Original Article

Institutional violence reported by birth companions in public maternity hospitals

Violência institucional referida pelo acompanhante da parturiente em maternidades públicas

Violencia institucional relatada por acompañante de parturienta en maternidades públicas

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Abstract

Objective: To estimate the prevalence and the factors associated with institutional violence against women during hospitalization for delivery, as reported by companions.

Method: Cross-sectional study conducted in three public maternity hospitals in the metropolitan region of Florianópolis, Santa Catarina, with 1,147 birth companions. Data were obtained through structured interviews conducted from March 2015 to May 2016. Data analysis was performed using single and multiple Poisson regression.

Results: Institutional violence against women was more frequently reported by male companions, who were partners of the women and/or father of the baby (74.7%). At least one type of violence was mentioned (73.5%). Structural (59.2%) and physical (31.4%) violence were the most prevalent. The factors associated with the outcome were term vaginal deliveries, occurred between Tuesday and Friday, and higher level of education of the companion.

Conclusion: The results of this study show that the presence of the companion does not prevent the occurrence of institutional violence. The prevalence of structural, physical, psychological and verbal violence against women during childbirth, as reported by the companion, points to the need for macrostructural changes to ensure care free of violence, with respect to women's role and rights.

Resumo

Objetivo: Estimar a prevalência e os fatores associados à violência institucional contra a mulher durante o parto referida pelo acompanhante.

Método: Estudo transversal, realizado em três maternidades públicas da Região Metropolitana de Florianópolis, Santa Catarina, com 1.147 acompanhantes de parto. Os dados foram obtidos por meio de entrevista estruturada, no período de março de 2015 a maio de 2016. Na análise dos dados empregou-se regressão de Poisson simples e múltipla.

Resultados: A violência institucional contra a mulher foi relatada com maior frequência pelos acompanhantes do sexo masculino, que eram companheiro e/ou pai do bebê (74,7%). Foi mencionado pelo menos um tipo de violência (73,5%), sendo os tipos estrutural (59,2%) e física (31,4%) os mais prevalentes. Os fatores associados ao desfecho foram o parto vaginal, a termo, ocorrido entre terça e sextas-feiras e a maior escolaridade do acompanhante.

Conclusão: Os resultados desse estudo mostram que a presença do acompanhante não impede a ocorrência da violência institucional. As prevalências de violência estrutural, física, psicológica e verbal contra a mulher

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durante o parto, relatadas pelo acompanhante, apontam para a necessidade de mudanças macroestruturais, que garantam o atendimento livre de violências, com respeito ao protagonismo e aos direitos da mulher.

Resumen

Objetivo: Calcular la prevalencia y los factores relacionados con la violencia institucional contra la mujer durante el parto relatada por el acompañante.

Métodos: Estudio transversal, realizado en tres maternidades públicas de la Región Metropolitana de Florianópolis, estado de Santa Catarina, con 1.147 acompañantes de parto. Los datos se obtuvieron mediante entrevista estructurada, en el período de marzo de 2015 a mayo de 2016. Para el análisis de los datos se empleó regresión de Poisson simple y múltiple.

Resultados: La violencia institucional contra la mujer fue relatada con mayor frecuencia por los acompañantes de sexo masculino, que eran el compañero y/o el padre del bebé (74,7%). Se mencionó por lo menos un tipo de violencia (73,5%) y las más prevalentes fueron la estructural (59,2%) y la física (31,4%). Otros factores relacionados con el desenlace fue el parto vaginal, a término, que ocurrió entre martes y viernes y una mayor escolaridad del acompañante.

Conclusión: Los resultados de este estudio demuestran que la presencia del acompañante no impide que ocurran episodios de violencia institucional. La prevalencia de violencia estructural, física, psicológica y verbal contra la mujer durante el parto, relatada por el acompañante, indica la necesidad de cambios macroestructurales que garanticen una atención sin violencia y con respeto al protagonismo y a los derechos de la mujer.

