Actions and reactions to obstetric violence: a qualitative study about waterbirth

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Abstract

This text is part of a research carried out between 2015 and 2016 aimed to investigate the social representations developed by women who gave birth in water about this type of birth. This is a qualitative study carried out with women who experienced waterbirth in a public and private hospital in Portugal. This article is part of this research, seeking to focus on an important theme seized in this investigation: obstetric violence. We seek to discuss the forms of obstetric violence present in the reports of women who have experienced waterbirth. Methodologically, the research was qualitative, using the snowball technique for access to participants and interviews with them. As a result, the existence of resistance and reactions of women is highlighted who, by naming the practices of obstetric violence, including disrespect in the birth scenario, sought to break in different ways with the asymmetry of the relationship with the child health professional, either by silencing and seeking contact with another professional in the care relationship or by denying the impositions to which they were submitted.

Keywords: Waterbirth. Obstetric violence; Resistance and non-submission

1. Introduction

Pregnancy is especially marked by rites of passage (Van Gennep, 2011), surrounded by deep personal and cultural knowledge (Jolivet, 2011). Likewise, childbirth is constituted by important rites that reintegrate women into society, also pointing out to them a new function, motherhood.

As Van Gennep (2011, p. 53) develops, "the rites of childbirth aim to reintegrate the woman into the societies to which she previously belonged or to designate for her a new situation in general society, as a

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mother, especially when it comes to the first birth (...)".

Thus, giving birth is a significant event, also a generator of changes in women's lives, and requiring humanized care.

The humanization of childbirth care is a topic discussed by Dias and Deslandes (2006, p. 360), who highlight the need to define the term and the scope of its guideline. The author's highlight:

> as central structures of the humanization process (...): a) respect for the physiology of labor, guaranteeing the presence of companion(s) of the woman's choice and physical and emotional support for her and her family; b) compliance with the woman's wishes expressed in her 'delivery plan', built throughout pregnancy together with health professionals; c) environment for her to be the protagonist of these moments that are so full of human meaning for her.

However, for Misago et al. (2001) the dehumanization of childbirth has been tried and reported in several countries as an essential impediment to the use of specialized assistance in childbirth with different manifestations of disrespect and abuse. Contrary to the ethical principles advocated by the World Health Organization (WHO), such as respect, autonomy, beneficence, and non-maleficence, underlying the conceptual framework of the ethics of care, they should guide the care provided to women during labor and delivery (American College of Obstetricians and Gynecologists [ACOG], 2007).

According to Davis-Floyd (1993), there is an "excessive medicalization of childbirth", based on the model defined as technocratic, which has as its principle the separation between body and mind, seeing the body as a machine (Davis-Floyd, 2001). The technocratic model evidences the control of childbirth, based on the principle of risk or pathology, ensuring that medicalization and intervention are a safe way to give birth (Zanardo et al., 2017). This care model, which has been mostly used around the world, is considered to be responsible for "the high rates of maternal and child mortality in several countries, disrespecting the reproductive and sexual rights of women, reducing this social, cultural and health event to a pathological, medical and fragmented phenomenon" (Tornquist, 2003, p. 420). At the heart of these criticisms is the "cesarean epidemic" exemplifying the "excessive technological intervention on the woman's body and dynamics", points out the author.

Jolivet (2011) and Alliance (2011) bring the concept of "safe motherhood", which goes beyond the prevention of morbidity and mortality, encompassing respect for the basic human rights of women, including respect for autonomy, dignity, feelings, choices, and preferences of women.

It is important to highlight that the type of childbirth does not establish a direct relationship with the so-called humanization, as observed by Pedroso and López (2017) in a study on the experiences of normal childbirth in women in a public maternity hospital. The prerogatives related to humanization in childbirth occurred partially, where they observed excessive obstetric interventions. According to the study, women revealed the existence of intimidating practices that can be read as obstetric violence. Thus, obstetric violence in giving birth and being born is not an experience related to the type of delivery before, it is related to the (bad) provision of care by the professionals who attend to it.

This article seeks to focus on obstetric violence in a specific mode of childbirth: waterbirth. To this end, reports of women who lived this experience of waterbirth and who highlighted disrespectful situations that can be framed as obstetric violence are discussed. The text is part of research carried out in Portugal.

