Revista Brasileira em Promoção da Saúde
Universidade de Fortaleza
Original Article
e-ISSN:1806-1230
DOI: 10.5020/18061230.2025.15775

Women's knowledge about obstetric violence and its implications: the pain they try to silence

Conhecimento de mulheres sobre violência obstétrica e suas implicações: a dor que tentam silenciar

Conocimiento de mujeres sobre la violencia obstétrica y sus implicaciones: el dolor que intentan silenciar

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ABSTRACT

Objective: To identify women's knowledge about obstetric violence and its implications. **Method:** A qualitative, descriptive-exploratory study conducted between February and March 2022 in the Western Border region of Rio Grande do Sul, Brazil. Data were collected through interviews and analyzed using content analysis. **Results:** The study included 15 women whose accounts highlighted experiences marked by unnecessary interventions, dehumanized care practices, and a lack of guidance. Many women are unaware of their rights and tend to normalize violent practices. Additionally, the obstetric violence they experienced left emotional and psychological scars, negatively affecting their childbirth and motherhood experiences. **Conclusion:** Findings highlight the urgent need to address obstetric violence in order to change this reality and prevent the normalization of unnecessary interventions during the pregnancy-puerperal cycle, thereby promoting more humanized care.

Descriptors: Parturition; Obstetric Violence; Women's Rights; Health Services.

RESUMO

Objetivo: *Identificar os conhecimentos de mulheres sobre a violência obstétrica e suas implicações.* ***Método:*** *Estudo qualitativo, de caráter descritivo-exploratório, realizado entre fevereiro e março de 2022, na Fronteira Oeste do Rio Grande do Sul. Os dados foram coletados por meio de entrevistas e submetidos à análise de conteúdo.* ***Resultados:*** *Participaram do estudo de 15 mulheres, cujos relatos destacaram vivências marcadas por intervenções desnecessárias, condutas desumanizadas, além da omissão de orientações. Obteve-se, ainda, que muitas mulheres desconhecem seus direitos e naturalizam práticas violentas, além da confirmação de que a violência obstétrica vivenciada por elas deixou marcas emocionais e psicológicas, influenciando negativamente a experiência do parto e a maternidade.* ***Conclusão:*** *Percebe-se a necessidade de abordar a violência obstétrica na tentativa de mudar essa realidade e evitar a naturalização das intervenções desnecessárias durante o ciclo gravídico-puerperal, proporcionando uma assistência mais humanizada.*

Descritores: *Parto; Violência Obstétrica; Direitos da Mulher; Serviços de Saúde.*

Received on: *02/10/2025*
Accepted on: *08/04/2025*

RESUMEN

Objetivo: *Identificar los conocimientos de las mujeres sobre la violencia obstétrica y sus implicaciones.* ***Método:*** *Estudio cualitativo, de carácter descriptivo-exploratorio, realizado entre febrero y marzo de 2022, en la Frontera Oeste de Rio Grande do Sul. Los datos fueron recolectados mediante entrevistas y sometidos a análisis de contenido.* ***Resultados:*** *Participaron en el estudio 15 mujeres, cuyos relatos evidenciaron experiencias marcadas por intervenciones innecesarias, conductas deshumanizadas y la omisión de orientaciones. Asimismo, se constató que muchas mujeres desconocen sus derechos y naturalizan prácticas violentas, además de confirmarse que la violencia obstétrica vivida por ellas dejó huellas emocionales y psicológicas, influyendo negativamente en la experiencia del parto y la maternidad.* ***Conclusión:*** *Se observa la necesidad de abordar la violencia obstétrica con el propósito de transformar esta realidad y evitar la naturalización de intervenciones innecesarias durante el ciclo gravídico-puerperal, garantizando una atención más humanizada.*

Descriptores: *Parto; Violencia obstétrica; Derechos de la Mujer; Servicios de Salud.*

