Humanities and Social Sciences Review,
CD-ROM. ISSN: 2165-6258 :: 08(02):117–128 (2018)

OBSTETRIC VIOLENCE IN BRAZIL: AN INTEGRATED MULTIPLE CASE STUDY

Murillo Dias

Rennes School of Business, France

Valeria Eunice Mori Machado

Fundação Getulio Vargas, Brazil

Obstetric Violence, a topic addressed and amplified in the present study, is a type of sexual violence and is of alarming seriousness. Research reveals that one in four Brazilian women suffered some type of violence at the time of delivery. In this research, two cases were investigated. First, the reality of hearing-impaired parturients who did not have the right to the interpreter and the accompanying person in the delivery especially analyzed the case of an interviewee who was subjected to sterilization without consent, among other violations. The second case discusses the high rates of cesarean deliveries, especially the city of Trindade, Goiás (Center-west Brazil), which reaches the rate of almost 100 percent of cesarean deliveries. In addition to maltreatment, physical or verbal coercion, the collective and indiscriminate practice of cesarean sections constitute obstetric violence. This is a public health problem and directly affects the rate of maternal mortality. WHO states that cesarean operations are only recommended when there is medical justification and that the ideal rate is 15 percent of total deliveries. In Brazil, it exceeds 80 percent . The conclusion is that there is numerous legislation that promotes the right to dignity in childbirth but without their full compliance. The absence of integrity programs and the adoption of unified measures among those involved to change illegal practices, naturalize violence and trivialize women's rights. Recommends the adoption of positive actions in order to eradicate and prevent obstetric violence and consequently guarantee the inalienable women´s rights.

Keywords: Obstetric violence, Women's rights.

Introduction

The Universal Declaration on Bioethics and Human Rights, adopted by Brazil, sets forth principles and procedures in order to guide the State in the formulation of its legislation, policies and other bioethical instruments. It should be emphasized that the patient's rights to autonomy, consent, and clear and unambiguous information were enshrined in the Declaration (UNESCO, 2006).

It should be clarified that many Brazilian legislations are unified in this sense. All patients have the right to clear information, including deaf patients with legal guarantees of accessibility and adequate treatment in health care (Brasil, 2002). Everyone has the right to consent to any treatment or intervention that may be submitted, except at the imminent risk of death, as provided in article 15 of the Civil Code (Brasil, 2002) and articles 22 and 24 of the Code of Medical Ethics, (CFM, 2009).

Despite the right to information and consent to be consolidated in the legal system, Brazil still presents cases of extreme violation of these rights at the time of delivery, which constitutes obstetric violence. This issue will be elucidated through two case analyzes that will be explored in this article.

According to the testimony of victims underway ministered at the Association of Deaf and Hard of Hearing Women of Goiás on November 4, 2018, recorded on video, many deaf women do not have interpreters at the time of childbirth. In spite of reproductive rights and family planning, there is an incidence of sterilization through tubal ligation without the consent of the deaf patient, which demonstrates a clear violation of the right to information and consent (Dias, M. & Machado, 2018).

Another extreme case in Brazil, here described, refer to the city of Trindade-GO, which has a population estimated at 125,328 inhabitants (IBGE, 2018). This municipality is marked by a place where women do not have the option of giving birth via vaginal delivery, because births occur only by surgical procedure, via cesarean section. It should be noted that the only public hospital in the city that performs births, HUTRIN (Trinity Emergency Hospital), offers only cesarean surgeries once a week and previously scheduled (Dias, M. & Machado, 2018).

The Constitution of the Federative Republic of Brazil establishes as fundamental rights that everyone is equal before the law and that no one shall be obliged to do or not to do anything other than by virtue of law (Brasil, 1988). Thus, except in case of risk of death, no one can be constrained to undergo, medical treatment or surgical intervention (Brasil, 2002). The collective induction to perform cesarean surgery constitutes a violation of the reproductive rights of patients who depend on the public health system of the city of Trindade-GO.

The disrespect for human rights at the time of childbirth and the objectification of the woman by the health team sets Obstetric Violence:

> "Any conduct, act or omission by a health professional, whether public or private, that directly or indirectly leads to the misappropriation of women's bodily and reproductive processes, and is expressed in inhuman treatment, abuse of medicalization and pathologization of processes natural, leading to the loss of autonomy and the ability to freely decide on their body and sexuality, negatively impacting the quality of life of women "(DINIZ, 2014).

