Chapter 119

Level Of Knowledge Of Nulliparous Women About Obstetric Violence From Different Social Classes In The Federal District And Surrounding Area - A Descriptive Study

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ABSTRACT

Introduction: According to WHO, obstetric violence is characterized by lack of humanity, respect and care for the parturient woman and her baby. Attitudes such as mistreatment, cursing and procedures without the woman's consent in health institutions are considered as obstetric violence, causing psychological and physical trauma to the pregnant woman's life. Objectives: To describe the level of knowledge of nulliparous women from different social classes in the Federal District and surrounding areas, regarding obstetric violence. Methods: This is a cross-sectional descriptive study, with a quantitative study, with the objective of evaluating the level of knowledge of nulliparous women
about obstetric violence. The methodology used is the snowball technique, in which
contacted women through social networks and sequential and continued referrals to
family and friends. The participants will be invited to participate in the survey and will receive
all information regarding the study, as well as your participation in the study.
Results: It was observed a high number of students with little knowledge about obstetric violence, mainly in the questions involving enema (bowel lavage) 44.6%, 32.7% of women are unaware of Kristeller maneuver as a type of obstetric violence and 31.7% of women are unaware of the use of trichotomy 26.7% do not agree. Regarding the restriction of locomotion of the parturient, 26.7% have heard about it, but do not know, and 13.9% do not agree. Conclusion: In general, this study showed a greater lack of knowledge about obstetric violence among nulliparous women, regardless of socioeconomic class.

Keywords: Obstetric Violence, Parturient, Nulliparous Women, Normal Delivery.

1 INTRODUCTION

During the puerperal pregnancy period, numerous hormonal and physiological changes occur in which the woman is predisposed to a greater emotional and physical vulnerability, due to the various body changes in which she goes through during the development of the fetus. Thus, it is of great importance that the pregnant woman has a good follow-up with a multidisciplinary team, because the arrival of the baby accompanies a social transition: from woman to mother. In this phase of life the emotional instabilities are remarkable because it is an explosion of feelings, such as fear (for wondering several times if what you are doing is right for that baby) and anxiety (for having sleepless nights and an unregulated diet) therefore, it is necessary the support and understanding of the health team so that the patient receives a care where she feels welcomed, comfortable and safe (DINIZ, 2018).

Obstetric violence occurs during pregnancy, childbirth, and the puerperal period, better known as the immediate postpartum period; therefore, it is violence that directly affects women in their most fragile moment. Obstetric violence can be caused in many ways, through the interaction between the woman and the caregiver; through problems in the health care system and or by the health care system; through intentional acts of psychological, verbal, and sexual violence; a variety of obstetric practices that can inadvertently cause suffering to those involved, such as episiotomies; denying attendants in the delivery room, neglecting or refusing to assist women during childbirth; lack of empathy from the care provider; lack of sensitivity to the mother's desire to see her child soon after birth; lack of consent for interventions such as cesarean delivery or the use of drugs to induce labor. (LUND; SWAHNBERG; SCHEI; INFANTI, 2018).

The increasing number of cesarean sections in Brazil indicates the importance of observing the health care of women and newborns regarding unnecessary cesarean surgeries, of which put their lives/health at risk. Without the correct indication, performing the surgery can lead to increased risk of serious complications for the age (Ministério da Saúde, 2015). Knowledge of obstetric violence (OV) is indispensable for women's and children's health and influences the culture and perception about childbirth by society. Articles suggest that women around the world experience mistreatment during childbirth, including physical abuse, verbal abuse, discrimination, non-consensual procedures, and unsupportive care.(Bohren, 2019). However, some concentrations of women with lower incomes, still report total ignorance and lack of clarity about the problem.(DINIZ, 2015).

In addition to inappropriate obstetric interventions, many women report painful childbirth experiences, with offenses, humiliations and prejudiced expressions related to women's health and sexuality that are commonly found in hospital networks. This daily and cruel reality reveals a serious violation of human rights and women's rights (Muniz & Barbosa, 2012). The intentional use of physical force or power, in threat or in practice, against oneself, another person or against a group or community that results or may result in suffering, death, psychological harm, deprivation or impairment in development, are thus defined as Obstetric Violence by the World Health Organization. (WHO, 2019).