Some studies defend the benefits of the practice of waterbirth, which is defined as the result of complete

underwater fetal expulsion in warm water (Nutter, Meyer, Shaw-Batista, & Marowitz, 2014).

In 2018, one of these studies by Australian midwives highlighted the benefits of waterbirth in reducing pain, in maternal relaxation, and as a positive experience. Although they highlighted some concerns, they still advised the practice of waterbirth, reiterating the benefits documented in the literature and the minimal risk to the woman and baby (Cooper, Warland & McCutcheon, 2018). At the same time, these benefits are not achieved when situations of obstetric violence interfere with this experience of waterbirth.

1.1 Obstetric violence: circumscribing the understanding of the topic

Gender violence is at the center of discussions about obstetric violence (Pulhez, 2013). As pointed out by Diniz (2019), obstetric violence is a form of "dehumanization of women", which can manifest in different ways, such as: verbal insults at the time of childbirth; not offering analgesia; the prohibition of the presence of doulas, or people trusted by the mother; in addition to several other manifestations that show disrespect for women in different phases of the reproductive cycle. This same author assesses the naturalization of abuse by women who do not identify these practices as violent.

Tesser et al, (2015) highlight obstetric violence as the manifestation of different practices of mistreatment that occur during obstetric care performed by professionals. This mistreatment can be physical, psychological; it can be given by verbal expressions, but it also comprises routine and usually unnecessary and harmful procedures, as assessed by Miller et al (2016) such as: episiotomies[8], bed restriction[9], Kristeller[10], routine use of oxytocin[11], trichotomy[12], absence of a companion [13] , and even, excess cesarean.

Studies carried out on different continents, with women who reported having been victims of obstetric violence, show the existence of attitudes considered by them as impolite, rude, brusque, obnoxious, and indifferent, some of them treating women with shouting and reprimand (Bohren et al., 2015). D'Oliveira, Diniz, and Schraiber (2002) discuss the theme of obstetric violence, showing that such situations experienced by women in maternity hospitals were often so tense that women were afraid to ask for help, scream or express their pain for fear of suffering some reprisal.

In other studies, some psychosocial consequences were found in women who suffered obstetric violence, such as: anxiety disorders and the woman's refusal to seek the health service in case of morbidities resulting from complications in childbirth (Diniz et al., 2016); panic, phobia, OCD and post-traumatic stress (Guimarães et al., 2015); physical and mental illness (Barbosa and Mota, 2016); interference in the woman's

[8] Episiotomy is a surgical incision in the perineum, the region between the vaginal and anus introitus, performed at the time of delivery to anticipate the exit of the fetus and avoid local perineal trauma; however, systematic reviews show that in addition to not shortening the expulsive period, its routine use in addition to not preventing severe perineal trauma, it is a procedure that already causes perineal trauma. (Jiang et al., 2017).

[9] Bed restriction limits women from adopting vertical positions and not moving, making labor longer and increasing the need for analgesia (Lawrence et al., 2013).

[10] Kristeller is a pressure maneuver in the region of the uterus towards the woman's vagina so that the fetus is born in a shorter time, which increases the chance of causing perineal trauma, increases maternal discomfort, greater risk of inadequate adaptation of the newborn (Hofmeyr, Vogel, Cuthbert & Singata, 2017).

[11] Oxytocin is a synthetic hormone that increases uterine contractility, when used routinely in labor, it generates adverse effects, being a non-recommended practice (WHO, 2015).

[12] Trichotomy is the procedure for removing pubic hair with a razor after a woman's hospital admission for childbirth, but this practice increases the risk of bacterial infection, increases the risk of HIV and hepatitis infection for both the woman and for health professionals (Basevi & Lavender, 2008).

[13] The absence of a companion for the parturient, the absence of a person chosen by the woman, produces deleterious effects during childbirth, such as reduced maternal satisfaction, increases the duration of labor and the use of analgesia, increases the need for instrumental delivery and cesarean section, and increased risk of inadequate adaptation of the newborn (Hodnett et al., 2013).

relationship with a possible next pregnancy (Nascimento et al., 2017); sleep disorder.

