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Original article

Dehumanization during Delivery: Meanings and Experiences of Women Cared for in the Medellín Public Network

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Dehumanization during Delivery: Meanings and Experiences of Women Cared for in the Medellín Public Network

Objective. This work sought to describe the meanings constructed in the experiences of women in relation to the care received by the healthcare staff at the moment of delivery. **Methods.** Qualitative study using the procedures proposed by the Grounded theory for data analysis. The sample comprised 18 women over 14 years of age, between 40 days and 6 months postpartum. Twelve of the participants were selected through convenience and to reach saturation of the categories, six more participants were included by using theoretical sampling. Semi-structured interviews were conducted in three information collection phases, and said interviews were analyzed line by line by using coding and categorization techniques. **Results.** The mothers described the parturition experience negatively, perceiving it as the implicit imposition of stoicism to repress their emotions, pain, and discomfort

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and prefer an attitude of submission to the health staff. The participating mothers critically conjure up the care received, which translates into procedures performed and verbal and psychological abuse. **Conclusion.** The mothers assign meanings to their experiences of the delivery process not so much as a transcendent human experience, but rather as a super-experience to the dehumanization of giving birth within the biomedical context.

Descriptors: dehumanization; humanizing delivery; parturition; health personnel; women; qualitative research.

La deshumanización en el parto: significados y vivencias de las mujeres asistidas en la red pública de Medellín

Objetivo. Describir los significados construidos a partir de la experiencia vivida por mujeres en relación con la atención recibida por parte del personal asistencial en el momento del parto. **Métodos.** Estudio cualitativo que utilizó los procedimientos propuestos por la Teoría Fundada para realizar el análisis de los datos. La muestra estuvo compuesta por 18 mujeres mayores de 14 años, entre 40 días y seis meses de postparto. Doce de las participantes se seleccionaron por conveniencia, y para llegar a la saturación de las categorías, se incluyeron otras seis participantes usando el muestreo teórico. Se realizaron entrevistas semiestructuradas durante tres fases de recolección de información, las cuales se analizaron línea por línea, utilizando técnicas de codificación y categorización. **Resultados.** Las madres describieron la experiencia del parto de forma negativa, pues la perciben como la imposición implícita del estoicismo para reprimir sus emociones, dolor e incomodidad y prefieren una actitud de sometimiento frente al personal de salud. Las madres evocan la asistencia recibida de manera crítica, la cual se traduce en procedimientos realizados sin consentimiento y maltrato verbal y psicológico. **Conclusión.** Las madres asignan significados a sus vivencias del proceso de parto no tanto como

una experiencia humana trascendente, sino más bien como una supervivencia a la deshumanización del dar a luz en el contexto biomédico.

Descriptores: deshumanización; parto humanizado; parto; personal de salud; mujeres; investigación cualitativa.

A desumanização no parto: significados e vivências das mulheres atendidas na rede pública de Medellín Colômbia)

Objetivo. Descrever os significados construídos na experiência vivida das mulheres em relação com a atenção recebida por parte do pessoal assistencial no momento do parto. **Métodos.** Estudo qualitativo que utilizou os procedimentos propostos pela Teoria fundada para realizar a análise dos dados. A amostra foram 18 mulheres maiores de 14 anos, entre 40 dias e seis meses de pós-parto. Doze das participantes foram selecionadas por conveniência, e para chegar à saturação das categorias, se incluíram outras seis participantes usando a amostragem teórico. Se realizaram entrevistas semiestruturadas durante três fases de recolhimento de informação, as quais se analisaram linha por linha, utilizando técnicas de codificação e categorização. **Resultados**. As mães descreveram a experiência do parto de forma negativa, a percebem como a imposição implícita do estoicismo para reprimir suas emoções, dor e incomodidade e preferem uma atitude de submissão perante ao pessoal da saúde. As mães evocam a assistência recebida de maneira crítica, a qual se traduz em procedimentos realizados e maltrato verbal e psicológico. **Conclusão.** As madres designam significados as suas vivências do processo de parto no tanto como uma experiência humana transcendente, senão melhor como uma supervivência à desumanização de dar a luz no contexto biomédico.