The mistreatment of women in health care facilities has its beginnings in pervasive gender differences and the imbalance of power between health care providers and women. Social contexts are created by intersections of power systems, for example: race, class, gender, and sexual orientation. Therefore, disrespect and abuse can be seen as a consequence of structural violence, which refers to the social forces that create and maintain inequalities within and between social groups, giving rise to conditions in which mistreatment and violence between two or more people can be enacted.(MILTENBURG, 2018) (LUND; SWAHNBERG; SCHEI; INFANTI, 2018).

Adolescent, unmarried, black-skinned (brown/black), low socioeconomic status, ethnic minority, migrant, and those living with HIV are particularly predisposed to experiencing abuse, disrespect, and mistreatment in hospital networks (WHO, 2014).

Obstetric violence (OV) is linked to the violation of women's rights during health care related to childbirth (Mihret 2019). In this sense, it is part of institutional violence, and can be affected in public networks and less frequently in private networks, and exercised by health services, which is characterized by negligence and mistreatment of professionals with their patients, including: the violation of reproductive rights, respecting the person's decision regarding the issue of wanting to have children; the pilgrimage through various services until receiving care and acceleration of labor to free up beds, among others (Gomes, 2014). As for women's satisfaction about the time of their own birth, there are reports of a considerable number of women who felt dissatisfaction about their experience by the powerlessness in the face of medical decisions and the lack of adequate information for their safety and that of their baby. (Katz, Amorim, Giordano, Bastos, Brilhante;2020)

Thus, it is paramount that every citizen has the right to the best possible standard of health. The reception should begin as soon as the patient arrives at the health care facility, being responsible for listening to her anguishes, complaints and concerns, ensuring the necessary attention and support for any need and eventuality that may arise, with the main focus being the search for the patient's trust and safety throughout the gravidic-puerperal period (WHO, 2014).

Taking all these aspects into consideration, institutional resources have been made by the Ministry of Health with the effectiveness of several programs and policies in health, among which, the Program for Humanization of Childbirth and Birth, the National Humanization Policy - Humaniza SUS, the Policy of Integral Attention to Women's Health, in order to increase the qualification of health care for women and babies.(FEBRASGO, 2019)

Thus, the greater the knowledge and access to information about their rights by pregnant women, there will be a decrease in the occurrences of any kind of violation, joining this to the fact of obtaining a greater participation of women and activist groups in favor of humanized childbirth, giving greater visibility and knowledge to the subject.(AMARAL; GUIMARÃES; JONAS, 2018).

Therefore, the objective of this work was to describe the level of knowledge of nulliparous women from different social classes in the Federal District, regarding obstetric violence .

Specific goals:

- Identify the social class with the highest rate of knowledge of Obstetric Violence;

- Relate social classes to the recognition of Obstetric Violence;

- Identify the social class with the most knowledge deficit on the proposed theme;

- Identify the age of nulliparous women and compare their levels of knowledge about Obstetric Violence;

2 THEORETICAL FOUNDATION

Brazil is a middle-income country with a Unified Health System, where 98.4% of births are performed in health institutions together with trained professionals, 85% of whom are obstetricians. In 2013, the maternal mortality rate was 69.0 deaths per 100,000 live births.

There is a certain lack of educational and informative groups for women to be empowered to make choices with full ownership about pregnancy and childbirth. 61.8% of them make at least seven prenatal consultations.(Gilo Diniz; Rattner; D'Oliveira; Aguiar; Niy, 2018)

The World Health Organization recognized in 2014, obstetric violence as a public health issue that directly affects the health of women and their babies (WHO, 2014). Obstetric violence is classified as any action or omission linked to women during prenatal, childbirth or puerperium, which causes unnecessary pain, harm or suffering to the parturient, and may be both physical and psychological and practiced without their explicit consent or as an affront to their autonomy.(Katz; Amorim; Giordano; Bastos; Brilhante, 2020). The term "obstetric violence" originated in South America in 2007, and is often used for this type of abuse, establishing the concept of obstetric violence as the disrespectful, aggressive and humiliating treatment of women and girls during labor and birth (Chadwick, 2016).