It is estimated that one in four women suffered some type of Obstetric Violence (ABRAMO, SESC, 2013). It should be mentioned that on December 4, 2018, during a public hearing, the Federal Public Prosecutor's Office, through the Regional Attorney Sérgio Lauria Ferreira, recognized obstetric violence as a sexual violence against women (DINI, 2018).

It should be mentioned that, in addition to all of the above, obstetric violence also constitutes acts committed by the doctor, hospital staff, doulas, family member or companion who offends, in a verbal or physical way, pregnant women in labor, in puerperal or in situations of abortion (Dias, M. & Machado, 2018). Also, do not inform about the procedures or perform them without consent, as well as make the pregnant or parturient believe that it requires cesarean section when it is not necessary, using imaginary or hypothetical risks not proven and without the due explanation of the risks that reach it and the baby is also considered as obstetric violence (GOIÁS, 2017).

It is important to mention that the spread of the term "Obstetric Violence" has bothered the medical profession. In this sense, the opinion document no. 32/2018 reads as follows:

> The term "obstetric violence" is an assault on the medicine and specialty of gynecology and obstetrics, contrary to established scientific knowledge, reducing the safety and efficiency of good care and ethical practice (CFM, 2018).

For CFM, the term Obstetric Violence should receive another designation, such as "Childbirth Violence", so as not to harm the specialty of gynecology and obstetrics and not negatively impact the safety and efficiency of the practice of care and ethics (CFM, 2018).

It should be noted that obstetrician gynecologists are not responsible for all deliveries. In some cities midwife activity in births is common. In addition, Brazil has law nº 7498/86, in force since 1986, which regulates the practice of nursing in the figure of obstetricians or midwives (Brasil, 1986).

Methods

The present multiple case study combines qualitative methods, such as: (a) extensive literature review, with focus in up to date Brazilian Laws, which are the current limitations of this article; (b) direct participation and observation by one of the authors, (c) descriptive case studies (Yin, 1988), and finally, (d) qualitative interviews. The cases have two unit of analysis: (i) the case of cesarean delivery involving obstetric aggression to a hearing impaired (Yin, 1988), and (ii) the Trindade case, county of the Goiás state, center-western Brazil. The primary data were collected through a semi-structured in-depth interview, based on Goffman's (1959, 1961) dramaturgical theory. N = 2 interviewees were invited via e-mail, because of their physical restrictions (auditive impairness), with 100 percent response rate. All respondents answered one hundred percent of the four questions posed, plus any additional questions raised during the interview. All the interviews were carried out respecting the native language, that is, Brazilian Portuguese, with the assistance of a translator to Libras. Citation were formally allowed. In Vivo codes were applied, to "honor the voice of the participant" (Saldaña, 2013, p.91). The primary data were then analyzed using text analysis. Secondary data were investigated through archival research based on data available from Federal, State Laws. The research is also limited to the Brazilian Laws on obstetric violence.

Trindade Case: Background

This section analyzes the case of the city of Trindade-GO, which has a rate of almost 100 percent cesarean section (MPGO, 2018) and its effects. The following section reviews the analysis of the Gisele case, a deaf woman who did not have an interpreter at the time of delivery (Dias, M. & Machado, 2018) together with a testimony of another deaf woman in perfect mental capacity who also had no access to communication in the and was subjected to sterilization without consent. The analysis will be made under the light of current legislation. Subsequently, the subject is expanded by discussing the position of the Federal Medical Council on the obstetric violence debate, lessons learned in the cases and best practices to be adopted.

Goiás is a Brazilian state that has one of the highest birth rates through cesarean surgery, reaching a rate of 67 percent (Guedes, 2018). The city of Trindade in the State of Goiás presents a rate of almost 100 percentcesarean section in the public health network (Dias, M. & Machado, 2018).

It is worth noting that besides being not more beneficial to the baby in most cases, the surgical procedure of the cesarean section is in line with higher rates of maternal death, about four to five times more than vaginal delivery (AMORIM, SOUZA, PORTO, 2010). According to the World Health Organization, the ideal cesarean rate is around 15 percent (WHO, 2015). The indiscriminate cesareans position Brazil as the second country with the highest cesarean rate reaching 55 percent , behind only the Dominican Republic. It is noteworthy that in the private health sector the cesarean section procedures reach the rate of 90 percent (MPF, 2018).