Descritores: desumanização; parto humanizado; parto; pessoal de saúde; mulheres; pesquisa qualitativa.

Introduction

The birth or arrival of a new life may be contemplated in our everyday lives as an event framed within the plane of what is "natural". We resort to the notion that women are in the capacity to reproduce, however, the manner or practices used during delivery tend to always be object of questionings, and may suggest the need for women to obtain expert intervention during this process. But, if we understand labor as a bio-cultural phenomenon,[1] where diverse ways of representing and signifying it are constructed, the care model and the praxis during this moment remain subjected to a specific time and context, reflecting the beliefs and structural principles of each society. Thus, globally, different ways of experiencing and caring for the delivery have been registered.

In the health services of the public network of the city of Medellín, the birth care model is inscribed in biomedicine or, as denominated by anthropologist Floyd[2] in a technocratic model of reproduction. It is characterized by separating the body and mind and by using the metaphor of the body as a machine, which permeates and conditions relations between physicians and patients. The possible causes of this phenomenon are articulated in a complex framework of power relations, expressed in discrimination and social and gender inequality endured by women in labor, experienced specially by those from the most impoverished socioeconomic levels. This phenomenon is also attributed to the precariousness of the health system, where long work shifts are common, along with the lack of supplies, propitiating low-quality practices in obstetric care, which derives into medical negligence and, as a last consequence, into expressions of institutional violence.[3]

Colombia has only recently begun to recognize this problem and, since 2010, obstetric violence is mentioned as a way of infringing the rights of women in the country, without existing a clear recognition on the theme[4] that is, legally typified as in other Latin American countries. Likewise, insufficient evidence exists to document this problem in Colombia and, particularly in Medellín. It should be noted, for the sake of accuracy and avoiding negative generalizations on the work of the health professionals who care for pregnant women that somehow the aforementioned describes what takes place in each and every one of the deliveries, but it does correspond to a close description of a phenomenon quite extended in obstetrics and gynecology services in the city, according to that gathered in the testimonies provided by the mothers interviewed. Evidencing the existence of obstetric violence in health services and the women's ignorance of their rights at the moment of delivery, will provide very valuable information to question a practice that apparently has been accepted by society as a whole and which goes against the wellbeing and dignity of the women, children, and their families. The aim of this study was to describe the meanings constructed in the experience lived by the women in relation to the care received by the healthcare staff during delivery.

Methods

A study with qualitative approach was conducted by using the procedures proposed by the Grounded theory to analyze the data.[5] Of the total number of mothers participating in the study, 18 complied with the inclusion criteria of being over 14 years of age, receiving parturition care in a health service of the public network of the city of Medellín (Colombia) and who had between 40 days and 6 months of postpartum. On average, the participants had complete high school educational level, belonged to a middle-low socioeconomic level, most had no work income, and were economically dependent on their spouses or their parents. Initially, the sampling was conducted through convenience and to reach the saturation of categories, the theoretical sampling was used; there was no prior relation with the study participants. The snow-ball technique was used to contact the mothers, that is, the first informants, who were contacted through direct approach, led us to other participants, who were called via telephone. None of the mothers contacted refused to participate or abandoned the investigation. To collect information, semi-structured interviews were applied to the mothers in three phases: the first applied eight, the second six, and the last applied four interviews to complete a total of 18 interviews. Each interview lasted an average of one hour and were not repeated to any of the participants; some were carried out in their homes and in public places and most of the encounters had the presence of close relatives. Each of the phases conducted an exploratory study to fine-tune the instruments designed. Informed consent forms were signed and the interviews were recorded after approval by the mothers. Finally, the interviews were transcribed after a brief period, and these were not returned to the participants for comments and/or corrections. Data collection began in August 2016 and ended in November of the same year.