It is estimated that 25% of women in labor were subjected to verbal threats and violence in a survey conducted in Brazil in 2010. Brown or black women, with less education and also those who are served by public sectors, report suffering verbal, physical or psychological abuse (Gilo Diniz; Rattner; D'Oliveira; Aguiar; Niy, 2018).

In 2010, the thesis "Institutional violence in public maternity hospitals: hostility instead of hospitality with a gender issue" was defended, in which puerperal women interviewed identified the practices considered by them as violent and reported the perception they had about their experiences of labor and birth (Aguiar JM, 2010). The studies previously done on this subject were essential for it to become more academically discussed. But violent practices in childbirth care still remain largely invisible to most pregnant women, health professionals, and managers (Sena LM; Tesser CD, 2017).

The term "Obstetric Violence" in the last decade in Latin America has become a legal foundation. Peaceful laws against Obstetric Violence - gender violence and violation of human rights - exist in Venezuela, Argentina, Mexico, Brazil and Uruguay. In European countries the social, political and medical debate on the topic is still weak (Quattrocchi 2011). Venezuela in 2007 defined VO as the appropriation of reproductive bodies by professionals, an inhumane treatment, medicalization abuse (turning something natural into medical issues) and turning something natural into a disease. These factors result in the loss of autonomy and women's ability to freely decide what they want to do with their body and sexuality, negatively impacting their quality of life.(CR Williams; C Jerez; K Klein; M Correa; JM Belizan; G Cormick, 2018)

In Brazil, due to direct pressure from the movement of women and professionals in favor of the humanization of childbirth, we have had better research on institutional violence during childbirth care.

Until then, the practices considered violent that happened during childbirth care were considered forms of institutional violence and therefore referred to as "institutional violence in maternity hospitals" or even "violence during childbirth". After the release of data showing that 25% of women who had normal deliveries in the public and private network reported having suffered abuse and disrespect during labor, delivery and/or immediate postpartum, the women's social movement, and specifically that of women mothers, began to collectively problematize the issue. That was when, for the first time in the country, the term "obstetric violence" was used, marked by the women's movement (Diniz SG, 2015).

Since 1985, the World Health Organization (WHO) has been concerned about improper medical procedures, such as excessive medicalization. The recommendation to the medical team and the administration of the institution was to review the use of technologies for the moment of delivery, the practice exercised by the medical team and at the same time the independence and autonomy of the woman's judgment, in order to lower the mortality rates and the perinatal and maternal morbidity. However, even with the WHO's position on this issue of women's health, the rates of obstetric violence have increased in middle- and high-income countries. In addition, other concerns are, the increase in the consequences and iatrogenic effects caused in women and newborns; the increasing rate of unnecessary cesarean sections in Brazil in recent years, leading the top of the scale with about 56% compared to other developed and underdeveloped countries.(Sadler, 2016)

The hyper medication of childbirth in Brazil is issued by the high rate of cesarean sections (Ministério da Saúde, 2017), with a high frequency of oxytocin, episiotomy, among others (Souza JP, 2014). There is a gap between the scientific evidence available since 1985 (Lancet, WHO, 1985) for care during childbirth of the Ministry of Health that have been updated requiring changes in the model of health promotion and quaternary prevention, based on the principle of bioethical non-maleficence: first do not cause injury (Souza JP, 2014).