WHO Guidelines (2018) states that all women are entitled to dignify and respectful care during the pregnancy-puerperal cycle. This same organization emphasizes that motherhood is a fundamental human right of all pregnant women and their babies, in such a way that the assistance provided by health professionals should be a better birth experience for women, with the absence of violence and discrimination during pregnancy and childbirth (WHO, 2018, 2014).

The non-compliance with these premises in the different phases of the reproductive cycle shows different modalities of obstetric violence that this article will seek to discuss. Therefore, the speeches of women on this theme will be privileged.

2. Methodology

Given the interpretative nature of the investigation, the research had a qualitative approach. As Martins (2004, p. 292) develops, "qualitative methodologies favor, in general, the analysis of microprocessors, through the study of individual and group social actions". It seeks "a close approximation of the data, to make it speak as completely as possible, opening itself to the social reality to better apprehend and understand it." Denzin, Lincoln (2006, p. 17), also highlight the complexity of the phenomena studied by qualitative approaches, defining qualitative research as "a set of material and interpretive practices that give visibility to the world" (Denzin, Lincoln, 2006, p. 17), and can be understood as a process of interpretation and understanding of the studied social reality, thought as dynamic and complex, constructed by different social 'actors', emphasizes Flick (2008).

Based on a qualitative approach, we investigated narratives of 21 Portuguese women about the experience of waterbirth, including prenatal and postpartum consultations. We found in this study that 14 of these participants reported having suffered some type of obstetric violence during pregnancy and childbirth. This verification took place through semi-structured interviews (Queiroz, 1983).

The duration of the interviews took an average of 60 minutes and took place from October 2015 to September 2016. The interviews were conducted according to the women's availability, in places such as home, work, cafes or squares, and others by videoconference. All were recorded on a digital device, after elucidation and voluntary signing of the Informed Consent Form, based on the Code of Ethics of the World Medical Association (Declaration of Helsinki) for experiments involving human beings. The investigation had ethical approval and was authorized by the National Data Protection Commission in Portugal.

To carry out the interviews, we used a semi-structured script with guiding questions about pregnancy (planning for a waterbirth), the experience of waterbirth, and the postpartum period. Although there were no specific issues related to obstetric violence, we evidenced them in the testimonies of the participants, in line with the considerations of Triviños (1987) who states that the questions bear fruit to new knowledge and hypotheses arising from the responses of the informants.

The inclusion criteria for this study were: women with 37 weeks or more of gestation, who experienced waterbirth in a hospital; who did not use medication to relieve pain during the birth process, and who reported having suffered some type of obstetric violence.

Study participants were recruited using the snowball technique. This technique consists of the researcher

asking each participant to suggest other possible participants from their social network be interviewed. It is a type of technique that is well suited to the focus of study that is centered on a delicate issue, such as obstetric violence.

The interviews were processed with management, storage, and processing in Microsoft Word® and Nvivo® version 10.0 programs to assist in the subsequent qualitative analysis. The analysis was carried out for this article through the interpretation of the speeches (Minayo, 2001), considering the reports of situations of abuse and disrespect, of different orders, not only the forms of violence that women suffered, but also the relationships and conditions that provided them, evidencing in this analysis, on the one hand, attempts at subjection by health professionals and, on the other, women's search for negotiation and resistance.

Below, we bring a table (Table 1) with the profile of the interviewees and we highlight some data from the interviews, referring to the experience of waterbirth.

Table 1. Characterization of the women interviewed who gave birth in water, in the hospital, according to sociodemographic, professional training and reproductive characteristics, 2016, Portugal.

Participant	Age	Marital Status	Studies	Parity	House
2	36	Consensual union	12 years	0	own
3	36	married	Postgraduate studies	0	own
5	32	married	Graduation	0	rented
4	33	single	12	0	rented
6	32	single	Graduation	0	
8	39	married	12	1	own
10	35	Consensual union	Graduation	0	own
11	37	married	Doctorate	0	own
13	35	married	Graduation	2	own
16	32	married	Graduation	0	own
17	38	single	Postgraduate studies	0	own
18	35	married	Graduation	3	own
19	31	Consensual union	12	0	own
21	35	married	Graduation	0	own