INTRODUCTION

Violence in childbirth care represents a serious public health issue that must be addressed and eradicated both in Brazil and worldwide.[1] It encompasses actions carried out by health professionals that result in abuse, disrespect, or mistreatment of women during the pregnancy-puerperal cycle, potentially causing long-lasting physical, psychological, and social consequences.[1] Throughout their lives, women may be exposed to different forms of violence, such as obstetric violence, which, although rarely fatal, can leave lifelong physical and emotional scars.[1-2]

In Brazil, data from 2012 indicated a prevalence of 18.3%-44.3% of cases involving physical or psychological violence, disrespect, lack of information, absence of privacy and communication, and loss of autonomy.[3-4] In Latin American countries such as Mexico, four out of ten women report having experienced obstetric violence. In Europe, countries such as Italy have reported that 78.4% of women have been subjected to some form of obstetric violence.[5-6]

The definition of obstetric violence used in most Brazilian studies is based on the legal frameworks of countries such as Venezuela and Argentina, which are recognized for leading efforts to eliminate all forms of violence against women.[1] Obstetric violence is thus understood as any action, either direct or indirect, perpetrated by health care teams — whether in public or private settings — that reflects the appropriation of women's bodies and reproductive processes. This form of violence is manifested through dehumanized care, excessive medicalization, and the pathologization of natural childbirth processes. As a result, women experience a loss of autonomy and the ability to make free and informed decisions about their bodies and sexuality, ultimately compromising their quality of life.[1-2]

These forms of obstetric violence stand in direct contrast to the principles of the Brazilian Prenatal and Birth Humanization Program and the World Health Organization's Guide to Normal Birth Care.[7-8] In this context, health promotion and collective health initiatives emerge as key strategies for addressing such violence, as they empower women, expand access to information, and encourage evidence-based practices grounded in respect for human rights. Despite growing discourse around this issue, tangible progress remains limited.

This study is therefore justified by the opportunity to critically examine the topic with women, contributing to their pursuit of greater autonomy and respect for their human, sexual, and reproductive rights. The following research question was proposed: *What are the implications of obstetric violence in women's lives?* The aim of the study was to identify women's knowledge about obstetric violence and its implications.

METHODS

This qualitative study was conducted in a city located in the Western Border region of Rio Grande do Sul, Brazil, between February and March 2022, and involved 15 women participants. Inclusion criteria comprised women over 18 years of age who reported having experienced obstetric violence during the pregnancy-puerperal cycle, starting from the year 2000 — the year the Brazilian Prenatal and Birth Humanization Program was launched.[7]

Participant recruitment was carried out using the snowball sampling technique, a non-probabilistic sampling method commonly employed in social research. In this technique, initial participants refer new participants, who in turn recommend others, and so on.[9] No exclusion criteria were applied.

The first participant was a woman within the researchers' social network. She reviewed and signed an informed consent form. A date and time for data collection were then scheduled. Data collection took place during the COVID-19 pandemic, allowing participants to choose between in-person or online interviews via Google Meet.

Data were collected through semi-structured interviews guided by an interview script developed by the researchers. The script included both closed-ended questions — for participant characterization — and open-ended questions that enabled a deeper understanding of the women's perceptions and experiences related to obstetric violence. After each interview, participants received an educational leaflet, which allowed the researcher to explain the concept of obstetric violence, situations associated with the term, and ways to prevent or report it.

At the end of each interview, participants were asked to suggest 1 or 2 potential new participants. Once these referrals were contacted and agreed to participate, the researcher proceeded with the same steps described above. A total of 7 women did not respond after the initial contact, and 2 declined participation at the first invitation.

Participant recruitment ended once data saturation was reached.[9] Interviews were recorded using a mobile audio application and lasted between 28 minutes and 1 hour, with an additional 30 minutes allocated for discussion of the educational leaflet.

The interviews were fully transcribed in Google Docs. Subsequently, data underwent thematic content analysis. The process began with a thorough reading of the interviews and organization of the material. Then, significant expressions or keywords were identified, from which the analytical categories emerged. Finally, data were interpreted and the results processed.[10] To ensure participant anonymity, flower names were used in place of real names.

