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Women's knowledge about obstetric violence in a Basic Health Unit in the West Zone-RJ

Conocimientos de mujeres sobre violencia obstétrica en una Unidad Básica de Salud de la Zona Oeste-RJ

Conhecimento das mulheres sobre violência obstétrica em uma Unidade Básica de Saúde na Zona Oeste-RJ

Juliana Gonçalves de Souza[1]
ORCID: 0000-0003-2191-121X
Marcelle Figueira Bernardo Dias Azevedo[1]
ORCID: 0000-0002-3568-4006
Maria Regina Bernardo da Silva[1]
ORCID: 0000-0002-3620-3091
Daniel Ribeiro Soares Souza[1]
ORCID: 0000-0002-9170-6193
Halene Cristina Dias de Armada e Silva[2]
ORCID: 0000-0001-7427-781X
Adriana Loureiro da Cunha[1]
ORCID: 0000-0002-6971-4357
Ligia D'Arc Silva Rocha Prado[1]
ORCID: 0000-0001-9690-9953

[1]Universidade Castelo Branco. Rio de Janeiro, Brazil.
[2]Universidade do Estado do Rio de Janeiro. Rio de Janeiro, Brazil.

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Corresponding author:
Maria Regina Bernardo da Silva
E-mail: m.regina2000@uol.com.br

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Abstract

The aim was to report the knowledge of women from a Basic Health Unit in relation to obstetric violence. Qualitative exploratory study with 11 women, in a Basic Unit in RJ, with SMS RJ No. 3,087,870. It was observed that women understand little the violent and invasive acts and that they have difficulties to define what is the obstetric violence suffered during childbirth, some of them report that the violence suffered is necessary because in some moments their lives and of the baby are put at risk. They reported vulnerabilities during labor, feel silent and report fear, are in a fragile moment in need of support. And the most cited technical procedures that characterize obstetric violence, used are: Recurrent Touch Exam, Episiotomy, Kristeller's Maneuver, Trichotomy, prohibition of ambulation and use of oxytocin. It is concluded that, many of these violence actions, are not understood by women as obstetric violence, because institutional violence is invisible or is socially accepted as natural, because it is justified as "practices necessary for the well-being of women" observed few women showed knowledge about obstetric violence and fragility in female autonomy, as they want their childbirth to be performed.

Descriptors: Obstetric Violence; Postpartum Women; Health Professionals; Knowledge of Recent Mothers; Obstetric Delivery.

Resumén

El objetivo fue reportar los conocimientos de las mujeres de una Unidad Básica de Salud en relación a la violencia obstétrica. Estudio exploratorio cualitativo con 11 mujeres, en una Unidad Básica en RJ, con SMS RJ No. 3.087.870. Se observó que las mujeres entienden poco los actos violentos e invasivos y que tienen dificultades para definir cuál es la violencia obstétrica sufrida durante el parto, algunas de ellas relatan que la violencia sufrida es necesaria porque en algunos momentos se pone su vida y la del bebé. en riesgo. Informaron vulnerabilidades durante el trabajo de parto, se sienten en silencio y reportan miedo, se encuentran en un momento frágil y necesitan apoyo. Y los procedimientos técnicos más citados que caracterizan la violencia obstétrica, utilizados son: Examen de Toque Recurrente, Episiotomía, Maniobra de Kristeller, Tricotomía, prohibición de la deambulación y uso de oxitocina. Se concluye que, muchas de estas acciones de violencia, no son entendidas por las mujeres como violencia obstétrica, porque la violencia institucional es invisible o es socialmente aceptada como natural, porque se justifica como "prácticas necesarias para el bienestar de la mujer" observaron pocos las mujeres mostraron conocimientos sobre violencia obstétrica y fragilidad en la autonomía femenina, ya que quieren que se realice su parto.

Descriptores: Violencia Obstétrica; Puérperas; Profesionales de la Salud; Conocimiento de las Puérperas; Parto Obstétrico.

