








OBSTETRIC VIOLENCE AND THE CURRENT OBSTETRIC MODEL, IN THE PERCEPTION OF HEALTH MANAGERS

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ABSTRACT

Objectives: to understand the perception of managers of public maternity hospitals in the Metropolitan Region II of the state of Rio de Janeiro regarding obstetric violence and the measures to face it aiming at guaranteeing the quality of care.

Method: a descriptive, exploratory study with a qualitative approach, conducted with 16 health managers from five maternity hospitals in Metropolitan Region II in the state of Rio de Janeiro. Data were collected through interviews, applied from May 2017 to May 2018, and submitted to content analysis in the thematic modality.

Results: the research pointed out the non-reception, technocratic principles of childbirth, refusal of the companion, disrespect to humanized practices centered on physiology and the choice of women, the need for health training as a guide for the humanization policy and the management of health units, professional unpreparedness for performance and lack of involvement of professionals with longer service time to modify practices in obstetric care. Thus, the need to break away from obstetric violence at the structural/institutional level was evident in order to guarantee quality care for women.

Conclusion: it is the responsibility of the managers to provide training to health professionals regarding performance that respects the scientific evidence, the centrality and the axes of policies and recommendations in the area of sexual and reproductive health, especially to women regarding their autonomy.

DESCRIPTORS: Health management. Obstetrics. Obstetric nursing. Humanized birth. Humanization of assistance.

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VIOLÊNCIA OBSTÉTRICA E O ATUAL MODELO OBSTÉTRICO, NA PERCEÇÃO DOS GESTORES EM SAÚDE

RESUMO

Objetivos: compreender a percepção dos gestores das maternidades públicas da Região Metropolitana II do estado do Rio de Janeiro acerca da violência obstétrica e as medidas para o seu enfrentamento visando à garantia da qualidade da assistência.

Método: estudo descritivo, exploratório, com abordagem qualitativa, realizado com 16 gestores de saúde de cinco maternidades da Região Metropolitana II do estado do Rio de Janeiro. Os dados foram coletados por meio de entrevistas, aplicadas no período de maio de 2017 a maio de 2018, e submetidos à análise de conteúdo na modalidade temática.

Resultados: a pesquisa apontou o não acolhimento, princípios tecnocráticos do parto, impedimento do acompanhante, desrespeito às práticas humanizadas centradas na fisiologia e na escolha da mulher, necessidade da formação em saúde como norteador da política de humanização e da gestão das unidades de saúde, despreparo profissional para atuação e falta de envolvimento de profissionais com mais tempo de serviço para modificar práticas no cuidado obstétrico. Assim, ficou evidente a necessidade de romper com a violência obstétrica que está em nível estrutural/institucional a fim de garantir um cuidado de qualidade à mulher.

Conclusão: cabe aos gestores propiciar o processo de formação dos profissionais de saúde em prol de uma atuação que respeite as evidências científicas, a centralidade e os eixos das políticas e recomendações no campo da saúde sexual e reprodutiva, sobretudo à mulher quanto a sua autonomia.

DESCRITORES: Gestão em saúde. Obstetrícia. Enfermagem obstétrica. Parto humanizado. Humanização da assistência.

LA VIOLENCIA OBSTÉTRICA Y EL MODELO OBSTÉTRICO ACTUAL, EN LA PERCEPCIÓN DE LOS GESTORES DE SALUD

RESUMEN

Objetivos: comprender la percepción de los gestores de las maternidades públicas de la II Región Metropolitana del estado de Río de Janeiro sobre la violencia obstétrica y las medidas para su enfrentamiento con el objetivo de garantizar la calidad de la atención.

Método: estudio descriptivo, exploratorio con abordaje cualitativo, realizado con 16 gerentes de salud de cinco maternidades de la II Región Metropolitana del estado de Rio de Janeiro. Los datos fueron recolectados a través de entrevistas, aplicados de mayo de 2017 a mayo de 2018, y sometidos a análisis de contenido en la modalidad temática.

Resultados: la investigación señaló la no aceptación, principios tecnocráticos del parto, impedimento de la compañera, falta de respeto a las prácticas humanizadas centradas en la fisiología y la elección de la mujer, la necesidad de la formación en salud como guía para la política de humanización y gestión de las unidades de salud, falta de preparación profesional por desempeño y falta de participación de profesionales con mayor tiempo de servicio para modificar prácticas en atención obstétrica. Así, se hizo evidente la necesidad de romper con la violencia obstétrica que se encuentra a nivel estructural / institucional para garantizar una atención de calidad a las mujeres.