3. Results

An important fact present in the participants' narratives was the satisfaction or not with the waterbirth experience. Of the twenty-one participants, thirteen stated that they were very satisfied with the experience as a mode of birth for their baby and that, if possible, they repeated this type of delivery. One woman stated

that she was satisfied because she entered the water at the time of expulsion, a factor that may have influenced her perception of satisfaction. Among women who experienced the entire process of labor and expulsion of the baby into the water and in the situation where the woman entered the water only to expel the baby, the issue of satisfaction with the experience of childbirth was relativized and even discarded. In both cases, we verified the existence of different manifestations of obstetric violence. Thus, alongside the satisfaction with the choice of waterbirth and even with the experience lived in this mode of birth, the presence of bad professional practices evidenced by disrespect, mockery, abuse, and disqualification, strained these experiences and, in some cases, emptied the sense of calm and tranquility that this type of delivery seeks to bring.

3.1 Different forms and perceptions of obstetric violence in the context of childbirth: the importance of enunciating terms in the recognition of maltreatment

The present research, carried out with women who gave birth in water, brings, in its reports, the enunciation of different types of obstetric violence. In many of them, violence is named by the woman who reports, as can be seen in this statement:

> *(...) at that moment I think it's stupid violence to take the father away from us and then start paraphernalia in the morning... a vaccine from here, weigh from there, a hearing test and we are completely alone, we don't have the father. I even remember crying and complaining about so much they wanted to do, I felt helpless on the other side. So up there I didn't feel at all well, I didn't feel respected and they didn't help me at all* (Participant 6 - 32 years old).

The naming of terms by women is an important step towards breaking the naturalization of abuse experienced in the context of birth. Diniz and Carino (2019, s/p) discuss this aspect and highlight: “It is common for women to rewrite their birth and puerperium histories as gender-based violence after hearing the word obstetric violence. It is a testimony choir about which there is a lack of vocabulary”.

In the statement above, the participant not only highlights the importance of the father's presence in the postpartum period, referring to a feeling of loneliness and impotence in the face of so many interventions performed on her baby but also verbalizes the word violence during her talk. Therefore, loneliness, impotence, violence, disrespect, and lack of support are the terms that define the discomfort and complaints of this woman in the childbirth experience.

As highlighted by Dias and Deslandes (2006, p. 351), “In recent decades, the biomedical model of childbirth care has been the target of criticism due to its negative results, its excessive medicalization”. The author highlights, among other factors, the loss of autonomy by the woman and the distance from the family, aspects also highlighted by the woman interviewed.

At times, this choir makes clear and different forms of obstetric violence against the woman's body can be expressed both by reporting what happened to them and by what they observed. One of the interviewed participants says that she felt disrespected in her religion, for not wanting them to perform the touch: *I even heard jokes because of my religion of not wanting to touch, it was my body and she said I didn't want to, I didn't know why who did not realize this* (Participant 18 – 35 years old).

The woman says that she also felt very embarrassed and that she was not informed about the need for it.

> *For me, I think it's an invasion of my privacy, my intimacy, mainly because it makes me feel*

embarrassed... for example, those experiences that I hear women told they were having children and were seen by doctors, sometimes five, six, seven interns, I think it's super violent, I think it's disrespectful to women (Participant 18).

However, the feeling of embarrassment is not something naturally given but socially constructed (Le Breton, 2009). At a given time and place, each individual behaves according to what each one internalizes as being appropriate, in each of the situations, which include expectations concerning gender relations. The exposure of the body, even for health professionals, obeys these expectations and its non-compliance can generate embarrassment on the part of those who are assisted.

> "Gender relations, socially and historically constructed, define practices about the body and sexuality so that the exposure of female genitalia and the manipulation of women's erogenous zones by the health professional can generate shame and embarrassment to women (...)" (Campos & Oliveira, 2011, p.392).

A research carried out with women about the Pap smear (Campos & Oliveira, 2018, p 392) reveals the existence of embarrassment and shame in carrying out the exam given the exposure of intimate parts of the body at the time of the procedure, especially if it is performed by a man. As the authors develop, "This feeling of shame is strongly related to gender relations, especially when a woman has to expose her body in front of a male professional".

We can this in the testimony of the participant (P18) who reported the issue of embarrassment, highlighting the experiences of other women who suffered unnecessary interventions and highlighted it as super violent and disrespectful to women. The testimony speaks of practices that, in addition to having their clinical indications widely questioned, have only didactic purposes, usurping women's autonomy, taking them from a place of the subject of rights, and treating them as an object of academic practice (Diniz et al., 2016).

