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REVISIONES

Expressions of institutionalized violence at birth: an integrative review

Expressões da violência institucionalizada ao parto: uma revisão integrativa

Expresiones de violencia institucionalizada en el parto: una revisión integradora

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ABSTRACT

This study **aimed** to synthesize the scientific literature published in articles about forms of institutionalized violence that occur during childbirth. It is an integrative review conducted in SCIELO, SCOPUS, PUBMED and LILACS bases using the descriptors "Childbirth AND" Parturition "AND" Obstetric "AND" Violence ". 13 articles were selected after meeting the criteria for inclusion and exclusion. Five categories emerged from the studies´ analysis: institutional violence in the power relationships; institutional violence to the female body; institutional violence through communication; institutional violence in the form of service; and institutional violence as a violation of rights. Although the scientific literature on the subject be improving, a number of studies is still incipient and with a low level of scientific evidence.

RESUMO

Este estudo teve por **objetivo** sintetizar a produção científica publicada em artigos acerca das formas de violência institucionalizada que ocorrem durante o parto. Trata-se de uma revisão integrativa realizado nas bases SCIELO, SCOPUS, PUBMED e LILACS com utilização dos descritores “Childbirth AND “Parturition” AND “Obstetric” AND “Violence”. Foram selecionados 13 artigos depois de atendidos os critérios de inclusão e exclusão. Da análise dos estudos emergiram cinco categorias, a saber: violência institucional nas relações de poder; violência institucional com o corpo feminino; violência institucional através da comunicação**;** violência institucional na forma de serviço; e a violência institucional como violação de direitos. Apesar da produção científica acerca do tema estar em

ascensão, o quantitativo de estudos realizados ainda é incipiente e de baixo nível de evidência científica.

RESUMEN

Este estudio tuvo como **objetivo** sintetizar la literatura científica publicada en artículos sobre las formas de violencia institucionalizada que se producen durante el parto. Se trata de una revisión integradora realizada en bases SCIELO, SCOPUS, PubMed y LILACS, utilizando los descriptores Childbirth AND "Parturition" AND "Obstetric" AND "Violence". 13 artículos fueron seleccionados tras atender los criterios de inclusión y exclusión. Del análisis de los estudios emergieron cinco categorías, a saber: violencia institucional en las relaciones de poder; violencia institucional al cuerpo femenino; violencia institucional a través de la comunicación; violencia institucional en la modalidad de servicio; y violencia institucional como una violación de los derechos. A pesar de que la literatura científica sobre el tema va en aumento, la cantidad de estudios es todavía incipiente y bajo el nivel de evidencia científica.

INTRODUCTION

Until the nineteenth century, the most childbirths were carried out in the home environment. However, from the twentieth century, the act of giving birth was institutionalized and started to occur in the hospital under medical responsibility. Since then, there have been advances in analgesia, control of bleeding, the discovery of antibiotics and surgical techniques, a fact that increased medical knowledge to contribute to the reduction of maternal and fetal mortality. Nevertheless, such advances did not minimize the problems of female dissatisfaction regarding the humanized care and promotion of autonomy over her body[1].

In recent decades, Brazil has sought a reorganization of public policies on women's health to guide them to the development of their participation during childbirth. Among the advances, there are the Humanization of Prenatal and Birth Program (PHPN); and, more recently, the emergence of the Stork Network, a tool for the humanization and quality of care of the mother and the child within the context of the Unified Health System (SUS)[2-3].

Despite good improvements in women's health care in the country, it is still realized that institutional violence against women in labor and the high number of caesarean sections are strong indicators that the delivery assistance requires a critical and reflective look by the government and the health professionals to allow the woman, a humanized satisfying and safe experience[4].

The institutionalized violence at childbirth has been associated with the precariousness of the health system, reduced investments in hospitals, unethical and disrespectful behavior of professionals, the indiscriminate use of amniotomy, episiotomy, synthetic oxytocin, repetitive vaginal touches, unnecessary cesareans and the use of words and ironic expressions directed at women during labor[5-6], being denounced since the 1980s by feminist movements and the goal of academic research from 1990[7].