Conclusión: corresponde a los gestores brindar el proceso de formación de los profesionales de la salud en pro de una actuación que respete la evidencia científica, la centralidad y los ejes de las políticas y recomendación es en el campo de la salud sexual y reproductiva, especialmente para las mujeres en cuanto a su autonomía.

DESCRITORES: Gestión de la salud. Obstetricia. Enfermería obstétrica. Nacimiento humanizado. Humanización de la asistencia.

INTRODUCTION

Guarantee universal access to safe and quality sexual and reproductive health, focusing on women's rights, in particular human rights in childbirth and birth, which can contribute to the reduction of maternal and perinatal mortality rates, since the increase in technology in this scenario, by leaving aside the physiology of childbirth, brought the pathological aspect of pregnancy/childbirth that culminates in a depersonalization of women before childbirth and their autonomy for the right to choose.¹ In this way, women are no longer the leading figure in childbirth, with this role being assumed by the health professional, including decisions that, in principle, would be her decision alone.

It is agreed among scholars on the issue that obstetric care should focus on the quality of care, involved in a structure of care provided to women during their reproductive process, as well as their own experiences of care. Such care must be related to respect and the preservation of human dignity, which means that all forms of abuse, discrimination, neglect, detention and denial of services must be avoided.² Often, disrespect occurs due to the care model since, if the female condition of law is recovered, there will be an appreciation of women and their centrality, while disrespect can result in the current obstetric model whose focus is the technological model of caring for the figure of the institution and the health professional supporting care practices.³

Thus, the World Health Organization (WHO) is increasingly showing a concern with the care offered to women, their physiology and their bodies, making it impossible to use innumerable unnecessary procedures in obstetric care, which is currently supported by the technocratic model in the field of childbirth and birth. This model has an ideological bias that, due to the current demands of public policies and scientific knowledge, should, in its rupture, propose the possibility of increasing obstetric violence in the daily lives of countless maternity hospitals.³⁻⁵

In this sense, obstetric violence is an urgent issue that affects countless women around the world and should be understood as one of the main drivers of unequal results in maternal and child health as it is a term that labels dehumanization, disrespect, abuse or mistreatment in the area of sexual and reproductive health and human rights. Legally defined for the first time in Venezuela, in 2017, obstetric violence is understood as the misappropriation of the woman's body by the health professional, expressed by inhuman treatment and by the pathologization of natural childbirth processes, resulting in loss of women's autonomy and inability to freely decide on their bodies and sexuality.⁶

In this context, there is an urgent need for changes on the part of health professionals, managers and public policies regarding the confrontation of obstetric violence as a proposal to break the current obstetric model, aiming at the rescue of female autonomy with a focus on sexual, reproductive and human rights. Thus, the understanding of the complexity of obstetric violence runs through the managerial level, an important mechanism to sustain care that respects human dignity.

Thus, the following guiding question is asked: What is the perspective of maternity hospital managers regarding obstetric violence? Their perception of the theme is extremely important to promote coping measures, thus enabling respect for women and more quality care. In this sense, the study aimed to understand the perception of managers of public maternity hospitals in the Metropolitan Region II of the state of Rio de Janeiro concerning obstetric violence and the measures to face it aiming at guaranteeing the quality of care.

METHOD

Descriptive, exploratory research, with a qualitative approach, considered appropriate to the objective of the study, since it seeks to reveal the perceptions about the subjective data of individuals about a certain problem.⁷

The study participants were 16 managers from public maternity hospitals in the municipalities of Niterói, São Gonçalo and Maricá, namely: *Hospital Universitário Antonio Pedro*; *Hospital Estadual Azevedo Lima*; *Maternidade Municipal Dr.^a Alzira Reis Vieira*; *Maternidade Municipal Dr. Mario Nijjar*; *Hospital Conde Modesto Leal*, health care network units of Metropolitan II in the state of Rio de Janeiro. There was no withdrawal or refusal by managers to participate in the research.