For instance, in Finland only 17 percent of deliveries are performed by cesarean surgery (Loiola, 2016). In 2015, the Nordic country obtained the maternal mortality rate of 4 deaths per 100,000 live births, while Brazil obtained the rate of 62 deaths per 100,000 live births, a figure almost 3 times higher than Chile (Collucci, 2018), as depicted in Figure 1, as follows:

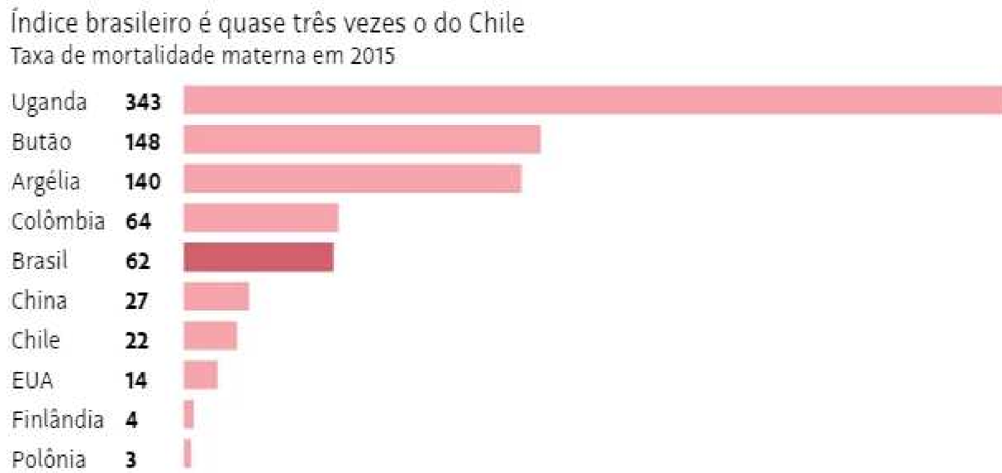

Figure 1. C-sections per coutry, Source: WHO, 2018. Reprinted under permission.

The Federal Council of Medicine (CFM), has shown that in cases of habitual risk, 20.6 percent is the maternal mortality rate for every 1000 cesareans, while the normal birth rate is 1.73 percent (MPF, 2018).

According to the World Health Organization, 287,000 women died of complications during pregnancy, childbirth and the puerperium in 2010 (WHO, 2014). In the face of this global context, for many years, countries have been struggling to reduce maternal mortality. In the year 2000, 191 countries adopted the objective to reduce maternal death. An opportunity that Brazil has agreed to reduce maternal mortality to 35 deaths per 100,000 live births by the year 2015, but the goal has not been reached. The result was 62 deaths per 100,000 live births in 2015, a figure that increased to 64 in 2016 (Brasil, 2016), as depicted in Figure 2, as follows:

Figure 2. Maternity taxes. Source: Brasil, 2016. Reprinted under permission.

The fifth millennium report mentioned that high rates of caesarean sections were an obstacle to success in reducing maternal mortality (Brasil, 2016). Studies show that the benefits brought to the fetus by cesarean section are small and related to the increase in perinatal morbidity and mortality (Amorim, Souza, Porto, 2010).

It is common to find difficulties in determining gestational age without the occurrence of errors (Pereira et al, 2014). The high rates of cesarean sections have been an alert as an important factor related to prematurity (Pedraza, 2013).

According to CFM, some studies, such as the Defining "Term" Pregnancy Workgroup, organized by the American College of Obstetricians and Gynecologists (ACOG), found that babies born before the 39th week could present with health problems and food difficulties. In view of this reality, on June 22, 2016, Brazil's Resolution No. 2144/2016 of the Federal Medical Council, CFM, was published in Brazil, which defined that elective cesarean section could only be performed as of the 39th week. Prior to the definition of this criterion, usual risk deliveries could be performed from the 37th week of gestation. (CFM, 2016).

Thus, prior scheduling of mass cesarean surgeries, such as in the city of Trindade-GO, besides violating rights and exposing women to risk of death (Dias, M. & Machado, 2018), can cause harm to the baby's health. Because of the fact that gestational age may be incorrect (Pereira et al, 2014) and scientific studies indicate that it is not healthy for a baby to undergo cesarean section before the 39th gestational week (CFM, 2016).

The process to achieve the effectiveness of the right to a decent birth finds resistance not only in inner cities like Trindade, but also at the national level. For example, contrary to scientific evidence and public policy, Federal Deputy Professor Victorio Galli proposed Law No. 5887/2016 in an attempt to overturn the resolution of the Federal Medical Council and authorize cesarean sections after 37 weeks. Project that was rejected by the merit committees and subsequently filed.

In a public hearing held on October 23, 2018, the Federal Public Prosecutor's Office acknowledged that obstetric violence is a sexual violence against women, and stressed that the high rate of cesarean delivery is a source of shame for the country, a crime against women who are exposed to the risk of death (Dini, 2018).