Introduction

Institutional violence (IV) results from unequal power relations in the interaction of subjects within an institution.[1] In obstetric care services, IV occurs in situations where the organizational structure and professional conduct cause harm to women, to the infant and to the family.[2] Disrespect and abuse during childbirth, also known as obstetric violence (OV), are manifestations of IV.[3-5] However, OV is characterized by intentionality and there is no standardized definition of typology and criteria for its identification in different contexts,[6,7] justifying the use of the term IV in this study.

Despite advances in health policies, IV against women during hospitalization for delivery remains disguised in care flows and has an unknown magnitude. It is estimated that approximately 25% of women who have given birth in Brazilian maternity hospitals in recent years have experienced some kind of violence, with a higher prevalence of violence among black women, with a lower level of education, in the public sector and without a companion.[8,9]

In Brazil, the presence of a companion during hospitalization for delivery is a right provided by law, but enjoyed by less than 30% of parturients.[4] The companion is usually part of the social network of the woman and provides her with comfort and safety, contributing for physiological delivery and satisfaction with birth.[10-14] In facility-based childbirth, the companion is an external evaluator of the care provided and is able to perceive the IV within the care protocols during the woman's hospitalization.[15-17]

In this context, the investigation of IV against women during hospitalization for delivery, from the perspective of the companion, can be an indirect measure and contribute for the elaboration of strategies to combat and prevent the problem. It is worth noting that, in Brazil, companions, regardless of their relationship with the women, are part of their support network, which has various roles in childbirth, including social control. The objective of this study was to estimate the prevalence and the factors associated with IV against women during hospitalization for delivery, as reported by companions in public maternity hospitals in the metropolitan region of Florianópolis (MRF), SC.

Methods

Cross-sectional study, part of a macro project approved by the Research Ethics Committee of the Federal University of Santa Catarina (protocol 541.296, CAEE 25589614.3.0000.0121). The study was conducted in the three largest maternity hospitals of the MRF, which are regional references in obstetric care and allow the presence of the companion during hospitalization for delivery, which is why they were selected for the study.

The study population was the birth companions. Those who stayed with the parturient during labor and childbirth were eligible. Women who did not speak or understand Portuguese, who had a multiple pregnancy, who had an urgent or elec-

tive cesarean section, who did not enter labor or women or newborns who did not survive were excluded.

The sample size was calculated considering the number of births in each maternity hospital in the year prior to the study planning (2013), with an estimated prevalence of 50%, confidence level of 95% and maximum error of 5%. The sample size calculated was 307 companions in Maternity A, 349 in Maternity B and 346 in Maternity C, totaling a minimum sample of 1,002 companions.[10] No specific probabilistic methods were used to select the subjects, as it was an intentional sample.

Of all the births that occurred in the maternity hospitals during data collection, 4,299 companions were identified, of which 4,004 were eligible. Among those who were eligible, 2,541 were not found by the interviewers during hospitalization, so the invitation to participate in the study was not possible. A total of 1,463 companions were invited, of which 289 (20.1%) declined the invitation. The time of the interview was the most frequent reason for non-acceptance. In the end, 1,147 companions participated in the study.

Data was collected between March 2015 and May 2016 through a structured electronic interview, conducted individually with the companions, during the women's hospitalization for delivery, in a private location. The interview consisted of closed questions about socio-demographic characteristics; previous experience as a pregnancy/birth companion; participation in prenatal, childbirth and postpartum and satisfaction with current experience. The construction of the instrument was based on the researchers' experience in women's health care, on the literature on the inclusion of birth companions in facility-based childbirth and on the national labor and childbirth survey "*Nascer no Brasil*".[18]

The data collected were reviewed daily, enabling the identification and correction of inconsistencies.[10] After the completion of data collection, part of the interview was replicated by telephone contact in a random sample of 5% of participants from each maternity ward, in order to compare interview responses. No inconsistencies were identified.