Regarding this problem, this study aims to synthesize the scientific literature published articles about the forms of institutionalized violence that occur during childbirth. The work is justified guided by the fact that there are few studies that address this issue, trying to instigate the understanding that the development of studies on forms of violence during childbirth deserves greater focus on national and international scientific production, because the treatment is a cruel and daily reality hurting the rights and dignity of women.

METHODOLOGY

Study of an integrative review type, which aims to seek, critically evaluates and synthesize available evidence on a research theme. This research method includes five steps, which are: 1) identification of the research question, 2) literature search, 3) evaluation of the data, 4) data analysis and 5) presentation of the results[8].

In this study, the guiding question was: What is the published scientific literature in articles about the forms of institutionalized violence that occur during childbirth?
The search was conducted in August 2014, in the Scientific Electronic Library Online (SciELO) and the following databases: Scopus, National Library of Medicine and National Institutes of Health (PUBMED) and the Latin American and Caribbean Health Sciences (LILACS).

The controlled descriptors identified in the Medical Subject Headings (MESH) were Childbirth, Parturition, Obstetric, Violence. These keywords were used in the following intersections using the Boolean AND: Childbirth AND Violence; Parturition AND Violence; Obstetric AND Violence.

The inclusion criteria for the publications were articles that addressed the institutionalized violence at childbirth, published between 2003 to 2013, available in full, free, in Portuguese, English or Spanish. Exclusion criteria were monograph work, dissertation, thesis, abstracts, articles published in scientific events, editorials and letters to the editor.

By applying the crossing of words, the following articles were found: Childbirth AND Violence (SCIELO=21); Parturition AND Violence (LILACS=07; PUBMED=45; SCOPUS=32); Obstetric AND Violence (SCIELO=15; LILACS=29; PUBMED=343; SCOPUS=329), totaling 821 publications. After the initial data collection stage and the inclusion and exclusion criteria applied by reading each article, the sample consisted of 13 articles; five were from SCIELO, two from LILACS, one from PUBMED and five from SCOPUS.

The quality of the studies was analyzed according to the classification of levels of scientific evidence, which correlates the methodological design of the study on the strength of scientific evidence of production[9].

By reading the articles, events and/or elements that characterize the forms of institutionalized violence that occur during childbirth were identified, which were grouped by similarity of content, emerging categories presented on the results.

RESULTS

The articles analyzed by this integrative review are shown in Table 02, to distribute the information regarding the ordinal identification of the manuscript, year and place of publication, reference, the level of evidence, objective and method of research articles.

Table 01: Distribution of articles according to the ordinal identification, year and country of publication, reference, the level of evidence, objective and research method. Santa Cruz, Rio Grande do Norte, Brazil, in 2014.

Id*	Year	Country of th study	Reference of the article	EL**	Method
01	2004	Brazil	Pereira WR. Poder, violência e dominação simbólica nos serviços de saúde.2014;13(3):391-400.	VI	Qualitative
02	2006	Brazil	Teixeira MZF, Pereira WR. Parto hospitalar - experiências de mulheres da periferia de Cuibá-MT.2006;59(6):740-4.	VI	Qualitative
03	2008	Brazil	Wolff LJ, Waldow VR. Violência Consentida: mulheres em trabalho de parto e parto.2008;17(3):138-151.	VI	Qualitative
04	2009	Venezuela	Cuevas MC. Patologizando lo natural, naturalizando lo patológico… improntas de la praxis obstétrica.2009;14(32):147-62.	VI	Qualitative
05	2009	Venezuela	Poljak. La violencia obstétrica y la esterilización Forzada frente al discurso médico. 2009;14(32):125-46.	VII	Opinion
06	2009	Brazil	Rattner D. Humanização na atenção a nascimentos e parto: breve referencial teórico.2009;13(1):595-602.	VII	Opinion
07	2011	Brazil	Aguiar JM, D'Oliveira AFPL. Violência institucional em maternidades públicas sob a ótica das usuárias.2011;15(36):79-91.	VI	Qualitative
08	2011	Argentina	Felliti K. Parirás sin dolor: poder médico, género y política en las nuevas formas de atención del parto en la Argentina (1960-1980).2011;28(1):113-29.	VII	Opinion
09	2012	Venezuela	Faneite DJ, Feo A, Merlo JT. Grado de conocimiento de violencia obstétrica por el personal de salud. Ver Obstet Ginecol Venez.2012;72(2):4-12.	VI	Descriptive
10	2012	Brazil	Diniz SG, D'Oliveira AFPL, Lansky. Equity and women's health services for contraception,	VII	Opinion