It is noteworthy that, with the advent of Brazilian Federal Law No. 10778/2003, gender violence began to be considered as a public health grievance (Dias, M & Machado, 2018). Therefore, through a systematic interpretation, it is concluded that the reality faced in the State of Goiás, especially in the municipality of Trindade, is a public health problem.

Gisele Case: Background

This section reviews the Gisele case, a deaf woman who did not have the right to the interpreter at the time of delivery (Dias, M. & Machado, 2018). She also mentions similar cases, which highlights the report of a deaf woman who delivered without proper communication and went through a procedure of tubal ligation without any consent, deepening the topic under discussion.

Giselle Lorenny Milhomem is a deaf woman who has had distressing moments in her delivery due to being deprived of the presence of her companion and having access to communication. All procedures and interventions were performed without prior clarification of the patient (Dias, M. & Machado, 2018).

On November 4, 2018, during a lecture called Dialogues on Obstetric Violence and the rights of deaf women that occurred in the Association of Deaf and Hard of Hearing Women of Goiás, there were reports of obstetric violence suffered by numerous deaf women who participated in the event, according to testimonials recorded on video. Among the testimonies recorded by video, the most common complaint is that deaf women did not have interpreters at the time of delivery, which made communication difficult and impaired understanding of the procedures that would be performed. Another recurring claim is about the violation of the right of the companion.

The most significant testimony during that event was a deaf woman, ACFS, that the identification will be kept confidential, which reports that during childbirth the victim was subjected to ligature without consent resulting from an agreement between the victim's mother and the doctor . They decided to perform a sterilization, they did not inform the parturient about the sterilization, which only knew that she could not have more children years later. He mentioned that her case is not isolated, which also happened

with several deaf people. He reported with great regret and indignation, through the interpreter of Libras Lucélia Fernandes, who:

> She (the victim's mother) did not have an education, a respect for me. And me, why? I am deaf? Many friends, too, have already happened, of the mother becoming pregnant and not knowing why she had a single child and she was rejected because she is deaf.
>
> She (the victim's mother) never gave me that role she gave clearance, no role whatsoever I went, and ... ligament surgery. My family thinks I'm silly, but I know how it is, I understand!
>
> (...)
>
> Many deaf people are passed on as ignorant, stupid and have a very big prejudice. We are humiliated, apologize, but they think I'm going to have sex with anyone, anyway, and have a child anyway. It's not like this! (Interviewee #1).

Note that the said sterilization of the deaf woman without consent occurred by a combination of the patient's doctor and the patient's mother. It occurs that the Brazilian family planning law prohibits sterilization without consent, before the age of 25 and for a woman who has less than two children (Brasil, 1996).

It is emphasized that the medical act of sterilization contrary to the provisions legally violates articles 14 and 15 of the Code of Medical Ethics, which determines the following prohibitions:

> Art. 14. Practice or indicate medical acts unnecessary or prohibited by the legislation in force in the Country.
>
> Art. 15. Failure to comply with specific legislation in cases of organ or tissue transplants, sterilization, artificial fertilization, abortion, manipulation or gene therapy.

See, in spite of reproductive rights and family planning, there is an incidence of sterilization through tubal ligation without consent of the deaf patient, which demonstrates a clear violation of the right to information and consent (Dias, M. & Machado, 2018).

From the reports of deaf women, the complete disregard for their physical conditions, which were manipulated as objects in the hands of the health team, without respect for their fundamental rights and guarantees.

It should be clarified that the doctor has professional autonomy, so he can refuse to practice medicine in situations and institutions that do not provide care respecting the accessibility of communication to deaf women. In deciding to act in disregard of the law, the health professional assumes responsibility for acting with negligence, for not ensuring the proper communication before performing a procedure. Sections III and IV of Chapter II of the Code of Medical Ethics provides as the rights of the physician, as follows:

> III - To point out faults in norms, contracts and internal practices of the institutions in which he works when he judges them unworthy of the practice of the profession or injurious to himself, to the patient or to third parties, and must address, in such cases, to the competent bodies and, obligatorily , the ethics committee and the Regional Medical Council of its jurisdiction.
>
> IV - To refuse to practice their profession in a public or private institution where the working conditions are not worthy or may harm their own health or that of the patient, as well as that of other professionals. In that case, it shall immediately communicate its decision to the ethics committee and to the Regional Council of Medicine (CFM, 2018, Sections III, IV)

According to Aguiar, the frequent result of these violence is the patient's exposure to unnecessary suffering and that have impacting and irreparable consequences (Aguiar, 2010).