Data analysis used coding and categorization techniques proposed by the Grounded theory. This called for a thorough examination of the data, that is, a line-by-line analysis of the interview texts and groupings were created that responded to the initial categories and to those emerging from the mothers' discourse, which permitted refining and constructing a second instrument. The data collected from the second application were analyzed through axial coding, which permitted nourishing the descriptive categories and start to identify possible relations among some of them, configuring some analytic categories. These last served as starting point to construct the last instrument, used to inquire on the voids still shown by the analytic categories in their content. This third information group was analyzed through selective coding, finally feeding the interpretative categories. From the comprehensive analysis of these last categories, a paradigmatic matrix was created that permitted establishing links among them and understanding more integrally the study phenomenon.

Four researchers participated in manually coding the data without using any software. The researchers were a male Nursing professional, a female Nutrition and Dietetics professional, and two female professionals from the Social area: Psychology and Anthropology; the first three had Masters degrees in Public Health and currently work as professors and researchers of the National Faculty of Public Health and are part of the group on mental health, GISAME, which is interested in and has worked on the theme of sexual and reproductive rights and has been trained in humane delivery. The study was governed by the ethical principles of resolution 8430 of 1993 by the Ministry of Health. The research was considered of minimum risk and was evaluated by the ethics committee of the National Faculty of Public Health at Universidad de Antioquia. The information the participants received about the researchers is that these were university professors, students, and researchers, interested in inquiring on the conditions in which deliveries are cared for in the health services. The participants signed an informed consent and were given explanations of, among other matters, the aim of the investigation, the confidentiality of their identity, and use of data exclusively for research purposes.

Results

The results shown in this article have as guiding thread the technocracy of the delivery process, which is structured into two sections. The first describes the analytic categories: meanings of the experience lived by the mothers, which contemplate the negative experiences and the stoic attitude some mothers assume, and the second describes the perception regarding the treatment provided and received that identifies the types of violence found.

First section: *Don't cry or complain because they will leave you suffering more!* Stories of negative experiences and stoic behavior assumed by some mothers as super-experience strategy against the care received

The conditions of vulnerability represented by the delivery as a process that generates uncertainty, fears, risks, and anxiety, situations which, together with cultural pressures and mediated by traditional values around the femininity, made some mothers opt for limiting or annulling the exteriorization of their emotions. This decision was largely linked to the need to propitiate comfort to the health staff, given that it is interpreted as an eloquent display of cooperation that can lead to a more condescending attitude or, at least, more considerate, that is, assuming a stoic attitude – of calm endurance of pain and difficulties – becomes a passive strategy in front of the staff caring for them. The belief exists that those who express their pain or nonconformity in some way can cause a cold or hostile reaction that affects the quality of care. … *I calmed down and was somewhat resigned to what they would do to me, to avoid retaliation from the health staff* (EC1P5C30); *While if the mothers manifest pain, weeping, screams, retaliation is taken that possibly have repercussions in significant delays in care and possible abuse by the health staff. Don't cry or complain because they will leave you suffering more! …I preferred to yield and ignore the abuse received* (EC1P2C10).

Throughout the delivery care, since admission to the Healthcare Center until birth, the mothers were under some type of conditioning by the health staff, who showed intolerance, anger, or rejection upon their complaints and weeping caused by pain during the delivery process. The expression…*Don't cry or complain because they will leave you suffering more* appeared as a constant cited by the women, who heard this comment from other mothers who had already gone through the parturition experience. These preconceived ideas or beliefs about care were confirmed and experienced in their own deliveries since the first wait time for hospital admission; the women observed how the medical and nursing staff did not provide care to women who cried and complained. Some women narrated how nurses made comments that reflected annoyance and desperation toward women with this type of behavior, comments like: …*She would tell me not to cry; that if I cried, she would leave me for last; that the doctors did not like our crying because we have to be brave; I was struggling to keep from crying, I had been warned of the consequences of crying, so the fear that they would let my child die was too much* (C6P3C9). *However, not only the health staff considers that women must endure the pain because they have to and must have this capacity because they are women; the mothers share the belief: …When I cried, I thought I was a bad mother* (FE2C3).

Suppression of joy, as well as of emotions, is one of the characteristics of the model of biomedical or technocratic delivery. Most of the women attended the Healthcare Center to give birth to their child without contemplating other possibilities or dimensions of the parturition experience, and without recognizing that it is part of their sexuality.