			abortion and childbirth in Brazil.2012;20(40):94-101.		
11	2012	Cuba	Jordá CBD, Gernal CZD, Álamo MA. El nacimiento en Cuba: análisis de la experiencia del parto medicalizado desde una perspectiva antropológica.2013;39(4):718-32.	VI	Qualitative
12	2013	Venezuela	Teran P, Violencia obstétrica: percepción de las usuárias. 2013;73(3):171-80.	VI	Descriptive
13	2013	Brazil	Aguiar LM, D'Oliveira AFPL,Schraiber LB. Violência institucional, autoridade médica e poder nas maternidades sob a ótica dos profissionais de saúde.2013;29(11):2287-96.	VI	Qualitative

* Identification of the article; ** Level of Evidence.
Source: Research data, in 2014.

With this integrative review, it was found that the article publications on the subject increased from 2009, with a higher incidence in 2009 and 2012. These articles are concentrated in Latin America, with a significant number of articles in Brazil, followed by Venezuela, Argentina, and Cuba. The studies were in the levels VI and VII of scientific evidence, which correspond to descriptive and quantitative research, qualitative research and opinion articles.

Similarly, it was observed the small number of publications on the subject and the lack of specific descriptors on the subject, besides the unavailability of articles published in other English-speaking countries and for free.

Table 03 shows the categorization of violence that occur in childbirth with their respective articles sources as well as the main points characterizing the violence. Thus, from the analysis, five topics emerged: institutional violence in power relationships; institutional violence with the female body; institutional violence through communication; institutional violence in the form of service; and institutional violence as a violation of rights.

Table 02: Categorization of forms of institutionalized violence in childbirth. Santa Cruz, Rio Grande do Norte, Brazil, in 2014

Category	Detalhamento da categoria
Institutional violence in power relationships (articles 1-13)	• Submission, passivity and obedience woman on the historical and cultural power of health professionals; • Power relationship in the discriminatory practices of gender, class and race / ethnicity.
Institutional violence with the female body (articles 1-13)	• Elective and hysterectomies Cesareans; • Use of unnecessary interventions and procedures such as enema, trichotomy, routine episiotomy, supine position in labor,

	abuse of ocitócito, Kristeller maneuver and immobilization in bed; • Conducting vaginal touches without authorization and prior explanation; • Disrespect to privacy; • Disrespect to physical pain and freedom of choice, trivialization of suffering; • Imposition of force and brutality in procedures; • Do not use of analgesia.
Institutional violence throu communication (articles 1 6-7, 19-13)	• Absence of clarification, behaviors, not information, denied, fragmented or confused information; • Absence of dialogue between professional and user; • Verbal aggression with increased tone, impatience, cursing, ironic phrases, rough treatment, intentional humiliation, threats, discriminatory offenses, repressive criticism, authoritarian speeches; • Lack of listening and disregard the opinion; • Indifference and inattention.
Institutional violence in t form of service (articles 02, 06-07, 10, 13)	• Bureaucratization of access to services; • Lack of hosting; • Inability to meet the needs in a solving way; • Delays in care; • Willful neglect of care; • Lack of professionals; • Differences in the care of private and public service; • Poor working conditions.
Institutional violence as violation of rights (articles 11, 12, 13)	• Absence of a caregiver; • Prevent early contact between mother and baby without justifiable clinical causes.
	•

.Source: Research Data, 2014.

DISCUSSION

The approach of institutional violence in power relationships had great prominence in this review, with an association between violence and power as the main theme discussed in all the analyzed articles.

The passivity of being a woman socially constructed; low educational level; racial prejudice, especially with black and Northeast; and the purchasing power of women were considered as risk factors by some studies for violence during the childbirth process[10,11,12,13,14,5,15].