Resumo

Objetivou-se relatar o conhecimento de mulheres de uma Unidade Básica de Saúde em relação à violência obstétrica. Estudo exploratório qualitativo com 11 mulheres, em uma Unidade Básica no RJ, com parecer SMS RJ nº 3.087.870. Observou-se que as mulheres compreendem pouco os atos violentos e invasivos e que as mesmas têm dificuldades de definir o que é a violência obstétrica sofrida durante o parto, algumas delas relatam que a violência sofrida se faz necessária pois em alguns momentos a vida delas e do bebê são colocadas em risco. Relataram vulnerabilidades durante o trabalho de parto, se sentem omissas e relatam medo, estão em um momento frágil precisando de apoio. E os procedimentos técnicos mais citados caracterizadores de violência obstétrica, utilizados são: Exame de Toque Recorrente, Episiotomia, Manobra de Kristeller, Tricotomia, proibição de deambulação e uso de ocitocina. Conclui-se, que, muitas destas ações de violências, não são compreendidas pelas mulheres como violência obstétrica, pois a violência institucional é invisível ou é aceita socialmente como natural, porque é justificada como "práticas necessárias ao bem-estar das próprias mulheres" observou-se que poucas mulheres mostraram conhecimento em relação a violência obstétrica e fragilidade na autonomia feminina, como desejar que seu parto seja realizado.

Descritores: Violência Obstétrica; Puérperas; Profissionais de Saúde; Conhecimento de Puérperas; Parto Obstétrico.

Introduction

Since 1990, a movement against the medicalization of childbirth has emerged worldwide, led by women dissatisfied with obstetric care or by professionals who have difficulty providing humanized care. With the popularization of the Internet, the number of non-governmental organizations (NGOs) increased, all in defense of normal birth and prolonged breastfeeding. Social movements also intensified, and women took to the streets demanding humanized childbirth, midwives, birth homes and the right to the companion's presence[1].

However, despite all this movement, it is observed that many obstacles hinder the advances in childbirth assistance, such as: the maintenance of medicalization of childbirth, the abusive use of technologies, insufficient financing, the poor regulation of the system, the fragmentation of actions and health services, the persistence of high rates of maternal and perinatal morbidity and mortality and the indifference to the presence of hostile treatments against women in public and private hospitals across the country[2].

The World Health Organization (WHO) prefers to use the term hostile, aggressive or disrespectful treatment when referring to obstetric violence, and it is still necessary to define its different facets to better elucidate this concept. But what this investigation found is that, although metaphorically made up, authoritarian conduct and the use of derogatory words, as well as threats and reprimands against parturients, are common in the daily care of maternity wards[3].

Health professionals tend to confuse the exercise of authority with a difficult work context. The difficulty of having an anesthetist available, for example, can lead the health professional to disregard the pain referred by the woman, not offering relief methods, as she considers it inherent to childbirth[3].

Despite the existence of humanization, obstetric violence is still observed in the daily lives of women while normal birth is ugly, primitive and dirty, performed only with those who are unable to perform the same type of delivery as in the obstetrician is easier to have a cesarean, as the woman does not go into labor and less painless because she does not need to feel the pain of contraction.

The participants' perspectives on violence in childbirth, in the speeches of nursing professionals, is revealed in different ways, the indignation on the part of nursing professionals about the role of doctors and their own colleagues in the delivery room, where it is it is possible to observe the neglect of the patient's pain and feelings, there is a violation of intimacy through prejudiced and discriminatory phrases and the use of unnecessary resources that exposes the baby and the mother to the most different risks[2].

What motivated the choice of this theme were the cases of violence suffered by family and friends during labor, witnessed closely as a companion and the neglect in the care provided and the perception of the lack of knowledge of women and health professionals themselves in relation to obstetric violence.

So, the research problem is: What is the knowledge of women in a Basic Health Unit about obstetric violence?

The objective of the research is to report the knowledge of women in a Basic Health Unit in relation to obstetric violence, to identify whether the women interviewed consider having suffered some act of violence during labor and to recognize the relevance of humanized care during labor. delivery.

Methodology

This is a descriptive field research, with a qualitative approach. The qualitative method was chosen for its applicability in studies of relationships, history, perceptions, beliefs and opinions, results of interpretations that man makes of its own way of life, constructions, thoughts and feelings. Configured in investigations of delimited groups and segments[4].