In this study, four of the seven categories of disrespect and abuse in obstetric care proposed by Bohren et al.[3] were used to construct the IV indicators. The categories were structural, verbal, physical and psychological abuse. Thus, if the companion reported that the parturient was a victim of at least one of the four types of violence, it was considered as a case or outcome of interest. For this purpose, the interviews included a set of nine questions addressing the care received at the institutions.

Structural IV is identified as non-care and/or poor care due to inadequate infrastructure, lack of human and material resources, unavailability of beds, and institutional routines that cause harm to the parturient. The questions used to estimate its frequency were: "Did health professionals offer liquids and/or food to women during labor?", "Was the place where labor and delivery occurred adequate?", "Was there professionals available to meet the demands of the woman at all times?". All questions were answered with "yes" or "no". A negative answer to at least one of these questions was considered as a case of structural violence.

Verbal IV, described as harsh treatment, threats, scolding, screaming and cursing perpetrated by health professionals during obstetric care, was investigated through the question "Was the woman exposed to any situation of verbal violence?". Answers were "yes" or "no" and positive answers were considered cases of verbal IV.

Shoving, painful and repeated exams, procedures that were harmful to health, restriction of movement and forcing the parturient to be in unwanted positions are situations considered as physical IV. In this study, it was assessed by the questions: "Was the woman exposed to any physical violence?" and "Was the woman lying down with her legs raised during normal delivery?". Answers were "yes" or "no" and positive answers were considered cases of physical IV.

Psychological IV is characterized by threats, denial of care or of pain relief, abandonment of care, intentional humiliation, embarrassment, imposition of decisions, disqualification of the woman's opinion, provision of dubious or false

information, trivialization or neglect of the woman's pain or of her needs. This type of violence was determined when the companion answered "yes" to the question "Was the woman exposed to any psychological violence?" and/or "no" to the questions "Did the professionals explain to the pregnant woman what was happening during labor? "and "Was the information related to the progress of labor passed on to women in a clear and easy to understand manner?".

The variables selected to characterize the birth in which the companion was present were: type of birth (vaginal birth or cesarean surgery), classification of birth according to the gestational age referred by the companion (term or premature), period of the week in which birth occurred (Saturday, Sunday and Monday, Tuesday to Friday); shift (day [7 a.m. – 7 p.m.], night [7:01 p.m. - 6:59 a.m.]) time spent next to the parturient from hospitalization to birth (in hours).

The variables used for the socio-demographic characterization of the companions were: gender (male, female), age (in years), self-reported skin color/race (white, black/indigenous, brown/yellow), education (in years of education) civil status (married/stable union, single/divorced/widowed), relationship with the woman (partner and father of baby, mother/sister/friend), previous experience with childbirth (yes, no), participation in pregnancy/childbirth course (yes, no), participation in lecture on pregnancy/childbirth (yes, no).

Data analysis was performed using single and multiple Poisson regression, with HC3 consistent covariance matrix estimator[19] to estimate the prevalence ratio (PR) of the companions who reported any type of IV against women during hospitalization for delivery in relation to those who did not. Regression analysis was performed in two steps. In the first, by simple regression, the association of each covariate was evaluated separately in relation to the outcome, selecting only the covariates with p-value<0.2. In the second stage, multiple Poisson models were tested. After obtaining the final model, possible interactions between: report of any type of IV versus age of the companion, report of any type of IV versus education of the companion and report of any type of IV versus childbirth classification were tested.

In all steps, the likelihood ratio test was used as a criterion for selecting variables and models. Confidence intervals for the PR of the final model were estimated at 95%. Data were analyzed using the statistical program R, version 3.3.2.