All ethical principles outlined in Resolution 466/2012 were strictly followed. The research project was approved by the Research Ethics Committee at Universidade Federal do Pampa on December 19, 2021, under approval number 5.177.573 and CAAE: 53729421.6.0000.5323. This manuscript was prepared in accordance with the Consolidated Criteria for Reporting Qualitative Research.

RESULTS

The women interviewed were between 25 and 53 years old. Among the 15 participants, most were white (n = 10), married (n = 9), had completed high school (n = 5), and were engaged in domestic work (n = 5). All lived with their children, and 11 also lived with their partners. Most participants were multigravida (n = 14), with 2 to 3 children (n = 11). Most of them had vaginal deliveries (n = 11). Most began prenatal care in the first month of pregnancy (n = 8) and attended more than 6 prenatal consultations (n = 14).

Based on the analysis of participants' narratives, data were organized into 3 thematic categories: "I did not choose to go through that. I suffered: experiences related to obstetric violence"; "I think we should know, it is our body: violence perceived through lack of information"; and "It left such a mark that I still remember it: the impacts of obstetric violence."

"I did not choose to go through that. I suffered": experiences related to obstetric violence

Most participants were familiar with the term obstetric violence and associated it with their personal experiences. They described interventions and practices during childbirth that they recognized as violent.

> *"I had an episiotomy in both of my normal deliveries, and it wasn't even necessary. […] They yelled at the mothers […] I thought it was normal […] but it's not, that's violence […] The doctors were rude, they left me suffering in pain, I didn't get proper guidance. […] I felt like I was in a slaughterhouse, especially with all the screaming […] I was naked, in that position [lithotomy], legs up, waiting to give birth […] I didn't know I could choose another position, they always tell you to stay like that […] And I didn't have a companion […] having someone with you makes all the difference, even just to make sure they're doing things right, a witness to what's going on […] I didn't get any guidance after giving birth." (Azaleia)*

> *"Obstetric violence is when health professionals hurt women during childbirth, not just doctors. It's when they turn childbirth into a medical event, and the mother and baby stop being the main focus. The health professionals take over. But actually, it's the mother and baby who do the birth; the professionals are just there to assist. It's when things are done without the mother's consent […] using forceps without asking, doing the fundal pressure, chatting like nothing's happening and distracting the woman, not respecting her as a whole. If she wants dim lights, then dim the lights; if she wants silence, keep it quiet. Anything that goes against her wishes is violence […] A nurse told me to stop screaming. She said, 'If screaming helped, pigs wouldn't die.' And I said to her, 'I'm giving birth. I'll do whatever I want.'" (Íris)*

> *"We learn more from the media than from the professionals […] Obstetric violence is making a pregnant woman wait around […] not being seen by staff […] My OB never told me I could have someone with me […] I didn't take anyone because I didn't know I could […] In the recovery room, they gave me my daughter and just left*

me alone with her. I had a panic attack, and no one came to help me. […] I got myself ready, shaved, you know, we prepare ourselves beforehand, but since he [second child] came early, they ended up doing everything [pubic shaving and enema]." (Lótus)

"My placenta was stuck, and the doctor kept pressing my belly to try to get it out. It didn't work, so he put his hand inside and pulled it out. The pain was insane, and my belly turned totally purple from all the pressure […] They don't care how you feel in that moment, you feel violated […] The doctor kept doing vaginal exams, over and over. The last one, I couldn't even lift my leg from the pain." (Margarida)

"I think we should know, it is our body": violence perceived through lack of information

Most participants reported not receiving information — either during prenatal care or at the hospital — about the procedures that would be performed during their hospital stay. According to them, this lack of information constitutes a form of obstetric violence.