In public health services in Brazil, the institutional violence at birth is determined by gender violence showing differences into inequalities; and as a hierarchical relationship in which

the patient is treated as an object and not as a subject of their actions and decisions about what is happening[14]. Domination by the symbolic power attributed to scientific knowledge of medicine.

Scientific-Technique authority is the source of medical power guided on two pillars: the scientific legitimacy of their knowledge and the dependence of the subjects about such information. Dependence justified by the importance of health for all, and the fact that non-compliance to medical authority may result in damage to health[16].

Power is a way of action on the action of others, exercised through the relationship established in society, in which the subject undergoes voluntarily to the behaviors prescribed by health professionals[17-18]. This is the case of modern medicine and logic embedded in the practices focusing on women in the hospital context.

Historically, obstetrics and gynecology professionals have dedicated to the female body control under androgenic perspective, that is their knowledge and forms of intervention are predominantly male[10]. Also, most doctors are men and women who tend to incorporate attitudes and knowledge of the category to which they belong[10]. Such asymmetry notes that gender relationships not only exist between men and women, but are also found among women, in the female condition, but not equal by the interbreeding of race and social class[10-14].

Therefore, it is considered that women are in a dual power relationship, as patients, and as females, adding the racial, socioeconomic discrimination and tolerance of violence as a practice that eliminates the impunity of those who commit it[14].

Another well-represented category was the institutional violence with the female body, whose evidence was cited in all publications. Overall, the reports of women who have experienced this type of aggression, express feelings of embarrassment, lack of privacy, pain and passivity before the disrespectful manipulation of their body.

In the studies, complaints about the use of the vaginal touches were highlighted, sometimes without respect to the women´s privacy, frequently performed by multiple examiners, either at the same time or small time intervals[19,10,11, 13,20,14,21,15]. The indiscriminate use of the technique shows the women not able to enumerate the touches received during the period of pre-delivery[15].

The unnecessary episiotomy and episiorrhaphy were cited as traumatic and painful interventions, even with the use of anesthesia, and even regarded as measures iatrogeny the delivery[12,13,20,22,15]. The use of the technique has been carried out without a selective and judicious approach, even with the disadvantages that the practice promotes as blood loss and increased risk for infections and severe perineal lacerations[23].

Frequently, women refer to the prescription of “injection force” and report that professionals “have pushed in the stomach to help the child to be born"[10-14]. These actions correspond to misuse of oxytocin and Kristeller maneuver[12-15]. They were also referred to uterine revision, enema and trichotomy as everyday practices[22].

The imposition of the lithotomy position during labor was a common finding of studies. In this condition, the mother adopts horizontal direction, keeping up with her legs up and sometimes tied[24,22,13].

This imposition is justified by the lithotomy decubitus facilitating medical work, allowing control of fetal heartbeats, local anesthetic administration, use of forceps, episiotomy, placental review and the provision of assistance to obstetric complications[13-24]. To be benefited, women trying to get up to stand in a vertical position are identified as practicing rebellious acts, and they are contained in the delivery table[10].

The performance of caesarean and sterilization through tubal ligation, when executed without prior family planning, was also considered as a practice that naturalizes male domination over the woman´s body[19].

Considering the subjective dimension, women who experience violence from their body suffer a kind of rite, where their sex organs can be seen and raided without any embarrassment by those who can make them, and respect the dignity and privacy of them[19].

There is no respect for pain, nor pled strategies to minimize it because, in the minds of professionals, women must endure suffering as something that is biologically inherent in their femininity and as the price to be paid for the sexual act that makes her pregnant[14].

The above practices are considered proscribed and castigated behavior by the World Health Organization (WHO) since 1996, according to the classification of care practices and birth, based on scientific evidence concluded through research worldwide. This article should guide to a normal birth, paying attention to what should be done and what should not be done in the delivery process[25]. However, they persist in the reality of health services, a fact that disqualifies care delivery.

The institutional violence through communication was reported in most studies with the particularity of being understood not only as verbal aggression, but also the absence of a qualified communication between professional and patient.