Results

Most respondents were male (76.9%), self-reported as white (53.8%); had a median age of 30 years (interquartile range=24-37); median level of education of 10 years (interquartile range=7-11) (data not shown); were married/in a consensual union (79.7%); were the partner and father of the baby (76.7%), remained with the parturient for a median time of eight hours (interquartile range=4-13) and had no previous experience as birth companions (76.0%). In addition, most of the respondents had not participated in childbirth courses (96.9%) or in lectures on pregnancy/childbirth (92.1%). Most participants were companions in a term (91.3%) vaginal delivery (75.1%) from Tuesday to Friday (60.6%) during the daytime (54.6%) (Table 1). Reports of IV against women during hospitalization for delivery were more frequent among male companions (74.8%), who were the women's partners and/or father of the baby (74.7%), who attended childbirth courses (73.2%) and lectures on pregnancy/childbirth (73.5%), and who were companions in term (73.5%) vaginal deliveries (77.6%), from Tuesday to Friday (75.9%) during the daytime (74.3%) (Table 1).

The percentage of reports of at least one type of IV was 73.5%. Structural IV was reported by 59.2% of the companions, physical IV by 31.4%, psychological IV by 15.9% and verbal IV by 3.5% (Table 2).

In the simple regression analysis, the covariates period of the week, shift, gender, skin color/race, civil status, previous experience as birth companion, participation in childbirth course and in lectures on pregnancy/childbirth presented p-values>0.20 . The

Table 1. Socio-demographic variables of the companion and of care, according to the reports of violence against women during hospitalization for delivery in public maternity hospitals

Variables	Report of institutional violence against women in childbirth		
	Yes n(%)	No n(%)	Total
Gender			
Male	658(74.8)	222(25.2)	880(76.9)
Female	183(69.3)	81(30.7)	264(23.1)
Self-reported skin color/race			
White	458(74.5)	157(25.5)	615(53.8)
Black/Brown	312(72.9)	116(27.1)	428(37.4)
Yellow/Indigenous	71(70.3)	30(29.7)	101(8.8)
Civil status			
Married/Consensual union	673(73.8)	239(26.2)	912(79.7)
Single/Divorced/Widowed	168(72.4)	64(27.6)	232(20.3)
Relationship with the woman			
Partner and father of the baby	655(74.7)	222(25.3)	877(76.7)
Mother/Sister/Friend	186(69.7)	81(30.3)	267(23.3)
Previous experience as birth companion			
No	645(74.1)	225(25.9)	870(76.0)
Yes	196(71.5)	78(28.5)	274(24.0)
Participation in childbirth course			
No	812(73.2)	287(26.8)	1109(96.9)
Yes	29(82.9)	6(17.1)	35(3.1)
Participation in lecture on pregnancy/childbirth			
No	775(73.5)	279(26.5)	1054(92.1)
Yes	66(73.3)	24(26. 7)	90(7.9)
Type of birth			
Vaginal delivery	667(77.6)	192(22.4)	859(75.1)
Cesarean section	174(61.1)	111(38.9)	285(24.9)
Classification of birth			
Term	767(73.5)	277(66.5)	1044(91.3)
Premature	74(74.0)	26(26.0)	100(8.7)
Period of the week			
Tuesday to Friday	526(75.9)	167(24.1)	693(60.6)
Saturday to Monday	315(69.8)	136(30.2)	451(39.4)
Shift			
Day	463(74.3)	160(25.9)	623(54.6)
Night	376(72.6)	142(27.4)	518(45.4)

Table 2. Prevalence of institutional violence against women during hospitalization for delivery, according to the type of violence reported by the companion (n=889)

Types of violence	n(%)	$CI_{95\%}$
Structural	634(59.2)	56.3-62.0
Physical	359(31.4)	28.7-34.1
Psychological	182(15.9)	13.8-18.0
Verbal	40(3.5)	2.4-4.6

covariate relationship with the woman was associated with the outcome but was removed in the selection of models. The covariate time spent next to the parturient (in hours) was not associated with the outcome, but was maintained in the final model to control confounding factors.

In the multiple regression analysis, three cases with missing data in the variables of this step were excluded (n=1,144). In the adjusted final model, the companions of parturients who had vaginal deliveries reported IV 1.48 more times than those who were companions in cesarean sections. On births between Saturday and Monday, the companions reported IV 17% less compared to the other days of the week. Each unit increase in time of education of the companion was associated with a 2% increase in the perception of IV. Birth companions of premature deliveries reported IV 30% less compared to companions of full-term deliveries (Table 3).