Performing sterilization of women without consent is not a case restricted to deaf women. According to a study carried out in Peru, health professionals performed cesarean sections for profit, sterilized the patients using the public service, by means of tubal ligation or withdrawal of the uterus, without the patients' knowledge to meet sterilization targets or quotas (CLADEM & CRLP, 1998). It is worth noting that in Brazil, the use of sterilization for demographic control is prohibited by Law 9663/96, sterilization without consent violates the fundamental human rights (Brasil, 1988).

In spite of the reproductive rights and freedom of family planning to have legal protection (Brasil, 1996), in 2018 the country witnessed the case of the compulsory sterilization of the homeless woman Janaína Aparecida Quirino, who was given by judicial order of the judge of law Djalma Moreira Gomes Júnior, from the 2nd branch of Mococa / SP (Migalhas, 2018), due to a request made by the Public Prosecutor of São Paulo with the justification that Janaína was a homeless, had several children and was a drug user.

Subsequently the decision authorizing compulsory sterilization was reformed by the Court of Justice of the State of São Paulo, but irreversible surgery had already been performed, which caused irreparable damage to the victim. The case gained great repercussion and representative entities from all over the country presented a rejection note and opposed the abusive judicial act (Migalhas, 2018).

The objectification of the patient, the naturalization of violence and the trivialization of women's rights are fundamental pillars of institutional violence, a theme that was addressed by Aguiar (Dias, M. & Machado, 2018), as follows:

> Structural difficulties, personal and professional training, and the impunity of these acts were pointed out as causes for institutional violence. The reports also demonstrated a banalization of institutional violence through jargon of a moralistic and discriminatory nature, used as a joke by professionals; in the use of threats as a way of persuading the patient and in the naturalization of the pain of childbirth as the price to be paid to become a mother. (AGUIAR, 2010, p.10)

It should be mentioned that the Inter-American Convention on the Prevention and Eradication of Violence against Women (Brasil, 1994) states that the State must act to modify legal or customary practices that support the persistence and tolerance of violence against women, all possible measures to eradicate gender violence (Dias, M. & Machado, 2018).

It is noteworthy that Brazil may be tried by the Inter-American Commission on Human Rights, in case of denunciations of these state violations and the ineffectiveness of public policies (Dias, M. & Machado, 2018).

Discussion

This section encourages some of the key points of the article and the analyzes of the cases presented earlier, of deaf women and the city of Trindade. Furthermore, it expands on the theme mentioning Brazilian public policies that guides the improvement of the health care of women and the baby, as well as the Federal Medical Council's view on obstetric violence. In the conclusion, later section, the discussion concludes with a deep reflection on the subject, showing lessons learned about the case, as well as recommendations for prevention and elimination of obstetric violence in Brazil.

The main reasons for maternal death are hypertension, hemorrhage or infections. The Ministry of Health points out that 92 percent of deaths during gestation, delivery or even 42 *post partum* are preventable (MS, 2018). It should be mentioned that babies are also harmed by inadequate care at birth. Caesarean surgeries are interrelated with prematurity and interventions during labor and birth, still frequent in Brazilian reality, which are factors associated with neonatal mortality (França et al, 2017).

Health based on scientific evidence and the adoption of adequate practices are topics of growing debate in Brazil and in the world. Improving and enabling health professionals to adopt clinical practice

based on best scientific evidence is an essential measure to prevent and eradicate obstetric violence and improve quality of care during childbirth, postpartum and puerperium (WHO, 2014).

Childbirth is recognized as a physiological event in women. Thus, the collection of scientific evidences, as well as the adoption of the non-intervention at the moment of delivery to prevent the woman from being subjected to painful and unnecessary procedures, is related to the humanization movement of the patient care (Rebello et al, 2012).

Since 1985, Brazil has been discussing adequate childbirth care, the year in which it hosted the international and interdisciplinary meeting between the WHO and the Pan American Health Organization in the city of Fortaleza, CE. The event welcomed several professionals who represented multiple areas of the health, including physicians, which led to the writing of the document entitled "Appropriate Technologies for Birth" (Costa, 2015).

Since then numerous laws have emerged that protect women and children. The Federative Constitution of Brazil protects motherhood, childhood and family planning (Brasil, 1988). In 1990, Brazil explicitly recognized the right to a decent birth and adequate care for mothers with the promulgation of the Convention on the Rights of the Child (Brasil, 1990).

It should be noted that the rights of persons with disabilities are also guaranteed by the Brazilian Federal Constitution (Brasil, 1988). Accessibility to communication is guaranteed by Laws 10,098 / 2000 and 10,436 / 2002 (Dias, M. & Machado, 2018), as well as by Decree No. 9,656 / 2018.