The Born in Brazil survey of 29,940 postpartum women identifies an excess of obstetric interventions by health providers during labor and birth, exposing women and newborns to iatrogenic effects such as labor dystocia, neonatal hypoxia, hemorrhages, and postpartum depression. The data reveal that more than half of the women underwent episiotomies; 91.7% gave birth in the lithotomy position, with the literature recommending upright positions. Oxytocin and artificial rupture of the amniotic membrane to accelerate labor were used by 40% of women; 37% underwent Kristeller maneuver, which is pressure on the uterus for the expulsion of the baby. Such attitudes are unnecessary and bring with them trauma and consequences for the rest of the life of the mother and baby.(Lansky, 2019)

The high proportion of women who underwent lithotomy during labor, Kristeller maneuver, episiotomy without information, and separation of the baby after birth reveals the persistence of practices that are questioned in childbirth care. The lithotomic position at birth, 46.4% of women who had a vaginal delivery, is an emblematic example, interfering in the way this woman longed to have the baby in a way that determines the physiology of normal birth. Clinical practice distanced from scientific evidence, lack of

transparency and concentration of power in decision-making in professional and institutional relationships with health users favors the trivialization of non-recommended procedures, which come to be considered normal.(Moreira MEL 2014)

The World Health Organization guides that cesarean delivery rates need to be between 10% and 15%, based on a study showing that rates above 15% do not reduce maternal and perinatal mortality and morbidity, let alone iatrogenic effects on the mother and baby's health. However, hospital networks do not seem to care about this recommendation, due to the high rates of cesarean deliveries in Brazil, with about 56% in general, including private and public networks, which have occurrences of approximately 45% and 85%. This context is employed due to high rates of interventions employed in the care of the parturient woman and the newborn (Zanardo, 2017).

Socioeconomic inequality factors are key determinants of women's experience of mistreatment in institutions and by health care providers. Thus, women's views of these attitudes are justified as a reflection of discrimination and oppression rooted in society at large. The influence of inequality in institutions intervenes in the perception and interaction of providers with women, and can affect their clinical decisions and obstetric practices.(Sen, 2018) One study, found that poor, racial and ethnic minority women who underwent public services were more likely to receive unnecessary episiotomies, while high-ranking women underwent private services and were more likely to receive C-sections (Diniz S, 2018).

The movement for the humanization of childbirth in Brazil had a start in several Brazilian states, all focused so that assistance has a different meaning, that is less technocratic and more directed in the figure of the woman (Diniz SG, 2015). Therefore, in order to promote better knowledge and safety to pregnant women in Brazil, the Unified Health System (SUS) established in 2011 the Stork Network, which aims to ensure women their rights to planning their pregnancy, childbirth and puerperium, as well as the child in his safe birth and healthy development (Rodrigues, 2017).

In addition to the implementation of the Stork Network in the Unified Health System (SUS), in 2000 the Ministry of Health created a project (PHPN), which aims to contribute to the improvement of access to health care for women and babies during childbirth and newborn care, ensuring the quality of care and improved access to information and resources made available. The goal of the project is to reduce maternal and perinatal mortality and morbidity and increase humanization within health institutions towards the woman and her baby, making the parturient woman the protagonist and her choices being met by the medical team.(Silva, 2017)

Regardless of the existing policies, the emergency in the question of knowledge of the characteristics of obstetric violence among Brazilian women and health providers, is necessary so that they can have an understanding and an education on this topic. In order that the woman is aware of her autonomy and her choices throughout the pregnancy-puerperal process, and obstetric care is free from any violence used to parturient and baby, so that they can experience the moment in a unique and humanized way. (Jardim, 2018).

3 METHODS

This is a study with descriptive cross-sectional method, of quantitative approach, with the objective of assessing the level of knowledge of nulliparous women about obstetric violence. The methodology used is the snowball technique, where women will be contacted through social networks and sequential and continued referrals from family and friends. The participants will be invited to participate in the research and will receive all the information regarding the study, as well as their participation in it. After understanding and acceptance, an informed consent form (ICF) will be made available for the continuation to take place.

Participants will receive a questionnaire, where they will give information about their socio-demographic profile: name, phone number, address, race/color, profession, income, age, marital status, religion, education and whether they have ever had an abortion. For the evaluation about VO, a questionnaire was introduced according to Matheus Borges and Welber Rocha (2017), with seventeen multiple-choice questions, consisting of three different answers: "() yes, () no, () I have heard about it, but I do not know". The "yes" is judged according to the type of obstetric violence, the "no" corresponds to the contraposition of the item judged as obstetric violence and the "I have heard of it, but I do not know" refers to the participant's understanding about the item judged, however unaware of its meaning or that it is an obstetric violence.