And the scenario was in a Municipal Health Center (CMS) located in the West Zone in the Campo Grande neighborhood in the city of Rio de Janeiro. The research subjects were women with babies up to 12 months of age, to assess whether they suffered obstetric violence.

Inclusion criteria were women, regardless of age; number of children; place of private or public delivery; and who had deliveries up to twelve months ago during the interview period. Exclusion of women who did not agree to participate or those who were not present during the research period.

Data collection was carried out during the months of May to June 2019, eleven (11) interviews were made, some women approached around nine (09) refused to answer. And the data analysis made was according to Bardin[5].

In the data analysis, the next step was the establishment of the categories created, from the grouping of the record units, ensuring the final part of the analysis. The categories highlighted for this study were: perception of violence during the assistance received; feelings experienced by women during hospitalization for childbirth and types of violence identified.

In the second stage, the coding units were chosen.

And in the third and last stage, the categories were integrated into larger themes. It is worth mentioning that this is a didactic presentation of data processing, that it happens in a continuous and simultaneous process, with structured and complementary steps with each other, to know the reality as it appears in the eyes of the researcher based on the Theoretical Reference.

The survey was carried out after approval by the Research Ethics Committee, opinion No. 3,087,870 of SMS / RJ.

Results and Discussion

To carry out this research, the participants have their identification preserved and of which eleven (11) have recently given birth, with babies up to 12 months old.

Chart 1. Socioeconomic profile of women at a Medical Health Center in the West Zone. Rio de Janeiro, RJ, Brazil, 2019

IDENTIFICATION	AGE	CIVIL	EDUCATION	INCOME	No. OF PREGNANCY	No. OF CHILDREN	LABOR	PRENATAL MONITORING	MATERNITY
ANTÚRIO	23	S	INCOMPLETE HIGH SCHOOL	1 SALARY	2	2	N	PHYSICIAN	PUBLIC
BEGÔNIA	22	S	COMPLETE HIGH SCHOOL	1 SALARY	2	2	N	PHYSICIAN	PUBLIC
CALÊNDULA	21	S	INCOMPLETE HIGH SCHOOL	1 SALARY	1	1	N	PHYSICIAN/NURSE	PUBLIC
CAMÉLIA	22	S	COMPLETE HIGH SCHOOL	1 SALARY	4	3	N	PHYSICIAN/NURSE	PUBLIC
CRAVINA	18	S	COMPLETE HIGH SCHOOL	1 SALARY	1	1	C	PHYSICIAN	PRIVATE
LÍRIO	24	S	COMPLETE HIGH SCHOOL	1 SALARY	2	2	N	PHYSICIAN	PRIVATE
ORQUÍDEA	35	C	ATTENDING HIGHER EDUCATION	2 SALARIES	3	3	C	PHYSICIAN	PRIVATE
GIRASSOL	25	C	COMPLETE HIGHER EDUCATION	5 SALARIES	2	2	N	PHYSICIAN	PUBLIC
ROSA	29	S	COMPLETE HIGH SCHOOL	1 SALARY	1	1	N	PHYSICIAN	PUBLIC
MARGARIDA	32	C	COMPLETE HIGHER EDUCATION	5 SALARIES	1	1	C	PHYSICIAN/NURSE	PRIVATE
JASMIM	30	C	COMPLETE HIGH SCHOOL	3 SALARIES	2	2	N	NURSE	PUBLIC

Of the 11 women interviewed, the age group was 18 to 35 years old, with a predominance of young people between 18 and 25 years old. The results showed that, of the 11 participants, two did not finish high school, seven completed high school, and only three entered university. Regarding family income, seven women reported living on less than 2 minimum wages, two have a family income of up to 3 minimum wages, and only two women have a family income of up to 5 minimum wages, and one did not know how to inform. As for the number of pregnancies and live children, it varied between 36.4% one child and 45.4% two children. Normal delivery being the most cited 73% and regarding prenatal care 64% by the doctor and 27.2% by the doctor and nurse, and 64% of the births took place in the public hospital.

The population of this study was constituted predominantly by women with low level of education and income. The women who had higher education tried to get information and to be interested in the subject addressed and to prepare for the experience of a next humanized delivery.