A quantitative study in Venezuela with 425 mothers found that the practice of talking to the woman by derisive comments, derogatory jokes, epithets in the diminutive and perform critical before the crying and pain during childbirth, are embodied as an inhumane and violent treatment[15].
Nevertheless, in the reality of services, the use of jargon similar to the following is common: “At the time of making the baby, she does not complain, it found it good ... but now she complains that it hurts”[19,11,12,13,14 5].

The use of jocular phrases full of prejudices and false moralism are justified as “humor jokes” not being identified by its executioners as a kind of violence. Conceptions of this nature end up allowing the practice of verbal violence to be accepted, tolerated and socialized in the care every day, making it an trivialized act[26-5].

Thus, the time that it would be the most delicate and important in a woman´s life, it ends up walking a path traced by rough treatment by impatience, moralistic nature of speech, threats, shouts, intentional humiliation and repression[14].

Still on the relationship between doctors and pregnant women, it is clear that there are miscommunications conditions to the woman waiting for explanations that never arrive. They never know what doctors do with their body, unaware test results and know little about the baby's health[19-22]. They are not consulted on their opinions[22]. In this

perspective, the non-information, information denied, fragmented, confusing and unintelligible use of technical terminologies for customers strengthens the system of domination and subjection of women in health services[10-14].

The symbolic power of medical practice says it is not necessary to inform about what they do when they are doing something to benefit others, nor the relationship between the subject should be done through horizontal dialogue, with an emphasis on listening to the patient[19]. Faced with the above, it is essential that professionals are willing to reorient their practices based on qualified listening, considering that the establishment of a good interpersonal relationship, surrounded by respect and co-participation of the mother can produce favorable effects on maternity experience[27].

The category of institutional violence in the form of service concentrates six national publications, whose elements correspond to the flaws in the health system organization and the direct provision of services.

Thus, they are considered as nuances of violence incorporated into the routine of the institutions, conditions such as difficult access; comings and goings of the hospital to the residence; wait long for the service; lack of acceptance; low network of care; precariousness of resources; poor structural conditions and lack of human resources needed to quality care. Intentional neglect is still cited, to be left alone in the delivery room as punishment for “bad behavior” and even stratification of care delivery quality from socioeconomic criteria, considering the different realities of public and private service[19,10,13,12,14,21,5].

They are also the actions or omissions of authorities, employees, directors or public agencies that are intended to delay, obstruct or impede women, access to public policies and the possibility of exercising the rights provided by law[13-15].

It is noteworthy the inference about the differences in women assistance, both public or private service, those who are paying or not. In the private service, the provision of care gains on a cautious care, which is permeated by previously clarified and well-executed behavior, because it is a paid product[19].

In the public service context, the assistance called as “free” appears as a generous gesture that must be upheld without explanations or questions, as the only option for those who cannot pay[19]. Therefore, there is a close relationship between the type of service and the existence or not of institutional violence to the childbirth.

Another interface was presented in a survey of professionals about their perception when violence during childbirth. These cited as constraints for the event, poor working conditions, both regarding physical structure of hospitals and human resources and excessive demand for speed in service production. The consequences range from a lack of professionals, disqualification from service on the demand for high productivity until the ban of the caregiver given the lack of physical space that ensures the privacy of other patients[5].

Finally, the institutional violence as a violation of rights was cited in four studies, of which one was held in Brazil and the other in Venezuela and Cuba. The category presents a discussion about the neglect of the right of the caregiver during labor, delivery and postpartum and not promoting early contact between mother and baby without clinically justifiable causes.

The right to the presence of a caregiver, elected by the family during labor, delivery and the immediate postpartum period is a recommendation by the World Health Organization (WHO) since 1985 [28].

In Brazil, this recommendation gains legal force through the Federal Law 11,108/2005 to compel public and private institutions to allow the presence of a companion of choice of the mother during childbirth process and the immediate postpartum period[29]. However, the existence of specific legislation does not guarantee the right.

In the studies analyzed, realities were identified where, in public institutions in Venezuela, women and adolescents partners or family were not allowed during their hospital stay[13]. In other contexts, despite the pregnant women and mothers have the opportunity to keep a companion with them throughout the birth and postpartum, there are still prohibitions for men in the delivery room and in the wards, by the lack of physical space ensuring the privacy of other patients[14-22].