The women coincided unanimously in that companionship is an important factor for their tranquility during the wait time, as well as the information provided by the health staff. Likewise,

most of the women expressed their desire to be accompanied by their loved ones in the operating room and for their companions to have the experience of seeing the birth of their children, given that they could have provided strength and support during this moment. …*I would have liked to be accompanied by my husband during my delivery, for him to give me peace of mind because the pain was very strong and throughout the pregnancy we had dreamt of that, for my husband to have been there by my side* (CE3P5). Of the procedures performed during admission, the vaginal exam may turn out to be a particularly uncomfortable intervention for the women, who can feel overwhelmed by this practice carried out not only by the medical staff, but also by practicing medical students. The health staff does not always request authorization from the pregnant women to perform this procedure: …*I had several vaginal exams; on admission, a practitioner did one; after the shift changed, the doctor performed another one…* (FE3C3P2).

The procedures carried out in the operating room during delivery, like caesarean sections, Kristeller maneuvers, forceps, among others are not informed or explained to the pregnant women, before or after the intervention, which is why the mothers do not understand the reason for the procedures being performed or what the practices consist of, and much less the consequences for them and their children: …*They took my child out with forceps and they never asked me if I wanted this or not, and they also did the Kristeller; I was pushing and touched the doctor slightly, and right there he said: don't touch me, don't grab me and he was all upset, he would get angry if I touched him and it was not my intention* (EC2P4C22).

Some of the mothers reportedly tried to start a dialogue with the health staff to communicate their concerns about the delivery process, however, they were met with a barrier to being heard, without getting satisfactory responses to their questions. On the contrary, sometimes they were made to feel responsible and guilty for the events taking place during the delivery process, in that if they did not comply with the standard and medical mandates, they could cause complications and affect their children: …*He responded with a very bad attitude, saying: You are not cooperating with the process, so I have to help you (forceps) to avoid bronchial aspiration by your child* (EC6P3C12).

Those pregnant women who reported bad experiences repeatedly complain about the poor conduct, impatience, lack of empathy and warmth, refusal to provide clear and opportune information to calm anxieties and a certain arrogant contempt toward the attitudes, expressions, and needs of the pregnant women. All these forms of aggressiveness or indifference, in some cases, constituted for them the most frustrating or stressful aspect of their delivery process; more so, if fitting, the physical and mental afflictions inherent to said process: … *The professionals fail because of their arrogance, which I completely disapprove* (EC1P6C41).

Of particular interest, it should be noted that although some pregnant women expressed indifference; a small group analyzed the situation critically and provided possible explanations regarding those attitudes, which could – in principle – be unexpected. They highlight among these explanations the mechanization of the medical practice and of the nursing care: a routine and bureaucratic activity (in the sense of ritual attachment, by pure inertia to the protocols, diagnoses, procedures, etc.) that postpone or cancel the ethical aspect of caring for the mothers: …*More human warmth from the medical and nursing staff (about what mothers state is lacking in the health staff), also, they become very mechanical, too technical, they should be a bit nicer or talk to them more* (EC4P8C52).

Second section: Spectra of violence: Mothers' perceptions of the treatment received during the delivery process

The stories by the women interviewed evidence different ways of experiencing the treatment received by the health staff; a perception based

on the framework of lack of knowledge expressed by most of the mothers on their sexual and reproductive rights during delivery. Thus, finding women who did not endure negative situations in the verbal treatment or in the procedures; other women, instead, recognize and report situations of violence during their experience during labor, although they have difficulties at the moment of verbalizing or stating that they received poor treatment by the health staff: *...Normal, it was okay, I would have liked for them to explain all the processes, they could have been friendlier and treated me better* (EC6PC27). Other women openly classified the treatment received as bad, besides identifying the negative experiences they endured and naming each of them emotionally; sad, horrible, nasty: *...Very sad because the mere fact of not being able to speak, of saying what was in my mind and much fear, I felt too much fear, too much and I would not want to repeat that experience* (C6P7C38).