The final model tested the interaction between the covariates: reports of any type of IV versus age of the companion; report of any type of IV versus education of the companion; and report of any type of IV versus childbirth classification. All presented p-value>0.10 (data not presented in table).

Discussion

In the maternity hospitals in the MRF, more than 70% of the companions reported some type of IV against women during hospitalization for delivery. The associated factors were term vaginal delivery,

Table 3. Crude and adjusted prevalence ratio (PR) of institutional violence against women during hospitalization for delivery, as perceived by the companion in maternity hospitals (n=1144)

Variables	PR*($CI_{80\%}$)**	p-value (LR-test)***	PR****($IC_{95\%}$)**	p-value (LR-test)***
Type of delivery				
Cesarean section	1	<0.001	1	0.001
Vaginal	1.47 (1.32-1.63)		1.48 (1.26-1.73)	
Period of the week				
Tuesday to Friday	1	0.001	1	0.001
Saturday to Monday	0.82 (0.76-0.89)		0.83 (0.74-0.94)	
Education (in years of education)	1.02 (1.01 - 1.03)	0.005	1.02 (1.01-1.03)	0.012
Classification of delivery				
Term	1	0.009	1	0.008
Premature	0.71 (0.60 - 0.84)		0.70 (0.55-0.91)	
Time spent next to the parturient (hours)	1.00 (0.99 - 1.00)	0.491	1.00 (0.99-1.01)	0.977

*Crude prevalence ratio; ** 80% confidence interval; *** Likelihood ratio test; **** Prevalence ratio according to adjusted final model

occurred between Tuesday and Friday, and with companions with a higher level of education. To the best of our knowledge, this is the first study on IV against women during obstetric care from the perspective of the companion.

The percentage of reports of at least one type of violence against women during hospitalization for delivery (73.5%) is close to that reported by puerperal women (70%) in a national study and in countries in Africa.[20-23] Social discrimination is one of the determinants of IV and it is very common in public maternity wards, where the majority of users belong to the lowest social classes.[8,24]

Vaginal delivery is a risk factor for IV, as it is commonly associated with the behavior of the parturient – considered inappropriate by the team –, with longer stay in the institution and with the socio-cultural construction of childbirth as an event of pain and suffering.[25,26] The increase in the chance of IV reports made by companions of vaginal deliveries in the maternity hospitals of the MRF was similar to that found in other studies with mothers in different parts of the world.[2,3,5,9,21,27]

The fact that birth companions of premature deliveries in the MRF reported less IV against women showed that it is a protective factor. This may be explained by the severity of the situation, which demands greater attention from caregivers to avoid the worst outcome, and by the tension and concern of the companion and of parturient, which might make it more difficult to perceive any violence.

Complaints of poorer care in hospital settings are more frequent on weekends.[22] However, in this study, companions reported 17% less violence in the period from Saturday to Monday, which may be explained by the higher number of students from health courses during weekdays. The number of people who interact with the parturient and her companion can lead to situations of violence, especially due to communication failures.

A higher level of education increases access to information and supports individuals to claim their rights, as the findings of the study suggest. Access to information about pregnancy, childbirth and hospitalization also helps the companions, making them empowered to identify and combat IV.[13,15,28]

The choice of the partner and father of the baby as birth companion was observed in other studies.[15,16,29] Diniz et al.,[4] in a national study on the inclusion of companions between 2011 and 2012, found better results in maternities in the South and Southeast regions (22.6% and 23.1%). However, the results of this study suggest that there are still challenges to be faced.