The issue of disrespect during childbirth was also highlighted by other participants, who brought up different situations.

> *(...) there were two delivery rooms, one next to the other and another birth was taking place in the room next door and the doctor made comments saying that I would scare the lady next door, that she would be scared, and at the time it kept moving inside my mind for a while because it wasn't very sensitive, I don't know if it was okay to scream, but….yes, maybe I screamed.* (Participant 11 – 43 years old).

The physician's search for control of the woman's expressions at the time of childbirth is seen by her as a lack of sensitivity. According to the interviewee, when she made louder sounds, which maybe were even screams, she was repressed by the doctor who said that she would scare the lady next door and that she would be afraid. If, on the one hand, the doctor was concerned about the woman who could be frightened by the cry of the interviewee in labor, on the other, he disregarded the individual need and possibilities of manifestation (of each woman), and this woman, bringing embarrassment.

Another participant reveals this same situation and the same feeling of discomfort due to the silencing to which she was submitted. The moment she was in pain, the scream was her best expression. However, forced into silence, the interviewee points out that until her baby was born, the cry was stuck and this final moment was then perceived by her as something very difficult:

> *The final moments were very difficult, for example, I remember they didn't let me express, I couldn't*

> *make noise, I couldn't scream. So, they had this attitude... covering their mouths so as not to let the air out and not to scream. They said not to scream. And I wanted to scream and then for a long time there was a stuck scream and that was what bothered me the most...this mixture of feelings.* (Participant 19 – 36 years old)

Le Breton (1997), in a study of the different places and meanings of silence, shows that censorship produces a negative silence. The action of the doctor who did not allow the woman to scream and even instructed her to cover her mouth can be seen as a form of censorship, of control over the woman's body and expressions in the birth scenario. A situation experienced as one of the most difficult, to the point where the woman said that her scream was stuck, which was the part that bothered her the most.

Thus, as already highlighted, obstetric violence is the set of reprehensible behaviors by professionals responsible for the well-being of the pregnant woman and the baby; they are various forms of dehumanization of women (Diniz, 2019), during pregnancy, childbirth, and postpartum.

Thus, the bad experiences by women are not limited to the moment of childbirth, referring to all other meetings with health professionals, which include conversations about the possibilities of forms of birth, and not only, but also all the other encounters in life that somehow remind them of that moment.

3.2 The choice for waterbirth: between disrespect, negotiation, and non-submission

Dias and Deslandes (2006) highlight,

> The routines of modern hospital obstetrics are part of a ritual full of symbologies (...), and all the procedures practiced in care reinforce the ideas that a woman is not capable of giving birth without medical technology and that her body, without this control, can bring risks to the baby (Dias & Deslandes, 2006, p. 354).

This idea of risk and control also guides the perceptions and medical practices in the hospital where the interviewed participants had their babies, to the point where the choice of waterbirth is questioned by physicians who, in many cases, even consider it necessary. fad, disregarding it as a viable option for women:

> *The way I was treated the doctor did not hide that he was completely against waterbirth, he was going to induce me right away because I had a lot of contractions, but there was no dilation, so he saw right away I wanted to have a natural birth and said: "Oh, so you're one of those people who wants to have a waterbirth", but I turned around, I replied that I wasn't a fundamentalist. He said that many women die, and I said that I wouldn't die for sure because I was inside the hospital* (Participant 5 – 31 years old).

In this statement, in addition to the issue of the physician's disregard for the woman's choice of waterbirth, another aspect calls attention, concerning the importance of negotiation in the physician-patient relationship. As the interviewee said, it was necessary to work around the situation and this workaround established the terms in which the negotiation could take place. It was necessary to show their confidence in the hospital environment and affirm that they were not radical concerning the type of delivery to be performed. By stating that she is not fundamentalist concerning the choice of waterbirth and showing that she trusts that she would not die because of being in the hospital, she puts herself in a negotiating position with the doctor. Thus, even if there was a conflict between the patient and the doctor regarding the choice of childbirth, it seeks to be softened by the woman, as she says, circumvented so that her choice could be considered.