There was an independent association between marital status (single / married women) and family income with the perception of obstetric violence. The report of Obstetric Violence was higher among single women, considering the total group of women and those who had vaginal delivery, respectively. Obstetric violence prevailed in women with an income between 2 and <5 minimum wages, compared to the group of women with an income> 5 minimum wages.

Brazilian studies have shown discrimination in childbirth care to which the poorest women are subjected. The possibility of under-dimensioning Obstetric Violence by the poorest women in this study (income <2 minimum wages) should be considered, due to the greater difficulty in informing about practices not recommended in childbirth care, as well as about health care rights. Similar results were found in another study[6].

The perception of women about the obstetric violence suffered

It is observed that the perception of women about violence in childbirth is related to the lack of quality in care, highlighting the absence of bonds and communication between professionals, patients, their families and other professionals, problems in medical diagnoses, lack of welcoming and resoluteness. Next, the interviewees' reports:

> *"[...] the doctor left me alone [...] I lacked information [...] I felt insecure, they only came to see me when I was already in an expulsive period"* (CALÊNDULA and CAMÉLIA).

There are several practices performed in maternity hospitals, where parturients are not informed or clarified about their real need. There are cases where the procedures

are carried out without warning and without giving the woman the opportunity to issue her consent[7].

Obstetric violence results in a violation of rights: the right to freedom from harm and abuse, information and autonomy, confidentiality and privacy, dignity and respect, equality and non-discrimination.

The absence of a link between prenatal and maternity services, that is, the discontinuity of care, is pointed out several times, as:

> *"I felt good during the pregnancy, but I didn't clear my doubts and I didn't have information about labor during the prenatal period [...]"* (ORQUÍDEA and ANTÚRIO).

The obstetric violence that occurs during pregnancy, more precisely, during prenatal care, happens with the omission of information and / or guidance by the health team, it was found that six women (55%) responded that there was an omission of information during prenatal care.

There was a scarcity or lack of information on the part of the health team about the basic issues of labor and delivery. The absence of information is configured as disrespect on the part of the health professional, and when the information is denied, fragmented, or confused, it is observed that it results in the fact that women feel manipulated, as if they had no will of their own, nor right of manifestation. This can also be characterized as a breach of a legally constituted right and permeates the annulment of its autonomy and right of choice, becoming a serious obstetric violence[8].

Feelings experienced by women in labor

It is observed that 60% of women had negative feelings experienced at the time of delivery and were common to parturients, which was also observed in another study[9]. Many reports expressed disapproval of the professionals' posture and recognition of victimization:

> *"[...] I was not well assisted [...] my choice of delivery was not maintained [...] after normal delivery, I had to do a reconstruction of the perineum, because they forced a normal delivery [...]"* (CALÊNDULA, GIRASSOL and ROSA).

The complexity involved in the process of choosing the mode of delivery. From the women's perspective, this choice is determined by the professional during the prenatal consultation or at the time of the exam, and the number of women who participate autonomously and consciously in this process is small. The option on the way of delivery is very much centered on the power of the doctor, even if this decision contradicts the desire and the birth plan carried out previously by women[10].

The trivialization of pain or suffering, also categorized in other studies[7,8] as objectification, they were given gifts. Therefore, it refers to the professionals' lack of listening, to the devaluation of the woman's speech, the non-use of pain relief methods, to the non-compliance with what the current regulations recommend. Verbal violence stands out as the second most identified type of violence, appearing in the form of rude treatment, threats, repressions, screams, humiliations, and disrespect:

> *"If you keep shouting your son it will take time to be born [...] I'm sure that when it was time to do it, he didn't cry [...] I don't know why he is sick, this is cool"* (JASMIM and MARGARIDA).

During childbirth, women are sensitized and vulnerable to violence. It is often a consensual violence, because moved by fear and subordination to the professional, some end up momentarily forgetting what they suffer, moved by the joy of birth[11].

Knowledge about violence suffered by the women interviewed

It is observed that 84% of the interviewees are unaware of the term violence, and 84% reported that they did not suffer any type of violence, but when asked about procedures that were performed during childbirth, they always reported gross procedures accompanied with some physical violence.

There are different types of obstetric violence and different forms of obstetric violence are intertwined. In view of this perspective, it was decided to identify them as negligence, verbal violence, psychological violence, physical violence, and poor quality of care[11].