The data will be obtained through Google forms. The link will be distributed to several online platforms, such as: WhatsApp, Instagram, twitter and e-mail, which will give access to the questionnaire. The data analysis was done through Google Docs, statistical analysis, with calculation of mean and standard deviation, score presentation and spreadsheet demonstrated from Excel program.

After data collection, booklets on the rights of women in the gravidic-puerperal period will be distributed in basic health units, family clinics, regional hospitals, via social networks such as WhatsApp, Instagram, twitter and e-mail and at the end of the survey questionnaire. Orienting the care that pregnant women should have in the pre and postpartum, so they can have a better perception of how and what procedures will be healthy for both (woman and baby).

4 RESULTS AND DISCUSSION

The data for the present study were collected from a questionnaire according to Matheus Borges and Welber Rocha (2017), made available through the google forms platform and posted on the social networks of the researchers themselves.

The criteria for the research were: women who have not yet experienced childbirth, who live in or around the Federal District. There were 101 participants, and there was no exclusion of participants. The questionnaire was composed of seventeen multiple choice questions, where each question addressed an item on obstetric violence, considered by the World Health Organization as the most frequent.

The results regarding the socioeconomic level of each individual are presented in table 1, corresponding to their color, race and ethnicity, marital status, level of education, occupation, who they live with, their type of housing, what zone they live in, and their socioeconomic level.

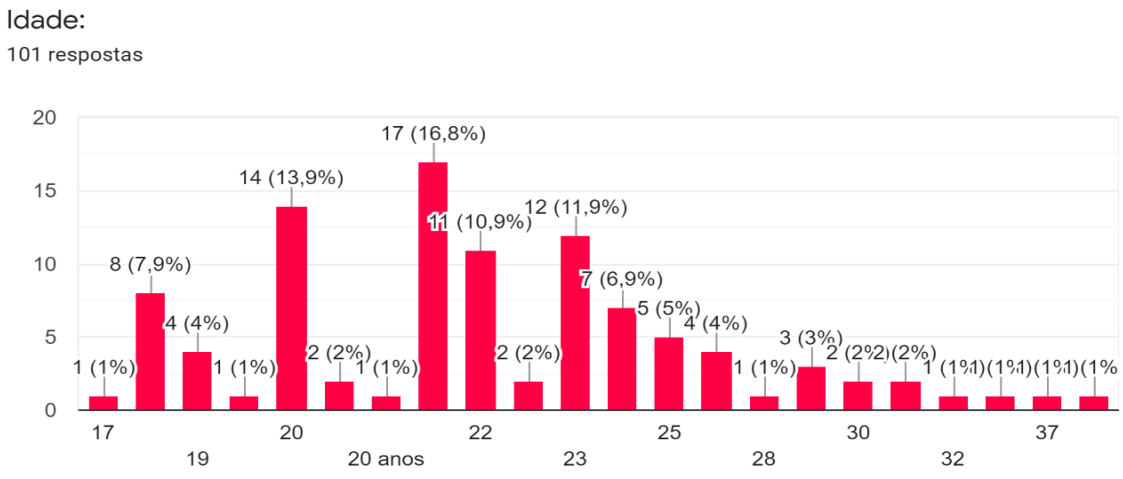
Table 1

Color/race or ethnicity %	**Marital status %**	**Education %**
Black 10,9% Indigenous 0% Yellow 3% Brown 41.6% Not identified 0%	Single 80,2% Married 11,9% Divorced 2% Widow(a) 0% Other 5.9%	Illiterate 0% Pre-school 0% Primary school 0% Incomplete elementary school 0% Complete elementary education 0% Incomplete High School 1% High school complete 13,9% Incomplete college education 58.4%. Higher Education complete 26.7%
Occupation %	**Who do you live with %**	**Type of dwelling %**
Student 57.4% Unemployed 8.9% Self-employed 7.9% 2% Retired 0% Employee Other 1% of the total	Spouse 13.9% Children 0% Parents 72.3% Parents-in-law 9,9% Grandparents 4% Others 9.9%	Rented house 13.9% Owned house 53.5% Rented Apt. Own apartment Farm 1% Social housing 0% (public company) Employee (private company)17.8% (private company)
What zone do you live in %	**Socioeconomic level %**	**Socioeconomic level**
Rural 4% City 96%	High 2% Medium-high 10.9% Medium 61.4% Medium-low 21,8% Low 4%.	Medium 61.4% Medium

Source: The authors

Table 1 shows the predominance of single women, students, white, with incomplete higher education, who currently live with their parents, own their own homes, and call themselves middle class.