The following inclusion criteria in the research were applied: being in full exercise of their activities in the health care unit; being a medical director or nursing director; being a medical coordinator or obstetric nurse coordinator. The exclusion criteria took into account the participants' length of service, thus preventing the participation of those with less than six months in the said positions.

Thus, the managers from each health unit were approached, when an attempt was made to establish an empathic relationship with the possible participants. Therefore, they were instructed on all the information relevant to the study, as well as their objectives and commitment to the researcher in order to comply with the ethical precepts established by Resolution No. 466/2012 of the National Health Council.

Together with the necessary guidance given to managers, an invitation was formalized to those who met the inclusion criteria. They were informed in detail about the Informed Consent Term (ICF) and the mechanisms for applying the research data collection. After acceptance, they were requested to sign two copies of the ICF, leaving one copy in their possession and the other with the researcher. At the time, everybody was informed that the anonymity and confidentiality of the respective information would be guaranteed using an alphanumeric code (G1... G16), which enabled the application of the data collection instrument.

In accordance with Resolution 466/2012 of the National Health Council, the study was approved by the Research Ethics Committee of the *Faculdade de Medicina do Hospital Universitário Antônio Pedro, Universidade Federal Fluminense*.

Data collection as performed through interviews conducted during the period of May 2017 in May 2018, consisting of open questions regarding the perception of managers in relation to obstetric violence. The participants' speeches were recorded on a digital device with their prior authorization and transcribed in full by the researcher in order to ensure the reliability of the testimonies; later, they were categorized. The collected data were organized according to the content analysis in the thematic mode.⁸

Therefore, the content analysis in the thematic modality proposes the analysis which takes place in three different poles, forming a specific script, explained below: 1) pre-analysis; 2) exploration of the material; and 3) treatment of results, inference and interpretation. In this case, two successive or interwoven phases of analysis are proposed, structural deciphering, centered on each interview, and thematic transversality, focused on the set of interviews, i.e., on thematic repetitions. This process highlighted the thematic units and, subsequently helped to analyze them according to the proposed objectives.⁸

Thus, after the identification of the Registration Units (RU), the colorimetry technique was adopted to identify and group the related RUs, which allowed an overview of the theme. The interviews gave rise to the following RU: technocratic assistance at delivery and birth; not linking the woman-centered care; institutional environment as a hindrance to care; failure to incorporate public policies in the care process; professional training/retraining for labor and childbirth; links between practice and models of childbirth care; management and its strategies to confront obstetric violence. In turn, these

RUs supported the construction of the thematic unit - Concept on obstetric violence: the meaning of managers, which supported the construction of the following thematic categories: 1) The interfaces of the concept on obstetric violence: the knowledge instituted in labor and childbirth care models; and 2) In-service training: an urgent strategy to face obstetric violence.

RESULTS

The interfaces of the concept on obstetric violence: the knowledge instituted in labor and childbirth care models

The participants pointed out the lack of reception as a sign of disrespect to the parturient within the maternity wards, which is considered a type of obstetric violence. This perception of managers is an aggravating factor in the field of childbirth and birth, since reception is one of the guidelines of public policies that establishes the guarantee of comprehensive care to women.

Disrespect for women in childbirth is that you don't give her the proper assistance she needs, right? From a technical and humanized point of view, this is disrespect to women in labor. You have to respect her will, you have to give her the best technique you have so that she has a good birth, respecting her will as much as possible, and that is reception of the woman's needs (G2).

Disrespect? Well, it starts with the initial approach, welcoming her, in which you no longer act with warmth and delicacy, in that moment she is beginning to face, which is the birth of a baby (G9).

Lack of respect, not treating her properly, not treating her the way you would like to be treated, I think that's it! I think that not calling them by name can be disrespectful (G13).

From the perspective of reception, it is identified in the statements of the managers that many health professionals work towards the humanization of childbirth, seeking to favor a good relationship with the pregnant woman, thus preventing any type of obstetric violence in the maternity hospitals related to not attending the woman's needs. It is important to emphasize that reception is an empathic relationship in which the basic principles of respect, the centrality of women and the humanization model of obstetric care prevail. Below are the testimonials on the subject:

When there is no reception, it is already disrespectful, it is linked to the fact that you do not offer this woman shared care with her husband or with whom she chooses, do not offer her all the information from the point of view of the physiology of pregnancy, or offer her all medications (G11).