"No one ever explained anything to me, and I didn't ask the doctor either […] If you don't get any guidance, you just wait and believe whatever they tell you. At that moment, it's all you have […] I suffered because no one guided me. […] Not being taught anything after birth made the pain last longer, made me suffer more, it felt like labor just kept going. It even made me dislike breastfeeding. My nipples were cracked, it hurt so bad, my baby was breastfeeding with blood. The pain was unbearable. And that could have been different if someone had shown me how to do it properly, how to help the baby latch. Then it wouldn't have cracked." (Azaleia)

Limited guidance on delivery methods was also noted. Most participants said they were not informed about their options, with few exceptions where cesarean sections were performed.

"It was a C-section because the doctor couldn't hear my daughter's heartbeat." (Girassol)

"I had two C-sections. The first one was because the baby was going into distress. The second one, I think, was because of the first birth, which was diagnosed as cephalopelvic disproportion." (Íris)

Most women (n = 14) did not receive any information about obstetric violence during prenatal care or at the hospital. Some of them (n = 3) were hearing about the topic for the first time. Only one participant had previously received information, and she had chosen to seek out further knowledge on her own.

"No one ever mentioned this. It's the first time I'm hearing about it." (Hortênsia)

"They talked about it in some of the meetings, but that wasn't really the focus. I looked it up on my own before." (Íris)

"It left such a mark that I still remember it": the impacts of obstetric violence

All the women agreed that obstetric violence can cause harm and long-term damage, both to the mother and the baby. However, the most significant effects were perceived in the woman's health. Most participants reported that obstetric violence had some impact on their lives. A total of 2 participants mentioned experiencing only verbal violence (being told not to vocalize pain) and did not feel it had long-term effects on them.

"Violence harms the mother's health, and that ends up affecting the baby's health too. You're in pain and emotionally wrecked. How are you supposed to take care of a baby like that? […] People kept saying: 'Pregnancy is beautiful.' I think it's horrible, it traumatized me […] horrible! A kind of torture that could be avoided." (Azaleia)

"I almost got depressed because of my first delivery […] As soon as I saw him all bruised up [forceps delivery], I started crying. I just wanted to leave the hospital. I was tired and in pain […] I decided I didn't want to have any more kids because of that pregnancy. When I found out I was pregnant again, I panicked, scared of going through all that again […] I went to therapy." (Magnólia)

"I had postpartum depression with my second pregnancy. It was really painful for me. I was alone there […] It stayed in my head. I was scared of being intimate with my husband. It took me months to feel ready for sex again because of the episiotomy pain." (Margarida)

"I never cried so much in my life […] it was awful! […] What stuck with me most was the feeling of being abandoned. No one cared. They didn't even explain that I could've had someone with me—neither during prenatal care nor there […] I was already fragile because I found out I had the disease [HIV] during the pregnancy. I felt like

they put me in that room just because I was HIV positive. I felt rejected […] That room didn't even feel like a maternity ward. It was just a weird, cold place." (Tulipa)

DISCUSSION

Most participants began prenatal care at the recommended time and attended more than 6 consultations. Despite this, they had limited access to information regarding the pregnancy-puerperal cycle, which may have contributed to their exposure to obstetric violence during pregnancy, labor, childbirth, and/or the postpartum period.

Similar findings were reported in a study conducted in the state of Goiás, Brazil, in which all participants received prenatal care, meeting the minimum number of six consultations as recommended by the Brazilian Ministry of Health. Nevertheless, even with adequate prenatal coverage, participants considered the quality of care unsatisfactory, as they lacked information about labor and the postpartum period.[11] Therefore, the lack of knowledge about the term *obstetric violence* may be linked to the absence of guidance and education during prenatal care.

Other authors suggest that women often gain knowledge about obstetric violence through online sources, television, lectures, or conversations with others in their social circles.[12] Thus, such information is not consistently addressed within health care services.