Table 2



Source: The authors

Table 2 shows that most of the participants are between 20 and 23 years old, with a higher prevalence at 21 years old.

Table 3

Questions	%Yes	%No	% Heard of, But don't know.	% Yes	% No	% Heard of, but don't know
1	74	4	23	73,3%	4%	22,8%
3	84	9	8	83,2%	8,9%	7,9%
5	77	9	15	76,2%	8,9%	14,9%
6	85	2	14	84,2%	2%	13,9%
8	85	3	13	84,2%	3%	12,9%
9	43	13	45	42,6%	12,9%	44,6%
10	60	14	27	59,7%	13,9%	26,7%
12	42	27	32	41,6%	26,7%	31,7%
13	56	12	33	55,4%	11,9%	32,7%
16	83	5	13	82,2%	5%	12,9%
17	83	3	15	82,2%	3%	14,9%

Total of samples: 101

Source: The authors

Table 3 corresponds to the results of the questionnaire by Matheus Borges and Welber Rocha (2017), 4% thought they did not know about the topic and 22.8% have heard of it, according to question 1. In question 3, aimed at verbal aggression that the parturient suffers during the procedure, 8.9% of women did not agree that it is a type of obstetric violence and 7.9% have heard of it.

In question 5, which deals with denying water or food during labor, 14.9% of the participants have heard of it and 8.9% do not agree that it is a type of violence. In question 6, it refers to the lack of information given to the parturient woman about a preferred position during labor, about 13.9% of the women do not know and 2% do not agree.

In question 8, aimed at the entry of a companion in the delivery room, 3% do not agree that it is violence and 12.9% do not know. In questions 9 and 10, they show high values according to the answers, where 44.6% of the participants have heard of intestinal washing, but do not know, and 12.9% do not agree. Regarding the restriction of locomotion of the parturient, 26.7% have heard of it, but are unaware of it, and 13.9% do not agree that it is obstetric violence.

According to the answers in questions 12 and 13, 31.7% of women are unaware of the use of trichotomy as a violence and 26.7% do not agree. The alarming rate of 32.7% women are unaware of Kristeller maneuver as a type of obstetric violence and 11.9% do not agree.

In question 16, about preventing or hindering mother-baby contact after birth, 12.9% did not know, and 5% did not agree that it is a type of violence. And finally, in question 17, which deals with preventing or hindering breastfeeding in the first hour of life of the newborn, 14.9% did not know and 3% did not agree.

Except for questions 2,4, 7, 11, 14 and 15, all the others had an alarming rate of women who do not agree that such a deed is considered obstetric violence, or have heard about it.

After an analysis of the data issued through the questionnaire, we realized that subjects such as bowel movements, restricting locomotion, trichotomy, and Kristeller maneuver are among the subjects of which there was more evidence of little or no knowledge in women who have an average socioeconomic level, and a higher level of education.

5 DISCUSSION

Obstetric violence is characterized mainly by medical and hospital negligence regarding the basic rights of the pregnant woman and her baby, leading to a series of disrespectful and violent factors, whether psychological or physical. The actions of medical teams bring a traumatic experience to the life of the parturient woman. not only at the time of delivery, but also in prenatal care causing feelings of fear, anxiety and negative thoughts.(de Souza et al.(2018)

In the nineteenth century childbirth was something that many saw as a natural and female process, with the arrival of technology normal childbirth began to be seen in the twentieth century, by mainly male doctors as risky practices, introducing the pregnant woman only as a "collaborator" of the process. The emergence of obstetric violence occurs with the need for agility and lack of patience in assisting a labor.(Russo et al.,2019)

This work was based on the National Guidelines for Assistance to Normal Childbirth cited by the MS (2016) and applied to women who have not yet had the experience of childbirth, from different social classes and who live in the Federal District and/or the surrounding area.