The lack of interpreters in health care impairs diagnosis and adequate service delivery. This situation does not only occur in maternity hospitals. In 2018, the Public Prosecutor filed a Public Civil Action for the State of Rondônia to provide health care to the hearing impaired through a pound interpreter (SECOM, 2018).

Communication is an essential pillar to provide due care and safeguard the rights to information, autonomy and patient consent. The World Health Organization recommends that women be actively involved in the decision-making process (WHO, 2014). In this way, the barrier of inaccessibility to communication impairs the rights of deaf women (Dias, M. & Machado, 2018).

In order to improve birth attendance, Brazil has adopted programs of good practices and good conduct, which aims at reducing maternal and infant deaths as well as reducing the high rate of caesarean sections. In the year of 2000, through the Ordinance / GM nº569, of 1/6/2000, the Ministry of Health instituted the Humanization Program in Prenatal and Birth.

In 2011, the Stork Network (*Rede Cegonha,* in Brazilian Portuguese), was created, a strategy of the Ministry of Health that aims to implement humanized neonatal care, pregnancy, childbirth and the puerperium, (Ministério da Saúde, 2011). In 2014, Ordinance No. 371 of 2014 of the Ministry of Health established guidelines for the organization of comprehensive and humanized care for the newborn (RN) in the Unified Health System (SUS), (Brasil, 2014).

Subsequently, the national guidelines for normal birth assistance were consolidated by the Ministry of Health with the support of numerous collaborators. It should be mentioned that the drafting group was composed of ten members with the following representation: 70 percent of physicians, 10 percent of obstetrician nurses, 20 percent of other support areas (Ministério da Saúde, 2017).

Despite the various measures to improve delivery at birth, the result was not satisfactory (ABRAMO, SESC, 2013). As a result, numerous women began reporting on abuses in social networks, and social movements emerged to denounce and spread facts that occurred during childbirth (CFM, 2018).

Social movements gained representativeness before the public power. In the document produced by the Ministry of Health: National Guidelines for Normal Childbirth Care, the advisory committee was represented by the Federal Council of Medicine, the Brazilian Nursing Association, the Federal Nursing Council, the Brazilian Medical Association, the Brazilian Federation of Gynecology and Obstetrics Associations, representatives of hospitals, as well as the NGO Artemis, the Parto do Princípio women network, the Network for the humanization of childbirth and birth, among others (Ministério da Saúde 2017).

The Federal Medical Council (CFM) issued report No. 32/2018 that recognizes the need for legislation, rules and protocols to achieve adequate care in the health care of the population. However, it

criticizes social activism and concludes that ordinances, official programs and frequent changes in the legislation of the Unified Health System question and decrease the participation of obstetricians. He argues that the implementation of public health policies deprives the use of proven and scientifically proven conduits. It also states that legislation on obstetric violence transfers all responsibility for inefficient and precarious access to health care for the obstetrician, which is done in an inconsequential way (CFM, 2018).

Legislation and draft laws that seek to prevent, punish, and eradicate obstetric violence in Brazil do not impute only medical professionals as aggressors. The state laws of Goiás nº 19.790 / 2017 and Santa Catarina nº17.097 / 2017, as well as the bill nº PL 7,867 / 2017, bring a plurality of possible aggressive agents. Obstetric violence is defined as the act practiced by the doctor, the hospital staff, a family member or companion, doulas and even third parties.

It should be noted that the opinion of the Federal Medical Council criticizes the birth plan. It should be clarified that the delivery plan is about disposition of wills, only a consolidated right of any patient (UNESCO, 2006). As mentioned exhaustively in this article, any patient has the right to information, to consent to procedures and interventions that will be submitted (CFM, 2009). Therefore, the right to the birth plan is not a regalia of the pregnant woman, it is only a practical form of the exercise of the right to autonomy and consent (Brasil, 2002).

Future Research and Limitations

The World Health Organization values the performance of multidisciplinary professionals during obstetric and neonatal care. Still, it advocates the understanding that childbirth is a physiological event and that women should be respected in the decision-making process. Medication and unnecessary interventions should be avoided (WHO, 2014).

Public power, public institutions, health care establishments, nurses, the multidisciplinary team and, above all, physicians play an important role in ensuring good behavior and practices in health care. In this way, data collection, research support. Efforts to prevent and deepen the understanding of obstetric violence are strongly encouraged for future research (Dias, M. & Machado, 2018).