Although the present study shows that most participants were familiar with the term obstetric violence, only one reported receiving guidance from health professionals on the topic. This same finding was observed in a literature review, which demonstrated that during prenatal care, pregnant women typically do not receive information about obstetric violence — making it less likely that they will recognize such violence when it occurs.[13] This underscores the limited opportunities women have for open dialogue with health professionals, leading them to often submit to imposed decisions.[14]

Thus, individual and collective educational actions promoted by health professionals — especially nurses — are essential to disseminate information that enables women to exercise greater autonomy during childbirth. To achieve this, it is crucial to create a safe and welcoming environment where women can express their feelings, expectations, desires, and concerns.[11]

Furthermore, health professionals must provide clear guidance regarding the risks and benefits of each delivery method. These explanations should be grounded in scientific evidence and conveyed in accessible language to ensure informed decision-making. Providing such information may help prevent the imposition of a delivery method by health care providers, thereby reducing instances of obstetric violence and its consequences.[12]

Participants' testimonies revealed that childbirth can be a significant and transformative experience in a woman's life. However, the lack of updated and evidence-based information throughout the pregnancy-puerperal period may cause these events to be remembered as negative and traumatic. In this sense, their experiences are often reduced to memories of disrespect, aggression, and violence.[12]

In this study, women frequently associated obstetric violence with their personal experiences. A similar finding was reported in a study conducted in Coimbra, Portugal, where 94.9% of participants understood the meaning of obstetric violence based on personal experiences related to the term.[15]

Thus, obstetric violence was found to have marked the participants' childbirth experiences. Their accounts revealed that, within obstetric care, women's preferences and autonomy are often disregarded. They also pointed out that health professionals tend to carry out procedures without prior explanation or consent, with the omission of information playing a significant role in enabling such actions. Moreover, participants noted that this omission increases their vulnerability to obstetric violence.

Accordingly, several authors emphasize that the prevailing model of childbirth care remains centered on the medical professional, reinforcing hierarchical power dynamics over women. As a result, the childbirth process is frequently shaped by the professional's unilateral decisions.[13]

Participants' accounts mentioned the performance of episiotomy and the Kristeller maneuver, the use of forceps, frequent vaginal examinations, episiotomy repair without anesthesia, restriction of movement during labor, the absence of a birth companion, the violation of their birth plans, negligence, and verbal abuse. Moreover, they perceived any action that went against a woman's wishes or rights as a form of obstetric violence.

Procedures and situations reported by the participants contradict the principles of the Prenatal and Birth Humanization Program, which ensures women's right to dignified and high-quality care throughout prenatal care, childbirth, and the postpartum period as well as to humanized, safe assistance. In a similar vein, since 1996, the World Health

Organization (WHO) has recommended best practices for childbirth, aiming to promote positive birth experiences and reduce the routine interventions often used in health care institutions to accelerate and standardize delivery.[4,7]

In this regard, obstetric violence is considered a violation of human rights and of the guiding principles established by the Universal Declaration on Bioethics and Human Rights (2006). According to this Declaration, the interests and welfare of the human being shall prevail over the sole interest of society or science. Therefore, medicine must prioritize patients' benefits and allow them the autonomy to decide what is best for themselves, with their choices being respected.[16]

The Declaration also states that no medical intervention should be carried out without the patient's prior, free, and informed consent.[16] This principle stands in stark contrast to the findings of the present study, as participants reported that procedures were performed without their prior consent, and their preferences were often disregarded.

Regarding episiotomy — frequently cited in this study — it is commonly misused in health care institutions. Routine episiotomy is often justified as a means to prevent more severe lacerations and to facilitate delivery. However, this practice can result in bleeding, infection, painful sexual intercourse, and long-term urinary incontinence. There is no current scientific evidence supporting the routine use of episiotomy for the prevention of severe perineal trauma.[17]

Participants also reported undergoing the Kristeller maneuver, which involves the application of fundal pressure during labor. This intervention lacks sufficient scientific evidence to support its routine recommendation and should be used with caution until further research becomes available.[7]

Accounts of forceps use were also noted. Forceps delivery is an extremely invasive procedure that may cause pain and physical and emotional harm to the mother. For the newborn, it can result in scalp lacerations, facial nerve paralysis, corneal injury, skull fractures, and cervical spine trauma.[18] Therefore, forceps should only be used when fetal well-being is at risk or when there is a prolonged second stage of labor.[19]