The high prevalence of reports of structural IV made by the birth companion (59.2%) provokes a reflection on the organization of the service, staff sizing, care routines and adequate infrastructure for childbirth. Resolution no. 36 of the Brazilian Health Regulatory Agency in 2008 established the minimum conditions to ensure quality and dignified care for the parturient woman.[30] However, a decade later, serious human rights violations such as loss of autonomy and harmful practices to the physical and emotional integrity of parturient women still occur.[31]

A note of the Secretary-General of the United Nations about an approach based on Human Rights of abuse and violence against women in reproductive health services, elaborated in the Special Rapporteur of the UN Human Rights Department, points out that, in the context of maternal and reproductive health services, the conditions and limitations of the health system are underlying causes of abuse and violence against women during childbirth care.[32]

Moreover, the existence of violence in obstetric care is associated with the culture of a childbirth based on the excessive use of technology, medicalization, professional control and intense suffering in the transition to maternity.[22,25,26,33] The national survey on obstetric care in Brazil showed that 65.5% of women who gave birth in maternity wards in 2011-2012 had their diet restricted, while 55% experienced mobility issues.[34]

Birth companions in public maternity hospitals in the MRF also reported physical IV against the parturient, with a prevalence (30%) close to those found in studies with women in Ethiopia (38.6%)

and Kenya (38%).[21,22] The similarity of this result with findings in countries with high social inequalities and few guarantees of rights, reinforces that social discrimination is a determinant of IV in childbirth.

Studies conducted with puerperal women in Brazil have reported lower prevalence of physical IV.[20,35] This difference between the reports from companions and from puerperal women can be associated with women's fear of denouncing the violence experienced, lack of knowledge about their rights, and tendency to minimize unpleasant situations prior to birth when the outcome is favorable.[31] Although companions are also emotionally involved and fragile, they are external agents who are able to observe the events with a more critical view. Methodological differences in the definition of physical IV may also have contributed to the differences found.[14,25,29]

Psychological IV, reported by caregivers (4.7%), is one of the most subtle and difficult to identify, as it is camouflaged in social relations and in the symbolic meanings of childbirth, with repercussions on women's lives.[4] Abandonment and neglect of the needs of parturient women are the most frequent manifestations of this type of violence, which is also associated with social and gender discrimination.[21,27]

The prevalence of verbal IV reported by the companions in this study was lower than that found by Lansky et al. [20] (33%) and by Mesenburg et al. [35] (10%), suggesting that the presence of the companion may reduce this type of violence, but is not enough to prevent it.[4,15,17]

A recent systematic review of the Cochrane Library conducted by Bohren et al (2019) pointed out that among the actions of the companions to improve the experience of women in childbirth is the fact that they can speak on their behalf when necessary.[12]

The limitations of this study include the fact that it was not designed to estimate IV against women during hospitalization for delivery, producing an indirect measure of outcome. In addition, the low number of studies with the companion as research subject restricts the comparison of findings with other scenarios.

Conclusion

The prevalence of structural, physical, psychological and verbal violence against women during childbirth, as reported by birth companions, shows that the presence of a companion does not prevent the occurrence of IV. The associated factors demonstrate that further progress is needed in the implementation of evidence-based practices and consolidation of the role of women as protagonists in their delivery in public maternity hospitals. For this, several barriers need to be overcome, especially in the attitudes and discourses of professionals and in the work process of the institutions. The high prevalence of IV reports made by companions reveal the gap between health policies and the reality of Brazilian maternity hospitals. Despite of the regulatory norms for obstetric care, there are still structural inadequacies, insufficient human resources and obsolete care flows which pose risks to the health of women and newborns. Further investigations with different methodologies are needed to unveil the potential of the companion as an agent of social control in relation to IV against women during hospitalization for delivery, contributing to the quality and safety of care.

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Collaborations

Marrero L and Brüggemann OM were responsible for the conception, methodological design, analysis and interpretation of the data. Junges CF participated in data collection and review of the submitted version. Scheneck CA and Costa R participated in the review of the submitted version.