It is also recommended to investigate the efficiency of the Brazilian law nº 13.460 / 2017. Thus, it is important to open a specific channel for the evaluation of the users of the health services, especially for women who were attended during pregnancy, at delivery, in the puerperium and in abortion situations. The creation of a transparency portal against obstetric violence and evaluation of health care are essential tools for subsidizing, adjusting behaviors and improving services, especially to meet quality standards.

Conclusion

The adoption of governance and integrity program by health institutions will give greater security to the procedures and will bring clarity to the decision making process, which will positively reflect the conduct of all those involved.

Finally, it is remarked that only by integrating all those involved to work together with the same vision that can be successful to solve the demands that hinder the quality of health care, restrict and violate the rights of women and children at birth.

References

1. Aguiar, Janaína Marques (2010). Violência institucional em maternidades públicas : hostilidade ao invés de acolhimento como uma questão de gênero / Janaína Marques de Aguiar. -- São Paulo, 2010. Tese(doutorado)-- Faculdade de Medicina da Universidade de São Paulo. Departamento de Medicina Preventiva
2. Arruda, K.G. M. ; Montagner, M. I. ; Montagner, Miguel Ângelo (2017) . A violência obstétrica: o que nos contam alguns números da pesquisa da rede Cegonha no Sistema Único de Saúde-SUS. In: Lídia de Oliveira

Xavier, Carlos Federico Dominguez Avila, Vicente Fonseca. (Org.). *Direitos Humanos, Cidadania e Violência no Brasil: estudos interdisciplinares*. 1ed.Curitiba: CRV, 2017, v. 5, p. 297-312.

3. Dias, Murillo de Oliveira; Machado, Valeria (2018). Obstetric Violence in Brazil: an Integrated Case Study In: *International Journal of Nursing, Midwife and Health Related Cases (IJNMH)*, Vol 4, Issue 6, December 2018, pp. 20-28.
4. Dini, Aline (2018). Violência obstétrica é um tipo de violência sexual, reconhece MPF, 2018 Retrieved from: <https://goo.gl/SUiDf7>. on 23 de December 2018
5. Diniz, (1997). Assistência ao parto e relações de gênero: elementos para uma releitura médico-social. 1997. Dissertação (Mestrado) - Faculdade de Medicina, Universidade de São Paulo, São Paulo.
6. Brasil (2002). Governo Federal. Código Civil Brasileiro. Lei nº10.406/2002.
7. Brasil (1994) Governo Federal. Convenção Belém do Pará. Decreto nº1.973/1994.
8. Brasil (1990). Governo Federal. Estatuto da Criança e do Adolescente. Lei Federal 8.069/1990.
9. Brasil (2010). Lei de Notificação compulsória. Lei Nº10.778, de 20 de julho de 2010;
10. Ministério da saúde (2000). Secretaria Executiva. Portaria nº569/2000
11. Ministério da saúde (2005). Secretaria Executiva. Portaria nº 1.067/2005;
12. Ministério da saúde (2014). Secretaria Executiva. Portaria nº371/2014;
13. Ministério da saúde (2017). Secretaria Executiva. Portaria 353/2017;
14. CLADEM & CRLP(1998). Silencio y Complicidad. Violencia contra las mujeres en los servicios públicos de salud en el Perú. Lima: Comité de América Latina y el Caribe para la Defensa de los Derechos de la Mujer (CLADEM) y Centro Legal para Derechos Reproductivos y Políticas Públicas (CRLP); 1998.
15. Collucci, Claudia(2018). Mortalidade materna sobe, e Brasil já revê meta de redução para 2030, 2018. Retrieved from: <https://goo.gl/2KRUX9 >. on December 25, 2018.
16. França, E. ; Rego, M. ; Malta, D.; França, J.; Teixeira, R.; Porto, D. ; Almeida, M. ; Souza, M. ; Szwarcwald, C,; Mooney, M. ; Naghavi, M.; Vasconcelos, A. (2017) . Principais Causas Da Mortalidade Na Infância No Brasil, Em 1990 e 2015: Estimativas do estudo de carga global de doença. In: *Revista Brasileira de Epidemiologia*, V. 20, P. 46-60.
17. Goiás (2017), Governo Estadual. Política Estadual de Prevenção à Violência Obstétrica no Estado de Goiás. Lei nº 19.790/2017.
18. Guedes, Aline. Especialistas apontam epidemia de cesarianas no Brasil, 2018. Retrieved from: < https://goo.gl/HU76To > on December 25, 2018.
19. IBGE (2018). *População*. Retrieved from: <https://goo.gl/xjCxNt>. on December 27, 2018.
20. Lansky, Sônia et al. (2014) Pesquisa Nascer no Brasil: perfil da mortalidade neonatal e avaliação da assistência à gestante e ao recém-nascido. Cad. Saúde Pública [online]. 2014, vol.30.
21. Loiola, Rita. Cesariana: por que ela é uma epidemia no Brasil, 2016. Retrieved from: < https://goo.gl/kgaAPk>. on December 25, 2018.
22. CFM (2009). Código de ética médica. Resolução CFM – 1931/2009. Conselho Federal de Medicina.
23. CFM (2016). CFM define critérios para realização de parto cesariano, 2016. Retrieved from: < https://goo.gl/GzsqNY >. on 23 de December 2018
24. CFM (2009). Resolução nº2.144/2016. Retrieved from: < https://goo.gl/cYruhf>. on December 29. 2018.
25. Migalhas (2018). TJ/SP reverte decisão que mandou esterilizar mulher compulsoriamente, mas procedimento já tinha sido feito. Retrieved from: < https://goo.gl/AMfQdg>. on December 27, 2018.
26. MPF (2018). Assessoria de Comunicação Social. Alta taxa de cesáreas no Brasil é tema de audiência pública, 2018. Retrieved from: < https://goo.gl/K4BTTd>. on December 25, 2018.
27. ODM (2014). Objetivos de Desenvolvimento do Milênio: Relatório Nacional de Acompanhamento/ Coordenação:Instituto de Pesquisa Econômica Aplicada e Secretaria dePlanejamento e Investimentos Estratégicos; supervisão: Grupo Técnico para oacompanhamentodos ODM. - Brasília : Ipea : MP, SPI, 2014. 208 p. : il., gráfs., mapas color.
28. ONU(1993) (Organização das Nações Unidas). Eliminação da Violência Contra as Mulheres, Resolução no. 48/104, de 20 de dezembro de 1993.