Frequent vaginal examinations — especially when performed by multiple professionals — are considered an inappropriate practice in many institutions and can pose several risks, including premature birth, increased risk of fetal contamination, infections, and maternal tissue trauma. Vaginal examinations are intended to assess labor progression, cervical dilation, potential risks, membrane status, and fetal presentation. However, such procedures should only be performed when necessary, after being explained to the patient and with her consent. A study affirms that excessive vaginal examinations are a form of obstetric violence, which is consistent with the findings of the present study.[7,20]

Although women are entitled to receive both pharmacological and nonpharmacological pain relief methods, 1 participant reported undergoing perineal suturing without anesthesia. The denial of pain relief measures constitutes obstetric violence.[19] Performing perineal suturing without anesthesia represents a violation of women's rights, as it causes unnecessary pain and discomfort that could be mitigated through pharmacological methods.

Participants' narratives also revealed restricted mobility during labor, with professionals enforcing the lithotomy position. However, women should be encouraged to adopt positions that they find most comfortable. Moreover, freedom of movement and positioning during labor is recommended, with squatting, lateral, or hands-and-knees positions being the most favorable for fetal descent and delivery.[7,19,21]

Participants' testimonies also revealed that women are not always allowed to have a birth companion of their choice during hospitalization, despite existing legislation guaranteeing this right.[22] However, the presence of a companion is widely recognized as a beneficial practice, contributing to pain relief and providing emotional support to the woman. Furthermore, the presence of a companion may reduce a woman's exposure to situations of obstetric violence.[21-22] Despite this, health care institutions and professionals often deny this right, citing justifications that lack legal validity.

Additionally, participants reported that their birth plans were not respected as legal documents. In contrast, the National Guidelines for Normal Birth Care identify the birth plan as a beneficial practice that should be encouraged. The birth plan reflects the woman's preferences regarding the procedures to be performed during labor, delivery, and newborn care. It is, therefore, a legal document that can safeguard women's rights while also encouraging healthcare professionals to reflect on their practices in order to improve the quality of care provided.[12,19]

Instances of negligence were also reported, involving either the denial or abandonment of care, as well as the disregard of women's needs. Disrespect, abuse, and mistreatment are present in various health care institutions, as reported in some studies. These are often expressed through the omission of information, denial of dignified care, and failure to comply with laws and regulations designed to protect individuals.[15]

Verbal abuse was another recurring theme in participants' narratives and is well-documented in literature. This form of violence includes verbal or behavioral acts capable of inducing feelings of abandonment, vulnerability, inferiority, insecurity, emotional instability, alienation, loss of dignity, and coercion. It encompasses offensive or humiliating

remarks, authoritarian, reprimanding, moralistic, or disrespectful language, threats, deceit, jokes, rudeness, and disregard for cultural norms as well as the use of language that is inaccessible or difficult to understand.[15,23-24]

Moreover, the testimonies suggest that obstetric violence is deeply intertwined with gender issues, reflecting historical power relations, inequality, and the control exerted by health professionals over women's bodies. This form of violence underscores the excessive medicalization of childbirth and the hierarchical nature of hospital care, where women's voices are often disregarded and their decisions about their bodies and birthing processes are delegitimized. It represents a form of symbolic and institutional violence sustained by patriarchal structures that normalize female subordination and hinder the recognition of obstetric violence as a social and public health issue.[25]

The findings also revealed that some procedures were not perceived by participants as obstetric violence, even though they are classified as such. These procedures include enema, pubic shaving, food and fluid restriction, and the use of oxytocin.