References

1. Starr P. Professionalization and public health: historical legacies, continuing dilemmas. J Public Health Manag Pract. 2009;15(6 Suppl):S26-30.
2. Morton CH, Henley MM, Seacrist M, Roth LM. Bearing witness: united States and Canadian maternity support workers' observations of disrespectful care in childbirth. Birth. 2018;45(3):263–74.
3. Bohren MA, Vogel JP, Tunçalp Ö, Fawole B, Titiloye MA, Olutayo AO, et al. Mistreatment of women during childbirth in Abuja, Nigeria: a qualitative study on perceptions and experiences of women and healthcare providers. Reprod Health. 2017;14(1):9.
4. Diniz CS, d'Orsi E, Domingues RM, Torres JA, Dias MA, Schneck CA, et al. Implementation of the presence of companions during hospital admission for childbirth: data from the Birth in Brazil national survey. Cad Saude Publica. 2014;30(Supl): 140–53.
5. Organização Mundial da Saúde (OMS). Prevenção e eliminação de abusos, desrespeito e maus-tratos durante o parto em instituições de saúde. Genebra: OMS; 2014.
6. Sen G, Reddy B, Iyer A. Beyond measurement: the drivers of disrespect and abuse in obstetric care. Reprod Health Matters. 2018;26(53):6–18.
7. Sando D, Abuya T, Asefa A, Banks KP, Freedman LP, Kujawski S, et al. Methods used in prevalence studies of disrespect and abuse during facility-based childbirth: lessons learned. Reprod Health. 2017;14(1):127.
8. Leal MD, Szwarcwald CL, Almeida PV, Aquino EM, Barreto ML, Barros F, et al. Reproductive, maternal, neonatal and child health in the 30 years since the creation of the Unified Health System (SUS). Cien Saude Colet. 2018;23(6):1915–28.
9. Venturi G, Bokany V, Dias R. Mulheres brasileiras e gênero nos espaços público e privado. São Paulo: Fundação Perseu Abramo; 2010.
10. Junges CF, Brüggemann OM, Knobel R, Costa R. Support actions undertaken for the woman by companions in public maternity hospitals. Rev Lat Am Enfermagem. 2018;26(0):e2994.
11. Teixeirense MM, Santos SL. From expectation to experience: humanizing childbirth in the Brazilian National Health System. Interface Comun Saude Educ. 2018;22(65):399–410.
12. Bohren MA, Berger BO, Munthe-Kaas H, Tunçalp Ö. Perceptions and experiences of labour companionship: a qualitative evidence synthesis. Cochrane Database Syst Rev. 2019 Mar;3:CD012449.
13. Brüggemann OM, Koettker JG, Velho MB, Monguilhott JJ, Monticelli M. Monticelli Satisfaction of companions with the experience of supporting the parturient at a university hospital. Texto Contexto Enferm. 2015;24(3):686–96.
14. Souza KR, Dias MD. Oral History: experience of doulas in the care of women. Acta Paul Enferm. 2010;23(4):493–9.
15. Batista BD, Brüggemann OM, Junges CF, Velho MB, Costa R. Factors associated with the birth companion's satisfaction with the care provided to the parturient woman. Cogitare Enferm. 2017;22(3):45–53.
16. Dulfe PA, Lima DV, Alves VH, Rodrigues DP, Barcellos JG, Cherem EO. Presence of a companion of the woman's choice in the process of parturition: repercussions on obstetric care. Cogitare Enferm. 2016;21(4):1–8.
17. Souza SR, Gualda DM. The experience of women and their coaches with childbirth. Texto Contexto Enferm. 2016;25(1):1–9.
18. Vasconcellos MT, Silva PL, Pereira AP, Schilithz AO, Souza Junior PR, Szwarcwald CL. Desenho da amostra Nascer no Brasil: Pesquisa Nacional sobre Parto e Nascimento. Cad Saude Publica. 2014;30 Supl. 1:S49–58.
19. Cribari–Neto F, Galvão NMS. A class of improved heteroskedasticity-consistent covariance matrix estimators. Commun Stat. 2003; 32(10):1951-80.