The following describes the most frequent patterns and practices of abuse in the narrations by the women:

Abuse during procedures. This ranges from the wait times to be seen to which the pregnant women are subjected, clarifying that beyond the wait time, which is part of the normal delivery process, it involves not explaining to the mother that this is part of her rhythm during labor. Using their bodies as didactic resource to perform vaginal exams, caesarean sections without justification, practices – like forceps and the Kristeller maneuver, which injured the users, and the impossibility of having skin-to-skin contact with the child: ...*The doctor told me; we have to perform a caesarean section, I got very confused and remembered what I had been told; they are looking for any excuse to perform caesarean sections* (F3P14C33).

Verbal abuse. This appears as a mechanism used by the health staff to gain dominance over the pregnant woman and carry out procedures without interruption. These can be expressed in comments that seek to repress emotions and manifestations of pain by using coercion; as well as value judgments in relation to the woman's sexual life: *...They performed a vaginal exam and it was very abrupt, I had bleeding, I screamed with pain, and was told that I had to be stronger because having children was not easy; how did I think those in the countryside have their children* (EC8P3C16).

Abuse through negligence. This is comprised by the lack of information the health staff provides to the mothers about the procedures that will be done, the responses to their concerns, or information on their status, that of their child and the postpartum care, as well as not consulting with them or telling them when the aforementioned is not possible, about the decisions being made during the course of the labor process: *...The doctors had no patience, you would ask them something and they remained quiet, they ignored you or spoke in very technical terms that could not be understood; they should be more human* (EC3P4C19).

Discussion

One of the main findings in this research was the stoic behavior during delivery assumed by most of the women; with the relation between this attitude and the treatment dispensed by the health staff being relevant, which undoubtedly can represent one of the most eloquent signals of domination, dehumanization, and violence of different type: institutional and gender. To understand stoicism, an inquiry was made of its original meaning related to an ancient Greek philosophical school founded by Zeno of Citium;[6] the term has evolved in its meanings until reaching a modern understanding associated to the attitude that consists in hiding emotions and laconism. Stoicism defined from ethics, praises "submission", citing Ferrater:[7] "happiness lies in accepting destiny, in the struggle against the forces of passion that produce restlessness." Thus, a "rational" person can choose a passive behavior on the face of adversity. In this case, the mothers assume a stoic behavior with the final objective of having a child safe and sound in spite of the violence exerted against them. Precisely, of the most interesting aspects

of "stoicism" during labor is that it evidences the power of the health staff to practice the biomedical intervention on women conceived, consciously or unconsciously, as "objects" rather than subjects. Inevitably, a clear and close relation is established between the stoicism that annuls women subjected to intervention or manipulation – during the difficult situation of giving birth – without the right to complain or reply (no communication or silencing the mother as a human being). The aforementioned coincides with the research "representations and practices on birth", which describes – from an anthropological vision – the identification of a whole series of potential risks around the pregnant woman, which supposes constant doubt on the gestation, which could predispose to fear and with this, the possibility of questioning the behaviors and attitudes of women during delivery. This imposes the medical control to which the women must be subjected, implicitly and explicitly reaffirming the social and ideological control of women.[1] Within this context, the "stoic" attitude certainly confirms this control, almost absolute, over the body and psyche of pregnant women by the health staff.

The health staff not only has physical control of women, they also bear emotional control, with women being objectified, without being able to express their fears, anguish, or pain, which should be in complete disposition of the health staff. The submissive – stoic – behavior of the pregnant women may not only result comfortable to the staff, it is closely related to the cultural belief that the delivery is a biologically painful event due to the gender role played by women. This refers to an evident religious root of the mythical story of genesis when Eve is condemned to give birth to her children with painful labor. In this order of ideas, it should be indicated that the manifestation of pain is constructed socio-culturally, as evidenced by the investigation: "Cultural Differences in the Perception and Parturition Experience. The Case of Immigrant Women", which describes how in some cultures women in labor are urged to remain silent, while in others they are permitted to manifest their pain. Likewise, it was noted that women from Eastern Europe and Sub-Saharan Africa are stoic in their behavior.[8]