Reception is about the humanization of labor and childbirth, disrespect for me is not to let this woman choose the child's birth path, to prevent her from having her companion close to her at the time of hospitalization, at the time of delivery or immediately after; not actively listening to this woman, this woman not having a certain place where her baby will be born (G14).

In the statements below, the principles and attitudes adopted during obstetric care are evidenced by managers, considering the current technocratic model.

It's us in training, I couldn't act on the technical issues of childbirth, work on good practices, we didn't offer, for example, or just the Swiss ball, walking, relaxing bath, we deprive her of this offer, that's all that happens today (G5).

We still see colleagues judging women, regardless of the woman's life and what she does with her life, because she got pregnant early, because she got pregnant late, or because she has 50 children. It is her problem and there are many professionals who say that: when you made the baby, you didn't scream, so you have to be quiet. This for me is disrespect, lack of humanization (G8).

We can consider that the lack of humanization is that you are not committed to qualified assistance, that there is no human relationship in the professional relationship, which is a concept of humanization (G15).

It can be seen in these statements that there is poor professional training in the obstetric area is evident, leading to disrespect for women, their socioeconomic and gender status and their disqualification and blame, causing obstetric violence to prevail due to the relationships of inequality and/ or structural/institutional level.

In this context, managers highlighted the importance of Federal Law No.11,108, of April 7, 2005, known as the "Companion Law", as a public policy to be followed by health institutions to guarantee respect for women, although the provision was not considered viable and applicable in the units surveyed, resulting in the impediment of the presence of the woman's companion in the pre-delivery, delivery and immediate post-delivery, thus configuring an obstetric violence of a structural/institutional character that needs to be corrected in a timely manner.

It is the right of the companion, there are even several, for example, here at the hospital this companion's law does not happen, do you understand? Here in the maternity hospital, there is no way, today here in the hospital, we don't even have it for the structural part, even the technical part, you know? Unfortunately, we can't do it (G1).

We have the Companion Law, but it is not always possible, comfort for this companion too, sometimes I work a lot with patient care, but the things related to it is very important, the culture, the family that comes. be it the father, the grandmother, so, sometimes, it is a mother who is not prepared to be a grandmother at that moment and she is the companion, then it is complicated (G3).

So, we have Law 11.108 that guarantees the free choice of companion, I will not remember them all now, but we have good practice policies for labor and childbirth. (G5).

According to the testimonies, some rights of the pregnant woman have not been guaranteed, such as receiving guidance on childbirth; the procedures that would be performed by the health professionals; freedom of movement during labor; the choice of position for the expulsion period; relaxation techniques to relieve pain; immediate mother-baby contact shortly after birth. It is worth mentioning that these rights are also part of public policies of international and national institutions and their non-compliance represents obstetric violence in the structural/institutional field that prevents women from receiving qualified care.

In obstetric care today, the most recent are the standards for monitoring childbirth by the Ministry of Health, which is our determination [...] to determine conduct, even care, regarding the procedures adopted in labor (G4).

Provide guidance on pregnancy, prepare the patient for entering the maternity ward, convince patients what labor is like, I know why my contact is by phone, WhatsApp, everything that happens, one patient or another who is part of the pregnant women group, teenage pregnant women, pregnant women with problems, they are always mobilizing (G6).

Only one manager referred to the humanization of the care provided to women in the case of abortion, a situation that has the potential to result in obstetric violence.

One of the public health policies [...] a public policy that is difficult to work with, this is the issue of disrespect, it exists, but the professionals do not always accept this, from childbirth interventions; it is the question of humanization, humanization started in 2000/2004, to what extent can we humanize women in the abortion process? (G16).

In-service training: an urgent strategy to face obstetric violence

In their statements, the managers showed the importance of training health professionals in assisting expecting women as a political and institutional framework for guaranteeing quality care.

Here in the obstetric block I do training with all of them [health professionals], so here are just those people who have that kind of feeling with the patient, this is discussed in groups, these courses are for all professionals (G8).

We work a lot together with the guidelines of Rede Cegonha which advocates this, exactly good practices, so, we work a lot in order to promote normal childbirth, multidisciplinary, interdisciplinary monitoring with obstetric nurses, with psychologists, with physical therapists, not only with the doctor, shared training (G11).