This perception may be related to the normalization of obstetric violence. In some cases, practices recognized as obstetric violence are accepted and perceived as normal or expected, as they are embedded in the cultural imaginary of childbirth. At the same time, health professionals may trivialize certain behaviors and procedures, thereby perpetuating the normalization of obstetric violence within obstetric care.[26]

Enemas, pubic shaving, and food and fluid restriction should be eliminated from obstetric care, as scientific evidence indicates that these practices are harmful and ineffective.[7,20] Nonetheless, health professionals often justify these procedures by claiming they are safety measures during childbirth.[27]

The administration of oxytocin — referred to by 1 participant as a "drip" — at any stage prior to birth is considered harmful or ineffective for the health of the woman and the baby. This pharmacological method is used to accelerate labor by increasing the frequency and intensity of contractions. However, the routine and unindicated use of oxytocin may prolong labor and the second stage of childbirth, potentially leading to adverse perinatal outcomes.[21] Its use is beneficial when administered prophylactically during the third stage of labor in women at risk of postpartum hemorrhage.[7]

Furthermore, data shows that such experiences may have both short- and long-term impacts on women's lives. Participants reported consequences such as the decision not to have more children due to fear of experiencing obstetric violence again; the choice of definitive contraceptive methods, such as tubal ligation; postpartum depression; fear of resuming sexual activity with their partners due to pain from episiotomy; preference for private health care; and emotional and psychological harm.

Some of these impacts have also been identified in previous research. In 1 study, participants reported anxiety disorders, post-traumatic stress, postpartum depression, and breastfeeding difficulties. The authors also noted a decrease in the use of postpartum health services, an increase in near-miss events, and changes in the choice of delivery method in subsequent pregnancies following experiences of obstetric violence.[1]

The idealization and romanticization of motherhood may silence women's experiences of pain, fear, suffering, and violence. This social construction tends to obscure the physical and emotional challenges of the pregnancy-puerperal cycle, making it more difficult to recognize abuse and dehumanizing practices such as obstetric violence. When their experiences do not align with these idealized expectations, many women feel guilty or invalidated in their emotions, which may intensify psychological suffering and hinder their pursuit of support.[28]

Because of the vulnerabilities identified — such as the persistence of obstetric violence and the limited implementation of humanized care practices — it is essential to adopt a broader concept of health. This expanded view understands health as more than the mere absence of disease and considers the social, cultural, economic, and subjective determinants that affect women's well-being. In this regard, collective health and health promotion emerge as powerful strategies to address the issue by promoting intersectoral actions, health education, the strengthening of women's autonomy, and person-centered care. These approaches enable the development of a health care model that respects human rights, values women's needs, promotes equity, and combats violent and dehumanizing practices in healthcare settings.[29-30]

In this context, health education stands out as an essential tool for preventing obstetric violence, as it empowers women by expanding access to information about their rights, the physiological processes of childbirth, and evidence-based care practices.[31] This is reflected in the testimony of 1 participant, who stated that her experience could have been different had she received adequate guidance.

Thus, by promoting women's autonomy and encouraging their active participation in decisions concerning their bodies and childbirth, health education helps to break with authoritarian and interventionist patterns still present in obstetric care.[31] To reduce or prevent instances of obstetric violence, it is essential to implement best practices in childbirth care, supported by continuous professional training through permanent education programs and user-targeted health actions.

Even after several years, many women expressed discomfort and resistance when discussing their experiences, indicating that childbirth may be a traumatic process in some cases. One of the limitations of this study was the participants' fear of sharing their experiences and talking about obstetric violence, as they were concerned that the information might be disclosed and lead to negative consequences.

Another limitation concerns the homogeneity of the sample, which may have restricted the diversity of experiences and perceptions regarding the topic. The participants shared similar sociocultural characteristics, which may limit the generalizability of the findings to other contexts or groups with different realities. Therefore, future studies with more heterogeneous samples may broaden the understanding of this phenomenon and reveal additional social markers.

CONCLUSION

This study gave voice to women who are often silenced within healthcare services and by the professionals who operate within them. It enabled the identification of women's knowledge regarding obstetric violence, their lived experiences, and the short- and long-term implications of the care they received.