Our study found that women experience during labor at least three types of violence: during procedures, verbal or psychological, and through negligence, which speak not only of the appropriation of their bodies, but of their emotions and conceptions about maternity. The types of violence found suggest, as indicated by Davis-Floyd,[9] that a separation exists between procreation and sexuality, woman and mother, fetus and mother. The reified parturient cannot express emotions, fears, or concerns, or even express an opinion about the procedures that will be performed, so their role is highly passive. This violence can also be analyzed from the context of inequality of power; on this regard, Bourdieu describes it as that exerted with consensus and unawareness of who endures it and hides the relations of force that are beneath the relation in which it is configured. "...violence that starts up submissions that are not even perceived as such, supported on «collective expectations», on socially inculcated beliefs», transforms relations of domination and submission even in affective relations".[10] These socially inculcated beliefs are given precisely because of a dominant patriarchal inheritance, a hegemonic-biomedical paradigm, which has the conception that the physician is the one who knows and the patient must be limited to only obeying and following physician's orders, among others. Thus, symbolic violence acts with complicity of the dominant and the dominated, given that both share the same discourse and social beliefs, forcing those dominated to assume a resigned attitude, without questioning or recognizing requests by the dominant party. Consequently, parturient women are accomplices of the appropriation by the obstetric staff of their bodies and reproductive health. In said situation, mothers do not often identify bad care, or inquire about their sexual and reproductive rights during delivery, increasing the symbolic power or legitimacy of this asymmetric relationship. Nevertheless, the social agents may also be endowed with the categories of perception and

assessment that permit perceiving, knowing, and recognizing it.[11]

These cases of violence are documented in research that describe situations of abuse and subjugation that coincide with our findings. For example, in the study: "Experiences of violence lived by pregnant women in health services in Bogotá", rough treatment and reprimands based on gender bias evidenced when women were object of scolding and claims based on the behavior they – supposedly – must have: "Let's see mommy, behave well", "because you were in good behavior, we will take care of you quickly"; these are some of the frequent phrases that, besides infantilizing women, leaves them without capacity to act. Likewise, said dehumanization is found in an investigation conducted in Venezuela in the Maternity Care Services and which coincides with the results from this research that showed that the most prevalent practices were: to hinder early attachment or skin-to-skin contact, which is reported by about one in every four users; criticism for crying or screaming during labor; impossibility to ask, manifest fears, or concerns (19.5%), and mockery, and ironic and disqualifying comments referred to by 15.3% of users.[12] It is an experience handed over from woman to woman through orality, constructing the imaginary of adequate behavior with which women enter the health centers. As well as during delivery, care is also reported by women as an experience lived unavoidably through pain; a necessary evil they must endure to have their children.

Contrary to that described previously and which differs from the results in this research, a study conducted in a maternity institution in Brazil: "The health staff and the safety of the mother-child binomial during labor and birth", found that through empathic support, professionals seek effectively to understand the feelings and discomforts of women during labor and delivery. Calling the woman by her name and not only "mamma", as is common, helped her sense the importance of her child's birth and exert her leading role, as is her right.[13] If the mother receives kind treatment, obtains respect for her body, and receives necessary and timely guidance, she will maintain her autonomy and the sense that she has gone through a marvellous experience; on the contrary, if she feels manipulated, does not participate in the decisions, and is examined rudely, it is quite likely that she is physically and morally violated; hence, her adaptation will be more difficult and painful.[16] Similarly, Michel Odent,[17] French obstetrician and pioneer of humane birthing, explains that within the hospital environment professionals defend what he calls "helping paradigm", imposed over the mother's desires. However, he advocates the "paradigm of protecting" the mother and child from interference foreign to the interrelation both create from the moment labor starts.

A form of protection is to help pregnant women control their pain through multiple therapies. It is important to highlight that currently health institutions offer all expecting women on arrival to carry out their labor process with epidural analgesia, which is aimed at managing and controlling pain in pregnant women. This analgesia is administered if the woman is in an active phase of the delivery process, that is, more than 4 cm of dilation and wishes to receive it, given that no woman is obligated to accept this procedure. This is a pharmacological and biomedical form of controlling pain. However, other non-pharmacological forms of controlling pain exist, which are not widely known by the health staff, probably due to the tendency to medicate life.[15] These forms are, for example, aqua therapy, music therapy, aroma therapy, and massotherapy among many others.