Nowadays, we have been working on guidance, I have worked with the team, the issue of guidance, training, health professionals when dealing with this woman, both in terms of approach and the right that this woman has to have a companion, the right that this woman has to make the choices she deems necessary, monitoring (G12).

Difficulties were also highlighted in promoting the training of health professionals with longer service and training time, since they react negatively to the changes implemented. Below are the statements which highlight this:

The strategies are broad, the orientation and training of people and teams and the conviction that is the most important, but the older ones are more reluctant to change, these are more difficult, so we have bad practices, but we are changing (G4).

We made a great advance here in our maternity hospital, from the formation of the in-service team, the older members are resistant, they do not make progress in good practices, but, even before the law was passed, the Companion Law, we already started taking the first steps to keep a companion together with women admitted to our maternity unit, nowadays it works, we have also made several attempts to make the hospital a Baby Friendly Hospital (G14).

Exactly this, we have a great difficulty with the older staff, we are making changes, for example, the physical structure due to constructions, we have to improvise, so the environment is very exposed, it is not restricted, separated with curtains, so it is difficult, they repeat outdated practices, but there are only a few, we are adapting to the changes well (G15).

Promoting health professional training is one of the guiding axes of the humanization policy and is one of the functions of the manager of public maternity hospitals, focusing on the quality of care as an institutional mission. Corroborating this statement, the participants showed that there are many graduated health professionals working in the area of sexual and reproductive health who are clearly unprepared to work in the obstetric area.

I let professional maturity lead. When I graduated, my condition was one and throughout my learning, during the exercise of my activity, it became another, but there is a lack of training (G2).

In my team, I try to call my colleague and ask how he would like to be treated, that is not enough, we have to exchange experiences, update knowledge (G13).

Participants also reported that some health professionals demonstrated ignorance in relation to the good interventionist practices used during childbirth, which could establish a relationship between these practices and obstetric violence in the structural/institutional field, supported by the autonomy of these professionals.

When I graduated, the standard prescription, when the woman entered the maternity hospital was zero diet and hair removal. If she was in labor, it was glucose. Today we have to listen to women and understand the scientific evidence (G4).

I don't see obstetric violence when a person performs a Kristeller maneuver when it is necessary, when it is necessary, I think it's great. There are many doctors who do it when it is not necessary. It is violence, the Kristeller maneuver is very violent in childbirth, forceps, the "episode", sometimes out of laziness to wait for humanized delivery, the right time, go there and cut, forceps. Here, in so many years, I only saw one delivery with forceps (G8).

Continuing the same theme regarding the lack of knowledge to work in the obstetric area, a participant made the following reflection:

What I think is most important after all my experience is a frank conversation between patient and doctor, many things are resolved with guidance and with dignified treatment and the way to speak directly with patients, this is good practice (G7).

However, through the statements of the managers, it is evident that the obstetric area, even with all the advances in public policies, still needs several ruptures, mainly regarding the implementation of the humanization model and the insertion of obstetric nursing in the practical field of care to the woman in the process of labor and childbirth.

In my experience, advances in teamwork and humanization, nowadays I see the monitoring of nurses specifically working both in the outpatient clinic and in the maternity ward, before I did not see that (G12).

We have a challenge ahead because our maternity unit works as a team, today it is under construction and we are working with reduced hospitalization capacity, but we have a big challenge that we want our team to be composed of obstetricians and midwives (G14).

DISCUSSION

According to the authors of a study,⁹ the reception and attachment of the pregnant woman are essential for the development of a new concept of care and are opposed to the current arrangement of obstetric and neonatal care in Brazil, constituted by the institutionalization and medicalization of childbirth and birth. In addition, there is a fragmentation of the health networks with issues regarding the flow of referrals and counter-referrals in the care of the process of gestating and giving birth, especially in the qualified access of women in the reproductive process, making it impossible to hold health professionals responsible, leading to the conclusion that it is necessary to expand co-management among the health care network.⁹

In this sense, another study¹⁰ points out that the current strategy of the *Cegonha Network* with the objective of improving obstetric care translates into a reference for reception and risk classification in the maternity hospital, in that women are linked from primary care. This guarantees attendance, but it requires the involvement and awareness of health professionals and the exercise of their empathy for ethical obstetric care.