20. Lansky S, Souza KV, Morais ER, Oliveira BF, Diniz S, Vieira NF, et al. Violência obstétrica: influência da exposição sentidos do nascer na vivência das gestantes. Cien Saude Coletiva; 2018; 24(8):2811-23.
21. Asefa A, Bekele D. Status of respectful and non-abusive care during facility-based childbirth in a hospital and health centers in Addis Ababa, Ethiopia. Reprod Health. 2015;12(1):1–9.
22. Abuya T, Ndwiga C, Ritter J, Kanya L, Bellows B, Binkin N et al. The effect of a multi-component intervention on disrespect and abuse during childbirth in Kenya. BMC Pregnancy Childbirth. 2015;15:224.
23. Sethi R, Gupta S, Oseni L, Mtimuni A, Rashidi T, Kachale F. The prevalence of disrespect and abuse during facility-based maternity care in Malawi: evidence from direct observations of labor and delivery. Reprod Health. 2017;14(1):111.
24. Nakano MS, Silva LA, Beleza AC, Stefanello J, Gomes FA. O suporte durante o processo de parturição: a visão do acompanhante. Acta Paul Enferm. 2007;20(2):131–7.
25. Castrillo B. Dime quién lo define y te diré si es violento. Reflexiones sobre la violencia obstétrica. Sex Salud Soc. 2016; (24):43–68.
26. Sadler M, Santos MJ, Ruiz-Berdún D, Rojas GL, Skoko E, Gillen P, et al. Moving beyond disrespect and abuse: addressing the structural dimensions of obstetric violence. Reprod Health Matters. 2016;24(47):47–55.
27. d'Orsi E, Brüggemann OM, Diniz CS, Aguiar JM, Gusman CR, Torres JA, et al. Social inequalities and women's satisfaction with childbirth care in Brazil: a national hospital-based survey. Cad Saude Publica. 2014;30 Suppl 1:S1–15.
28. Teles LM, Américo CF, Oriá MO, Vasconcelos CT, Brüggemann OM, Efficacy of an educational manual for childbirth companions: pilot study of a randomized clinical trial. Rev Lat Am Enfermagem. 2017; 25:e2996.
29. Monguilhott JJ, Brüggemann OM, Freitas PF, d'Orsi E. Nascer no Brasil: the presence of a companion favors the use of best practices in delivery care in the South region of Brazil. Rev Saude Publica. 2018;52:1–11.
30. Agência Nacional De Vigilância Sanitária (ANVISA). Diretoria Colegiada. Resolução no. 36 de 3, de junho de 2008. Dispõe sobre Regulamento Técnico para Funcionamento dos Serviços de Atenção Obstétrica e Neonatal. [Internet]. Diário Oficial da União: seção 1: Poder Executivo, Brasília (DF):ANVISA; 2008. p.50. [citado 2018 Jan 2]. Disponível em: https://www20.anvisa.gov.br/segurancadopaciente/index.php/legislacao/item/rdc-n-36-de-03-de-junho-de-2008.
31. Portela MC, Reis LG, Martins M, Rodrigues JL, Lima SM. Obstetric care: challenges for quality improvement. Cad Saude Publica. 2018;34(5):e00072818.
32. United Unions. Special Rapporteur on violence against women, its causes and consequences [Internet]. Geneva: United Unions; 2019 [cited 2019 Sep 16]. Available in: https://www.ohchr.org/en/issues/women/srwomen/pages/srwomenindex.aspx
33. d'Oliveira AF, Diniz SG, Schraiber LB. Violence against women in health-care institutions: an emerging problem. Lancet. 2002;359(9318):1681–5.

34. Baldisserotto ML, Theme Filha MM, da Gama SG. Good practices according to WHO's recommendation for normal labor and birth and women's assessment of the care received: the "birth in Brazil" national research study, 2011/2012. Reprod Health. 2016;13(S3 Suppl 3):124.
35. Mesenburg MA, Victora CG, Jacob SS, Ponce de León R, Damaso AH, Domingues MR. Disrespect and abuse of women during the process of childbirth in the 2015, Pelotas birth cohort. Reprod Health. 2018;15(1):54.