Further, scientific evidence shows that pain is multi-causal and does not necessarily obey to alterations in the woman's physiological equilibrium. Hence, the response to pain must focus on different fronts, like – for example – diminished anxiety through support and information, diminished anguish and loneliness through accompaniment from loved ones, the sense of illness and lack of control from their active participation in the labor process.[16] For Odent,[17] "during labor and birth, the child releases its own

endorphins, from which it follows that during the hour after birth we have a mother and child impregnated with opiates". This provides a sense of pleasure and wellbeing, for the mother and the child. These nonconventional therapies are for some specialists in Humane Labor highly valuable in controlling the mother's pain and anxiety.[17] For them, these aids make labor much easier and pharmacologically reduced.[18] It is, thereby, valid to state that in most institutions the possibility exists of having access to pharmacological analgesia; however, pregnant women many times because of the imaginaries constructed, due to the stoic position they assume according to the stories and experiences from other mothers, and because of fears and beliefs around the delivery process decide not to manifest pain or to seek access to these types of therapies.

Furthermore, the dehumanization of the delivery means naturalization of violence practices and instrumentation of the obstetric treatment exerted on women conceived merely as objects or bodies subjected to intervention who are denied, implicitly, their human nature and their rights inherent to such. It is a serious matter that must lead to serious reflection and reevaluation of not only the delivery care but of the medical practice in general to recover not only the dignity of the women, but also the important work of health professionals.[19] Here, as in many other chores, we prove the adage that states: "science without conscience is bad science".[20] It is concluded that pregnant women introduce a richness and variety of meanings around the experiences during their delivery process. For them, it is a moment of life crossed by uncertainty, angst, loneliness, fear, and pain.

In the imaginary weaved, is the duty to themselves, and especially to save their children, of assuming a stoic attitude against manifesting their emotions, specifically the pain and fear they experience. This attitude, according to their own beliefs, diminishes wait times and avoids, to a certain extent, abuse from the healthcare staff. However, not even this attitude keeps them from being the object of practices that violate their rights, like performance of procedures without their consent, indifferent attitudes from the staff that make them feel ignored, value judgments to which they are subjected, and certain expressions and gestures by the staff caring for them that further undermine them. All this leads to thinking that the labor and delivery process of birth is a dehumanizing, difficult moment of life, impregnated with much pain and fear; an experience that definitely no woman would want to repeat. In closing, it is fundamental to highlight that this study presents a valuable contribution for the Nursing discipline, given that it has permitted understanding experiences of pregnant women and their human responses in the experience of a vital process, like the delivery process. This understanding must lead to reflecting upon nursing care being currently offered to pregnant women in the health institutions from the Medellín Public Network. Boff[21] states: "…What is opposed to the lack of interest and indifference is care: Caring is more than an action; it is an attitude. Hence, it goes beyond a moment of care, of zeal and care. It represents an attitude of concern, preoccupation, responsibility, and effective commitment with another". This commitment is the call made to care professionals from the experiences and meanings of the mothers enduring this process with fear, uncertainty, and pain.

From these findings, which evidence the dehumanization of women during their care in the delivery process, emerges the pressing need for nursing professionals and, in general, health professionals to advocate, get trained, and commit to providing humane care during the delivery process, for the marvelous moment of birth to be impregnated with the best care possible, with care that really impacts upon the wellbeing of the mother-child-family trinomial and that the healthcare staff can be seen as protector, caretaker, and assistant in all the stages of this transcendental moment in the life of every woman. Today, more than ever, a strong call is made to those who provide care to favor the newborn's capacity to love, which is achieved by permitting and caring for that contact between the mother and child; some authors, among these Odent,[17]

have stated that this is where the revolution lies, which is needed during a time marked by violence and lack of love; that is that from the earliest stage after birth, the child should develop genuine, human, and transcendent love. The question is: are we prepared and willing to allow it?

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