The importance of negotiation between doctor and patient is discussed by Adam and Herzlich (2001, p. 101) who highlight the existence of a diversity of possibilities "the forms of the relationship range, therefore, from the active domination of the doctor over a passive patient to several forms of negotiation between two partners, each seeking to assert their point of view with the available resources."

This negotiation is not always easy. In the case under study, even if waterbirth is performed in a hospital, the choice for it is not always smooth and respected:

> *The doctor who was there, responsible for the service, made fun of the situation of me wanting a natural birth and said that if I wanted a natural birth I would stay there until tomorrow, but that the epidural would be done in no time. Then the doctor with a mustache appeared there talking about my birth plan and waterbirth, but if I wanted, he would give me an epidural, because I didn't need to suffer... I said I want a natural birth, I wanted to be respected too*. (Participant 21 – 38 years old).

The disrespect and belittling suffered by the participant, who was mocked for her choice for natural childbirth, shows an asymmetrical relationship also found in other contexts in which the health professional meets pregnant women. A study carried out by Pedroso and López (2017) on childbirth experiences in a public maternity hospital in Porto Alegre, Brazil, shows how disrespectful and derogatory behaviors by health professionals who care for pregnant women are outside the humanization recommended by the WHO and health institutions.

In this research, the disrespect for the choice of waterbirth was presented in several statements, such as the one below:

> *In the prenatal period, I was thirty-something weeks and at one point I told them "ah but I'm going to do the waterbirth" and I felt enjoyed by the lady. She said to me "oh yeah? So, tell me "and she crossed her leg," so tell me! So and why?" as if that was a fad and I told him "because I believe it's the best thing for me and the child and I want to be respected". She continued to laugh and said "oh yeah, this is the fashion now". I was made fun of and I left there very sad. She was extremely impolite and laughed and made fun of me; I found that behavior absurd. From then on, I didn't speak anymore, only to those who helped me prepare for the birth I had at the public health center, who spoke to the nurse who was following me and she reassured me*. (Participant 6 – 32 years old).

The disregard and disrespect suffered by the interviewee about her choice of waterbirth resulted in a break in the relationship with the professional who attended to her. As the interviewee says about the health professional, "she was extremely impolite and laughed and made fun of me". When disrespected, the patient is silenced, breaking the relationship with the professional. This silence expresses the denial of the relationship, an active way of showing the professional not only the discomfort caused by the disrespect suffered but also denying to remain in this place of someone who is not being respected. She not only remains silent but speaks only to those who helped her prepare for the birth.

In power relations, according to Foucault (2006), there are always a multiplicity of resistance points. In the case brought up by the interviewee, it is possible to affirm that the silence, the refusal to speak with the professional who disrespected her, expresses an important form of resistance and denial of subjection. The interviewee builds the bond, necessary for care, with the nurse who reassured her in preparing for the birth. As Merhy (1998, p.109) argues, "health service users seek trusting relationships (...)". It is with these professionals that users will seek to establish their bonds, communication being part of it.

The possession of information about their rights also allows women to break with the condition of subjection that may be presented to them. In this rupture, there is re-appropriation of herself, of her body, breaking the asymmetrical relationship between her and the health professional, as shown in the statement below:

> *At the hospital, I was seen by the doctor on duty, he touched me because I allowed it because I knew it could help me. And he told me, "you're not even in labor. I'll give him a pill and induce labor" and I said no thanks and he said "sorry?" and I said "no it won't. If I'm not in labor I'm going home", he said "ah but you know you have to report here tomorrow" because that was in my process. So, I said "come and get me from home" and he said "you know what you're doing?" and I said "so if the doctor says I'm not in labor, I'm going home and when I get back". And so it was.* (Participant 6).

In this speech, the participant's autonomy about her own body can be seen, which is exercised based on previous information and anxieties about her delivery. Thus, even in a space that presents a medical hegemony about the individual, she manages to position herself, showing an ability to experience her body as a subject. A subject body that, in the terms of Merleau-Ponty (1971) "is placed in reality and can experience itself and the world".

In the situation presented, the participant then imposes her will, returning to her home once she was aware that she had not yet gone into labor. She refuses to take the birth induction pill and returns to the hospital after going into labor at her home. The role of the physician, at that moment, would then need to be one of listening and welcoming. As Dias and Deslandes (2006) develop, "A central aspect in the dialogue with obstetricians is the redefinition of their role in assisting low-risk childbirth, since affective support and care, more than intervention, are the that has been advocated for these situations" (Dias & Deslandes, 2006, p. 365).