In general, studies are similar in the neglect of the right of the caregiver for the perception of professionals about the importance of this subject and the structural inadequacy of the institutions[30]. Regarding the early contact between mother and baby, a study of mothers found that 23.8% of the total survey sample reported that they had early contact with the prevented newborn[15].

The reasons of such deprivation are from neonatal complications, but most of the time, they find an excuse in the medical care of routine and primary care[31], a reality that denies the possibility of initiating breastfeeding within the first hour of birth, as recommended by the WHO. As well as the delay in contact between postpartum and newborn can be configured as a source of anxiety and frustration for women[13,22]. The recommendation of early approach is based on evidence that the first time the infant has greater ability to perform the stimulation of alveolar-mammillary search, as well as the immediate suction promoting the production of prolactin and oxytocin[32].

The risk for failure of breastfeeding becomes more relevant due to the delay in contact between mother and baby since the initiation of breastfeeding in the first hour of life is associated with longer duration of breastfeeding[32].

FINAL CONSIDERATIONS

Although the scientific production of institutional violence of the childbirth is increasing in the last ten years, some studies are still incipient, considering the complexity of the issue and its social relevance. Also, existing publications have a low level of scientific evidence, having only, descriptive studies, qualitative, and opinion articles.

The terms of institutional violence to delivery are done through multifaceted practices. This study highlights the violence through communication, relationships of power and the manipulation of the female body.

Thus, it is necessary to have practical changes in the reality of services, with the adoption of a qualified, humanized and centered assistance on the role of women to provide her birth experience as an odd event of their life. It is hoped that this work can instigate the production of new knowledge on the subject, envisaging the preparation of studies with the highest level of evidence.

REFERENCES

1. Stancato K, Vergílio MSTG, Bosco CS. Avaliação da estrutura e assistência em sala de pré-parto, parto e pós-parto imediato-PPP de um hospital universitário. Ciência, cuidado e saúde [periódico na internet] 2011 Jul/Set [acessado em 22 de agosto de 2014] 10(3):541-548.
2. Dias MAB. Humanização do parto: política pública, comportamento organizacional e ethos profissional. Rio de Janeiro: Editora Fiocruz;2010.
3. Brasil. Lei 569 de 1 de julho de 2000. Institui o Programa de Humanização no Pré-natal e Nascimento, no âmbito do Sistema Único de Saúde. Diário Oficial da União. 1 de julho de 2000.
4. Jamas MT, Hoga LAK, Reberte LM. Narrativas de mulheres sobre a assistência recebida em um centro de parto normal. Caderno de Saúde Pública. 2013;29(12):2436-46.
5. Aguiar JM, Oliveira AFPL, Schareiber LB. Violência institucional, autoridade médica e poder nas maternidades sob a ótica dos profissionais de saúde. Caderno de Saúde Pública. 2013;29(11):2287-96.
6. Sanfelice CFO et al. Do parto institucionalizado ao parto domiciliar. Revista Rene [periódico na internet]. 2014 [acesso de 21 de agosto de 2014] 15(2):362-70.
7. Behague DP. Beyond the simple economics of cesarean section birthing: women's resistance to social inequality. Culture, Medicine and Psychiatry.2002;26:473-507.
8. Whittemore R, Knafl K. The integrative review: updated methodology. Journal Advanced Nursing. 2005;52(5):546-553.
9. Melnyk BM, Fineout-Overholt E. Making case for evidencebased practice. In: Melnyk BM, Fineou-Overholt E. Evidence based practice in nursing & healthcare. A guide to practice. Philadelphia: Lippincot Williams & Wilkins;2005:3-24.
10. Teixeira NZF, Pereira WR. Parto hospitalar-experiências de mulheres da periferia de Cuiabá-MT. Revista Brasileira de Enfermagem. 2006;59(6):740-4.
11. Wolff LR, Waldow VR. Violência consentida: mulheres em trabalho de parto e parto. Saúde e Sociedade.2008;17(3):138-51.
12. Ratter D. Humanização na atenção a nascimentos e partos: breve referencial teórico. Interface Comunicação Saúde Educação.2009;13(1):595-602.
13. Poljak AV. La violencia obstétrica y la esterilizacíon forzada frente al discurso médico. Revista Venezuelana de Estudios de la Mujer.2009;14(32):125-46.
14. Aguiar JM, D'oliveira AFPL. Violência institucional em maternidades públicas sob a ótica das usuárias. Inferface Comunicação Saúde Educação.2011;15(36):79-91.
15. Terán P; Castellanos C, Blanco MG, Ramos D. Violencia obstétrica: percepción de las usuárias. Revista Obstetricia y Ginecologia de Venezuela.2013;73(3):171-80.
16. Starr P. Orígenes sociales de la soberanía profesional. In: Starr P, editor. La transformación social de la medicina en los Estados Unidos de América. México DF: Biblioteca de la Salud/Secretaría de Salud/Fondo de Cultura Económica;1991:17-44.
17. Foucault, M. O sujeito e o poder. In: Rabinow, P, Dreyfus HL, Foucault M. Uma trajetória filosófica para além do estruturalismo e da hermenêutica. Rio de Janeiro: Forense Universitária;1995:231-49.
18. Foucault, M. Microfísica do poder. 24ª ed. Rio de Janeiro:Graal;2007.
19. Pereira WR. Poder, violência e dominação simbólicas nos serviços públicos de saúde. Texto Contexto Enfermagem.2004;13(3):391-400.
20. Cuevas MC. Patologizando lo natural, naturalizando lo patológico...Improntas de la práxis obstétrica. Revista Venezuelana de Estudios de la Mujer.2009;14(32):147-62.