29. Pedraza, Df; Souza, M. M.; Cristovao, F. S. ; França, I. S. X.(2014) . Baixo peso ao nascer no Brasil: revisão sistemática de estudos baseados no sistema de informações sobre nascidos vivos. Pediatria Moderna, v. L, p. 51-64, 2014.
30. Pereira, A. ; Leal, M. ; Gama, S.; Domingues, R. ; Schilithz, A.; Bastos, M.H.(2014) . Determinação da idade gestacional com base em informações do estudo Nascer no Brasil. Cadernos de Saúde Pública (ENSP. Impresso), v. 30, p. S59-S70, 2014.
31. Rebello, M.; Rodrigues Neto, J. (2012). A humanização da assistência ao parto na percepção de estudantes de medicina. Revista Brasileira de Educação Médica (Impresso), v. 36, p. 188-197, 2012.
32. Rede Parto Do Princípio (2012). Violência Obstétrica- "Parirás com dor". Dossiê elaborado pela Rede Parto do Princípio para a CPMI da Violência Contra as Mulheres, 2012.
33. São Paulo, Estado (2010), Autos nº 0017488.30.2010.4.03.0100. Ação Civil Pública. Poder judiciário. Comarca de São Paulo.
34. SECOMRO (2018). MP ajuíza ação para obrigar Estado a oferecer atendimento em Libras no Complexo Hospitalar de Cacoal. Retrieved from: < https://goo.gl/KE3L1c>. Acesso em :28 de December 2018.
35. SESC, ABRAMO (2010), Fundação Perseu. Pesquisa. Mulheres Brasileiras e gênero nos espaços público e privado. 2010.
36. TRF3 (2015), Assessoria de Comunicação Social, 2015. Médicos devem ser mais bem remunerados em partos normais. Retrieved from: < https://goo.gl/4ngmjJ>. on 28 de December 2018.
37. UNESCO (2005). Declaração Universal sobre Bioética e Direitos Humanos. Cátedra Unesco da Universidade de Brasília /Sociedade Brasileira de Bioética. Brasília, 2005.
38. Valadades, Carolina (2018). Ministério da Saúde investe na redução da mortalidade materna, 2018. Retrieved from:< https://goo.gl/Rbs9w2>. on December 25, 2018.
39. WHO (2018) recommendations: intrapartum care for a positive childbirth experience. Geneva: World Health Organization; 2018. Licence: CC BY-NC-SA 3.0 IGO.
40. WHO (2018b). Maternal Health and Respectful Maternity Care (2014). Retrieved from http://www.genderhealth.org/files/uploads/change/publications/RMC_Fact_Sheet_FINAL.pdf acessado em 04.09.18