The perception of this lack of affective support can generate a bad and stressful experience of childbirth, even in the situation of birth in water, which has as one of its foundations the fact that warm water relieves the experience of pain and calms down. But it is mainly the time to be able to be immersed in it, to experience the whole process that makes this calm possible. When this does not happen, the experience can turn out to be very bad, as shown by the interviewee:

> *In the space of a quarter of an hour, as I finished the shower and got dressed, I was asked, shall we go to the water (birth pool)? But I said I need to know how I am to see if I can take this pain or not." A midwife-nurse told me "look, you have to make the decision now because we have to have the pool filled as you are in a very advanced stage of the birth and that is now in an instant. Believe me, you'll feel better in the water". So, I went into the water with nine centimeters of dilation. And unfortunately, I was just expelled in the water, I wasn't there in time to calm my contractions and pain because my work was too fast due to induction. I'm aware that's why* (Participant 3 – 35 years old).

As she reports, it was not possible to calm down in the water or feel better in this environment, as the nurse argued that this would happen, because the interviewee only entered the pool at the time of the baby's expulsion, not being able to experience the entire process in the water. As highlighted by Pedroso and López (2017, 11790), "Women are placed in a passive place in the parturition process and professionals maintain their authority status, thus establishing a vertical and depersonalized relationship".

At the same time that the contemporary woman is seen as the subject of her choices, she is faced with prescriptions dictated by scientific evidence that will result in decisions about what is considered best for the baby, not always being able to experience the rite of passage from of a mode of birth that she considers ideal (Tornquist, 2002), which can be evidenced in this work, for example, by the fact that the hospital has the possibility of a waterbirth but, at the same time, presents resistance about it.

Participant 3's report shows how the use of the bathtub was offered in an imposing way, implying that what mattered was that the baby was born in the water and not that she could enjoy all the benefits contained in this non-pharmacological method for the pain relief, in the moments that preceded the induction of labor, that is, having the experience of an entire process in this environment that could bring calm, pain relief and relaxation that she was looking for.

Such professional conduct distances abysmally from one of the WHO premises (2018, p.25) for assistance to women aiming at a positive birth experience for her, which consists of "supporting the emotional needs of women with empathy and compassion, encouraging her, praising her, reassuring her and actively listening to her. Helping her to understand that she can choose and the professional must ensure that her choices are respected".

Although waterbirth is a modality considered satisfactory for women because it can provide calm and relaxation in the water environment in which they are immersed (Bovbjerg et al., 2016), it is essential that this is carried out from an approach in human rights and good obstetric practices. These, advocated by the WHO, have as a central premise that in an approach based on human rights, women should not be fragmented and reduced to an isolated procedure, on the contrary, women need to be empowered to claim their sexual and reproductive rights (WHO, 2018).

Also, the authors d'Oliveira et al. (2002) point out that although most health professionals around the world work to provide adequate care, even in adverse conditions, they understand that exposing the problem of obstetric violence will enable a "feedback-reflection-change", which will contribute to continuing to support the efforts of teams of dedicated professionals committed to improving their practice.

4. Conclusion - Final Comments

This text sought to discuss the forms of resistance and reactions of women who, by naming the practices of obstetric violence, which included disrespect in the birth scenario, sought to break in different ways with the asymmetry of the relationship with the professional of health, either by silencing and seeking contact with another professional in the care relationship or by refuting the impositions that were imposed on them. The memories resulting from the childbirth experiences remain with the women and can often be shared with others, contributing to a climate of trust or doubt around pregnancy and childbirth and, consequently, the dissemination of positive and pleasurable or negative and traumatic. Regarding bad experiences, unlike the naturalization and trivialization found in research on the experience of childbirth, we observed that the search for information and new knowledge with professionals aligned with good obstetric practices, through consultations in prenatal care, courses preparation for childbirth, and elaboration of the birth plan, was fundamental for them to take ownership of their rights and, in all cases, to have been able to name from the smallest to the greatest violence suffered, so that they could seek to break with them, either at the

time they appeared, or later, in the review of the lived experience, both active and important for facing these bad practices in the health field.

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