. These people, victims of violent practices, have in their memories memories of

that day related to the feeling of suffering they obtained[7].

According to some reports of women who "gave birth", an experience considered positive during the delivery period can generate an important and significant change in a woman's life. So, it also happens in a negative experience, which can change your perspective of life forever, resulting in memories that result from traumas obtained at that moment so fragile and emotionally unstable. In obstetrics, these care practices have a major impact on women's physical and emotional health[9].

> *"I did not identify violence during childbirth. I wish my delivery had been normal, however my son was sitting, he didn't turn. However, after delivery I felt invaded and psychologically assaulted by the nurse during the breastfeeding process. I am a mother for the first time, I took classes, I studied breastfeeding, but it never comes out as we want or imagine. I had difficulty breastfeeding my child in the first hours, the nurses seeing the situation had no handling in how to deal with the situation, they simply put their hands on my chest without asking and started to squeeze it and the physical and psychological pain was part of the scene for 30 minutes, I just cried while they talked about how much I was not trying to learn, how much I did not want to breastfeed my son, this torture for a day and a half. I believe that I endured all this violence because I was weakened by the whole situation. After a hot shower and a lot of crying, that's where I thought I could stop the situation and understand that I'm not a bad mother and that I did want to breastfeed my son, but I didn't want someone squeezing and squeezing my chest and saying that I'm not trying. I had to sign a term to leave the hospital 'came knowing how to breastfeed'. Upon arriving home alone in the room, only my son and I both connected and he suckled for 30 minutes my milk came. Violence can be so subtle, but it has catastrophic damages"* (MBM).

A study reports that there is a certain difficulty in overcoming the trauma. Even this type of violence aimed at women must cause an increase, in the postpartum period of depression[13].

Informative folder

To finalize this topic of results and discussions, and in order to fulfill one of the objectives proposed in this research, it was decided to set up an information folder (Attachment) and make it available to women after the virtual agenda application offered by the school. interviews in order that they understand, in fact, the meaning of the topic addressed. It was suggested that women seek more knowledge about the theme: "obstetric violence". It is believed that, when researching more on the subject, they will understand that whoever provides disrespectful assistance (doctors, nurses, others) should be reported. Thus, avoiding the feeling of helplessness, fear, and loneliness, and encouraging them to seek help if they suffer any type of violence. So, the importance of knowing the meaning of this word and the rights of women in relation to their bodies.

Conclusion

It is understood that over the years, the data related to the types of delivery have equalized, with women having more freedom of choice between cesarean and vaginal delivery (in the private health system). In this study, the data found corroborate the new scenario described. However, it is important to highlight the losses caused to the mother and baby when there is any imposition regarding the choice of women. In this research, it was also observed that most women have higher education and, consequently, are more educated women. This does not become true when it comes to obstetric violence since knowledge in specific areas (undergraduate and graduate) does not make these women knowledgeable about all subjects, including obstetric violence. According to the data collected through the questionnaires, this group of women was the most claimed to have suffered some type of OV.

There was also a lack of knowledge on the topic addressed, although many of them stated that they knew what Obstetric Violence was. After completing the questionnaire, many reported and reported having undergone various types of unnecessary procedures, considered OV, and that they themselves were unaware of such, evidencing the lack of knowledge. In addition to the claim to have knowledge about the Birth Plan.

It is evident the need to continue this study with other groups of women so that knowledge about the topic becomes increasingly comprehensive. To idealize a world without obstetric violence is to believe that health professionals carry out their assistance in a dignified manner and with respect to the human being served by them.

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