The authors¹¹ affirm a care inherent to the human being, an ethical and empathic care, which is essential for the development of human relationships and interactions, which makes the health space one of the environments that require a lot of attention, since they are those where the human being needs humanized care, and assistance is one of those pillars of care. The health professional must safeguard respect for women in the field of childbirth and birth as the rights to quality care that meets their needs and their understanding as a human person, encompassing biological, psychological, social and cultural aspects.

This care, according to the managers' perception, supports safe, comprehensive, empathic and ethical care, which perpetuates respect in this care relationship, not situations prone to obstetric violence, since, when this empathic process with the other is not the human characteristic, there is an imminent violence against the female figure in the field of care and also in relation to disrespect in the way in which the approach is given to her, to her desire and to humanized treatment.^{2,11} Thus, there is a need to break away from the obstetric model focusing on the humanity of women, on their condition that must be respected, with a view to guaranteeing care that meets their expectations and desires. The important person in this context is the woman herself, who has the actions to direct care, in a perspective shared in the autonomy exercised in her body.³

As observed in the statements made by the managers, obstetric violence is inserted in the principles of the technocratic model of childbirth and birth, supported by the autonomy of the health professional, in view of their ideal in the context of obstetric care, in which many do not follow the scientificity of obstetric care and act according to their ideals.^{1,3-4} These ideas are supported by participative management in the process that culminates in obstetric violence. Thus, management must guarantee respectful care supported by scientific evidence.

Thus, there must be a good relationship between women and health professionals to promote more humanized and holistic care.¹¹ This is a process that must be implemented by management with the qualification process of the Health Unit, incorporating the humanized co-participation model as an institutional mission, since this humanized model, according to the authors,¹² must break with the structures still inserted in obstetric training, with qualified doctors and nurses in order to rescue the value of women and their centrality of care, as well as the insertion of humanized practices in order to promote women's autonomy.

In addition, women are disqualified with the introduction of numerous statements of discrimination and prejudice regarding their socioeconomic status and their relationship regarding their sexuality and reproduction. The power relationship between the health professional who blames their reproductive condition is inserted in an obstetric violence in the structural/institutional field, supported by the inequality of power.¹³ In this context, the management of health units must work to unify centered care on women, free from discrimination and prejudice.

Since 2005, Law No. 11,108, known as the 'The Companion law', determines the health service's obligation to allow a companion accompany women in labor, childbirth and the immediate post-partum period. In order to regulate the presence of the companion in the public and private spheres, other documents were also published so that this right was guaranteed to all pregnant women and, above all, respected by the health care institutions.¹⁴ Thus, it becomes a legally earned right due to the humanization movement and the collective of women, therefore, its guarantee must be respected and its cancellation contributes to the insertion of institutional protocols, which are administered by the unit's management, a participative management in the veiled annulment of women's rights.

In this sense, pregnant women are often prohibited from having a companion of their choice to support them in the birth process due to the care practices adopted in health services.¹⁵ Thus, the lack of structure becomes a support for the disrespect to women, but the health manager must ensure that their right to free choice is respected, as established by *Rede Cegonha*, which allows the financing of new units and modernizations of the hospital structure with the purpose of guaranteeing the right to the companion. Thus, the dissolution of this right constitutes a platform for obstetric violence, represented by the structural/institutional field, based on the rules and routines instituted in obstetric care.

The humanization model recommends respect for women regarding the right to a safe birth, with the receipt of information regarding the care offered, the guarantee of freedom and autonomy over their bodies, pain relief techniques, in addition to skin-to-skin contact after birth and late umbilical cord clamping. These humanized practices support care centered on the parturient.^{3,6} Therefore, the testimonies of the managers affirm that when the professional does not respect these guidelines, they favor obstetric violence, given their autonomy exercised over her body, as the acceptance of obstetric conduct becomes acceptable to women and health professionals.

There is a need for the qualification in health management as a process to face obstetric violence. Maternity hospital managers need to implement co-management as proposed by *Rede Cegonha*, including health professionals, managers and users in discussions on the implementation of norms, routines and missions of maternity hospitals, favoring a qualified and safe reproductive health care offer.