21. Diniz SG, D'oliveira AFPL, Lansky S. Equity and women's health services for contraception, abortion and childbirth in Brazil. Reproductive Health Matters.2012;20(40):94-101.
22. Jordá CBD, Gernal CZD, Álamo MA. El nacimiento en Cuba: análisis de la experiencia del parto medicalizado desde una perspectiva antropológica. Revista Cubana de Salud Pública. 2013;39(4):718-32.
23. Oliveira SMJV, Miquiline EC. Frequência e critérios para indicar a episiotomia. Revista Escola de Enfermagem da USP.2005;39(3):288-95.
24. Felliti K. Parirás sin dolor: poder médico, género y política em las nuevas formas de atención del parto em la Argentina (1960-1980). Histórias, Ciências, Saúde. 2011;18(1):113-29.
25. World Health Organization. Recomendations for Appropriate Technology Following Birth. WHO Regional Office for Europe. 1996.
26. Pizzini F. Communication hierarchies in humour: gender differences in the obstetrical/gynaecological setting. Discourse & Society.1991;2:477-88.
27. Rodrigues AV, Siqueira AAF. Sobre as dores e temores do parto. Revista Brasileira de Saúde Materno Infantil.2008;8(2):179-86.
28. Organización Mundial de la Salud. Recomendaciones de la OMS sobre el nacimiento. Declaración de Fortaleza. Tecnología apropiada para el parto. 1985;2:436-7.
29. Brasil. Lei nº 11.108 de 07 de abril de 2005. Dispõe sobre a garantia as parturientes o direito à presença de acompanhante durante o trabalho de parto, parto e pós-parto imediato, no âmbito do Sistema Único de Saúde - SUS. Diário Oficial da União. 7 de abril de 2005; 184º da Independência e 117º da República.
30. Brüggemann OM, Ebsen ES, Oliveira ME, Gorayeb MK, Ebele RR. Motivos que levam os serviços de saúde a não permitirem acompanhante de parto: discursos de enfermeiros. Texto Contexto Enfermagem. 2014;23(2):270-7.
31. Puig G, Sguassero Y. Contacto temprano piel a piel entre las madres y sus recién nacidos sanos. La Biblioteca de Salud Reproductiva de la OMS. 2007.
32. Esteves TMB, Dumas RP, Oliveira MIC, Andrade CAF, Leite UC. Fatores associados a amamentação na primeira horas de vida. Revista Saúde Pública.2014;48(4):697-703.

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