Regarding socioeconomic issues, the highest incidence was among middle-class white women, single, with incomplete higher education, who own their own house and live with their parents. Women with low education and poor, have a greater predisposition to suffer obstetric violence, while women with greater knowledge suffer less for questioning attitudes and procedures, which generates withdrawal and rethinking of the medical team.(Andrade, 2016)

We understand that obstetric violence affects women differently, regarding issues of race, color, social class and marital status, adding the justifications of the actions performed by the medical team. The place of delivery also differs in the treatment with the woman, for example, private hospitals have a high rate of unnecessary cesarean sections while public hospitals mistreat the parturient in several ways and in a general issue in the term violence.(De Lima, 2018).

As for the results, we observed that enema and Kristeller maneuvers are the most unknown maneuvers by women, which according to the National Guideline for Assistance to Normal Childbirth (2016) determines that they are not routinely performed during labor; however, regarding enema, hospitals claim that its use brings benefits for childbirth and consequently the reduction of maternal and/or neonatal infections. This statement has no proven scientific studies on the welfare of the parturient woman and the

neonate. According to the MS (2016), this action only brings psychological and physical harm to the mother, such as discomfort and embarrassment, and contamination of the perineum through liquid feces. The addition of a cost for the equipment used for each labor is also presented.

The Kristeller maneuver consists of compressing the uterine fundus during the second period of labor aiming at the early exit of the baby (FioCruz, 2018). Although it has been banned by the Ministry of Health (MH) and the World Health Organization (WHO), it still remains rooted as one of the common procedures between the parturient woman and the medical team, and even though every year several women enter the obstetrics and/or gynecology area, these habits tend to become common and they are the ones who practice them the most, which generates a certain concern for the health and physical and mental well-being of the mother-baby relationship (NUNES, 2021).

Other issues were observed such as the locomotion of the parturient and the prohibition of food and/or drinks. The prevention of food or liquids during labor occurs through fear of aspiration of stomach contents, if you need general anesthesia (Borges, 2017). Many women said they were unaware of this procedure, however, studies prove the effectiveness and better labor in women who eat, drink liquids and move around without insecurity (Bomfim, 2021).

The use of trichotomy (shaving of the pubic hair) is rarely discussed and few people know that it is a type of obstetric violence based on beliefs and values, based on traditions and thoughts considered culturally outdated, reporting an impossibility of infection. Having no evidence of benefit to the parturient (Tesser CD, Knobel R, Andrezzo HFA, Diniz SG, 2021)

Regarding breastfeeding, we realize that there are women who do not know their right to breastfeed in the first hours after the baby's birth. However, the Ministry of Health does not agree with these positions and according to Ordinance 371/2014, every parturient woman has her independence, and the contact of mother and baby after birth is ensured, especially breastfeeding in the first hours. (MS, 2014).

The Ministry of Health seeks to ensure as a woman's right a fair and humanized care from the beginning of pregnancy until the birth of the child.

6 FINAL CONSIDERATIONS (OR CONCLUSION)

In view of the aspects examined, we realize the great difficulty in the knowledge of women about differentiating what is or is not obstetric violence. We observed that regardless of social class, color, race and/or marital status, many women are unaware of procedures used during labor.

For this reason, humanized childbirth has become a distant dream for lower class women who need access to public hospitals, face such violence and animosity from the staff in charge on the day.

In our analysis, we noticed the absence of information regardless of the participants' socioeconomic class, even though they live in a generation that has easy access to information through social media. However, taking into account that this subject has little visibility in the media and few reports from victims, a high rate of inadequate answers on the following topics did not go unnoticed: enema, Kristeller maneuver,

trichotomy, prohibition of solid and liquid foods during labor, impediment to locomotion, and impediment to breastfeeding in the first hour of life.

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