Permanent education in health was described in 1978 by the Pan American Health Organization “as a dynamic teaching and learning process, active and continuous, with the purpose of analyzing and improving the training of people and groups, in the face of technological developments, social needs and institutional objectives and goals “. ^{16,332} Thus, the training of health professionals, especially those who perform obstetric care, constitutes an indispensable management process for improving the quality of care and professional performance, ensuring the development of professional competence, with the objective of acquiring knowledge, skills and attitudes to interact and intervene in reality, in addition to contributing to the recurrent problems of lack of professional training.¹⁷

Thus, when there is a participative management in the care of women during labor and childbirth, the training of health professionals and the improvement of quality is allowed. Thus, the trained professional understands the dimensions of care and, as a result, training is a tool for coping with obstetric violence.

It is verified in the statements of the managers that the culture of obstetric violence is sustained in the practical daily practice of obstetric care, because the more experience the professional has, the more difficult training becomes to enable changes in the care practices of women in the process of childbirth. It is noteworthy that the manager has been appointed by public health policies as the professional capable of transforming this reality of dehumanization and obstetric violence which women experience during labor and childbirth. To achieve this goal, they must consolidate their knowledge so that, based on scientific evidence, they can face the identified obstacles, make appropriate decisions and guarantee a qualified, safe, happy, healthy birth process free of harm.¹⁸

The training of health professionals is one of the guiding axes of the Humanization Policy, described in the current National Permanent Education Policy approved in 2003, as a proposal to change the institutional reality.¹⁶ The lack of professional qualification regarding obstetric care demands can contribute to the promotion and support of obstetric violence. Therefore, professional improvement is essential as a way of coping with obstetric violence.

In this context, the lack of knowledge or interest in learning non-interventionist childbirth practices means guaranteeing unqualified and unsafe care, in addition to the disrespect for women, culminating in the spread of obstetric violence situations caused by the introduction of practices such as routine episiotomy and Kristeller’s maneuver, among others. Thus, in view of the statements of the managers, it is clear that the idea of humanization must always emphasize practices based on scientific conformity for the moment of delivery.

Regarding the interventionist behaviors, the importance of the manager in the scenario of care during labor and birth is emphasized, since they have the possibility to promote health training in the institution and can show the need to link the practice with the scientific evidence, in addition to the sensitive care and the rescue of the role of women in the birthing process.¹⁹ This confrontation of management creates a new possibility to guarantee quality care, breaking away from the structure of the humanization model for childbirth and birth.

This rupture in the model of care during childbirth and birth is necessary to change practices in caring for women and to face obstetric violence. And, when shared care is instituted, with multidisciplinary teamwork, with the obstetrician and obstetric nurse, it is guaranteed that care is directed to women. Including her health demands and needs and is always in favor of respecting her condition and the physiology of childbirth.

It is recognized that maternity hospital managers are important agents of transformation from the technocratic model for the humanized model, since reproductive health care must be developed in accordance with the principles of national and international public health policies, especially in dealing with any form of obstetric violence experienced by women in the gestation and birthing process.

The impossibility of maintaining contact with health managers who were performing management activity or who were in a meeting with the organization of the institution at the time of data collection is pointed out as a limitation thereby reducing the number of participants.

CONCLUSION

Confronting obstetric violence is necessary, according to the managerial level of health institutions, to ensure care that is focused on respect for women and their autonomy, as well as for the physiology of childbirth and birth. Thus, the managers' understanding of the problem and the reaffirmation with the humanization model favor that the woman is respected.

It is noteworthy that the managers presented a broad concept about obstetric violence, according to their professional experience and also as their understanding of the theme. However, even with the global view on the concept of obstetric violence, there were "traces" of care focused on technocracy in its management, but already in a process of transformation, driven by public health policies in the field of sexual and reproductive health, in particular the *Rede Cegonha* strategy.

As for in-service training, Permanent Education in Health was highlighted as the main training tool for health professionals to reduce obstetric violence rates in maternity hospitals. Permanent education, for these managers, ensures the development of professional competences aimed at acquiring knowledge, skills and attitudes to interact and intervene in reality, in addition to contributing to the solution of problems arising from poor or a lack of training.

It is hoped that this research has contributed to the identification of actions used by managers to tackle obstetric violence, a focus that is not centered on a health professional, but on the management, assistance and organizational structure of the health care network of women in the area of reproductive health, allowing to conclude that supporting the care model assumed by the management in the maternity facilitates the involvement of health professionals in the configuration of qualified and safe work process for women and their babies during delivery and birth.

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NOTES

ORIGIN OF THE ARTICLE

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CONFLICT OF INTEREST

There are no conflicts of interest.

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