Physical violence is associated with neglect, marked by feelings of shame, embarrassment, and pain.

> *"The doctor put me in the serum, I kept feeling pain [...] He cut me, the cut was big, I took 15 stitches inside and 15 outside [...]. I was unable to sit for a few days [...] there was a very big scar, I lost the sensitivity of the place"* (BEGÔNIA and CALÊNDULA).

Episiotomy is often unnecessary, done without indication, can cause serious damage to this woman as was reported above, she may experience pain and loss of sensation and even sexual problems for some time.

Many women are unaware that the interventions they suffer are considered violence, such as episiotomy, a technical term used by professionals and that is not part of the daily life of all women[12].

In humanized assistance in childbirth and birth, women acquire an important feeling of strength and optimism during labor and in baby care. Humanizing childbirth suggests leading women as protagonists, interacting closely with the decisions that will be made about their care[13].

This humanization aims to provide women with autonomy and self-confidence in labor, with the aim of respecting their rights. When assistance to pregnant women is performed in a humanized way, assistance becomes less interventionist, discarding the possibility of performing procedures such as Episiotomy and Kristeller Maneuver[14].

Women who reported repetitive vaginal touch, serum oxytocin and Kristeller during delivery were found to be normal:

> *"[...] I don't think touch is violent, even if it's all the time"* (ROSA).

> *"[...] the push in my belly was for the welfare of my baby who was born"* (MARGARIDA).

The assistance that was offered was not assistance aimed at good practices, the vaginal touch was performed numerous times, Kristeller Maneuver was used, so, probably, this woman "got used" to experience the experience of the delivery with the use of unnecessary interventions, considering these practices as something "necessary" for her and the baby.

The lack of information and empowerment of these women reflects in higher levels of violence and it is up to the professional, to analyze the degree of understanding of the patient and to carry out effective communication, enabling a respectful dialogue and humanized assistance.

Only 01 (16%) interviewed women reported having suffered violence:

> *"[...] they said all the time that my nausea was fresh [...] I would change my postpartum care [...]. I was not free to walk in the room [...]"* (BEGÔNIA).

It is clear the lack of knowledge of these women about what obstetric violence is, being identified only in moments that occur as verbal violence and mistreatment, therefore not perceived when performing unnecessary procedures, because even when exposed to the experience of violence a parturient not considered as such. These procedures, most of which are unnecessary in most cases, are an aid to facilitate childbirth, and when this "collaboration" is not carried out, consequently the assistance received is not perceived as efficient. Thus, demonstrating the great deficit of knowledge of women about their rights to humanized childbirth assistance and, above all, based on evidence.

It was observed that 90% of women claimed not to have the right to walk during labor.

> *"I couldn't get up, the doctor said that my baby would fall to the floor and could die [...]. I tried to walk so that the pain would ease, but the nurse said I was disturbing the team* [...]" (LÍRIO and CRAVINA).

The term humanization means creating better conditions, respecting the parturients' limits and needs, in humanized childbirth. Walking provides relief and comfort and can facilitate the baby's descent, making your baby's birth a pleasant and special moment.

Final Considerations

The research showed that obstetric violence has been frequent in the hospital, expressed in subtle ways, such as omission of information and through the use of procedures that are not proven by Science. It was also found that many of these violence actions are not understood by users as obstetric violence, because institutional violence is invisible or socially accepted as natural, because it is justified as being "practices necessary for the well-being of women" it was observed that few women interviewed show knowledge about obstetric violence and fragility in female autonomy to define how they want their delivery to be performed.

The humanization process of childbirth and birth assistance is fundamental and a means for this to occur effectively is through information so that the woman understands her active role during all labor, delivery, and birth. For this to happen, health professionals need to be aware that the delivery process is not just about scientific evidence.

It is proposed, therefore, that through the dissemination of information about what is obstetric violence and the emergence of public policies for the recognition of violent acts at the time of childbirth, that the guarantee of the parturient is safeguarded and, mainly, the possibility of denouncing and protect yourself. In addition, to make them aware of the duty of health units to treat them with respect, so that they understand that every parturient has the right to assistance during childbirth and the puerperium, allowing this process to be experienced in a humanized and safe way.

As a result of this, we reiterate the ways of combating the practice of obstetric violence, whether through quality prenatal care, in addition to humanized delivery and postpartum assistance. This assistance involves several beneficial aspects, such as commitment, empathy, and respect. Hospital assistance in obstetric care should then become safe, guaranteeing each woman the benefits of scientific advances without, however, neglecting her autonomy and her physical and psychological well-being.

References

1. Leão MRC, Riesco MLG, Schneck CA Ângelo M. Reflexões sobre o excesso de cesarianas no Brasil e a autonomia das mulheres. Ciênc saúdec oletiva [Internet]. 2013 Aug [cited 2015 Dec14];18(8):2395-400. Available from: http://www.scielo.br/pdf/csc/v18n8/24.pdf
2. Aguiar JM, D'Oliveira AFPL, Schraiber LB. Violência institucional, autoridade médica e poder nas maternidades sob a ótica dos profissionais de saúde. Cad Saúde pública [Internet]. 2013 [cited 2016 Feb 05];29(11):2287-2296. Available from: http://www.scielo.br/scielo.php?script=sci_ar ttext&pid=S0102-311X2013001100015
3. Cavalcant PCS, et al. Um modelo lógico da Rede Cegonha. Physis Revista de Saúde Coletiva. 2013;23(4):1297-1316.
4. Minayo MC. Apresentação. In R. Gomes, Pesquisa qualitativa em saúde. São Paulo: Instituto Sírio Libanes; 2014.
5. Bardin L. Análise de Conteúdo. Lisboa: Edições 70; 2009.
6. Wolff LR, Waldow VR. Violência consentida: mulheres em trabalho de parto e parto. Saúde e Sociedade. 2008;17(3):138-151.

7. Pontes MGA, Lima GMB, Feitosa IP, Trigueiro JVS. Parto nosso de cada dia: um olhar sobre as transformações e perspectivas da assistência. Rev Ciênc Saúde Nova Esperança. 2014; 12(1):69-78.
8. Rodrigues DP. Violência obstétrica no processo do parto e nascimento da região Metropolitana II do Estado do Rio de Janeiro: percepção de mulheres/puérperas [dissertação]. Rio de Janeiro (RJ): Escola de Enfermagem Aurora de Afonso Costa, Universidade Federal Fluminense; 2014
9. Nagahama EE, Santiago SM. Parto humanizado e tipo departo: avaliação da assistência oferecida pelo Sistema Único de Saúde em uma cidade do Sul do Brasil. Revista Brasileira de Saúde Materno-Infantil. 2011;11(4):415-425.
10. Oliveira VJ. O sensível e o insensível na sala de parto: interdiscursos de profissionais de saúde e mulheres [Tese] [Internet]. Belo Horizonte (MG): Escola de Enfermagem, Universidade Federal de Minas Gerais; 2016 [cited 2017 Feb 27]. Available from: http:// www.enf.ufmg.br/pos/defesas/580D.PDF
11. Martins AC, Barros GM. Will you give birth in pain? Integrative review of obstetric violence in Brazilian public units. Rev Dor [Internet]. 2016 jul-set [acesso em 12 de maio de 2019];3. Disponível em: http://www.scielo.br/scielo.php?script=sci_arttextHYPERLINK "http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1806-00132016000300215"&HYPERLINK "http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1806-00132016000300215"pid=S1806-00132016000300215
12. D'Oliveira AFPL, Diniz SG, Schraiber LB. Violence against women in health-care institutions: an emerging problem. Lancet. 2002;359(9318):1681-1685.
13. Silva LM, Barbieri M, Fustinoni SM. Vivenciando a experiência da parturição em um modelo assistencial humanizado. Rev bras enferm [Internet]. 2011 [cited 2017 Jan 28];64(1):60-5. Available from: http://www.scielo.br/pdf/reben/v64n1/v 64n1a09.pdf
14. Souza KJ. Violência institucional na atenção obstétrica: proposta de modelo preditivo para depressão pós-parto. 2014. 106f. Dissertação (Mestrado em Saúde Coletiva) – Programa de Pós-Graduação em Saúde Coletiva, Universidade de Brasília, Brasília, DF, 2014.