Although most of the participants were familiar with this type of violence, the lack of guidance and the omission of information may have contributed to their exposure to obstetric violence. In this context, the women were subjected to practices and procedures considered ineffective or lacking scientific evidence to support their use. These experiences left emotional, psychological, and physical scars in their lives.

Notably, some participants' experiences occurred shortly after the year 2000. Therefore, it is possible that, in recalling these events, they may have omitted or forgotten specific aspects of what they experienced during childbirth. Nevertheless, it is clear that violent situations leave lasting impressions, and despite the passage of time, these women have not forgotten what they went through.

The findings of this study may contribute to knowledge development in Nursing and related fields, encouraging reflection on the need to offer new ways of thinking and acting in favor of a more humanized and respectful healthcare system. Thus, this study's contributions extend to both education and care, supporting broader discussions on the topic and reinforcing the importance of preventing the normalization of violent practices during the pregnancy-puerperal cycle.

Accordingly, the strengthening of public policies that prioritize woman-centered care is essential to ensure women's rights and promote obstetric care environments free from violence. Moreover, it is urgent to reorient health services — particularly in terms of professional training, the reorganization of work processes, and the implementation of practices grounded in listening, welcoming, and supporting the autonomy of pregnant women. The persistence of technocratic and interventionist models reveals the ineffectiveness of decontextualized approaches and underscores the urgent need for structural changes in the health care system.

CONFLICTS OF INTEREST

There were no conflicts of interest involving the participants or any other direct or indirect contributors to the development of this research.

AUTHOR CONTRIBUTIONS

Fabiula Aquino Vilaverde contributed to the conception and design of the study, data collection, analysis, interpretation, and manuscript writing. **Jussara Mendes Lipinski** contributed to the study design and manuscript writing. **Lisie Alende Prates**, **Cristiane Lima de Moraes**, and **Ana Paula Lima Escobal** contributed to data analysis, interpretation, and manuscript writing. **Cenir Gonçalves Tier** and **Fernanda Emanuelli Dias Tito** contributed to manuscript writing.

FUNDING

This study received no funding.

REFERENCES

1. Ortega IMA, Rojas MCS, Bailón PMAB, Martínez JRM. Violencia obstétrica en el Hospital San José de Taisha, año 2020. Mas Vita Rev Cienc Salud [Internet]. 2021[citado 07 fev 2025];3(1):66-84. Disponible en: https://doi.org/10.47606/ACVEN/MV0062

2. Leite TH, Marques ES, Esteves-Pereira AP, Nucci MF, Portella Y, Leal MC. Desrespeitos e abusos, maus-tratos e violência obstétrica: um desafio para a epidemiologia e a saúde pública no Brasil [Internet]. Cien Saude Colet. 2022[citado 07 fev 2025];27(2):483-491. Disponível em: https://doi.org/10.1590/1413-81232022272.38592020

3. Leite TH, Marques ES, Corrêa RG, Leal MC, Olegário BCD, Costa RM, et al. Epidemiologia da violência obstétrica: uma revisão narrativa do contexto brasileiro [Internet]. Ciênc Saúde Coletiva. 2024[citado 07 fev 2025];29(9):1-13. Disponível em: https://doi.org/10.1590/1413-81232024299.12222023

4. Leite TH, Pereira APE, Leal MC, Silva AAM. Disrespect and abuse of women during birth and postpartum depression: findings from a national survey on childbirth in Brazil. J Affect Disord [Internet]. 2020[cited 2025 Feb 07];273:391-401. Available from: https://doi.org/10.1016/j.jad.2020.04.052

5. Instituto Nacional de Estadística y Geografía. encuesta nacional sobre la dinámica de las relaciones en los hogares. México: INEGI; 2021 [citado 07 fev 2025]. Disponible en: https://www.inegi.org.mx/programas/endireh/2021/

6. Scandurra C, Zapparella R, Policastro M, Continisio GI, Ammendola A, Bochicchio V, et al. Obstetric violence in a group of italian women: socio-demographic predictors and effects on mental health. Cult Health Sex [Internet]. 2021 [cited 2025 Feb 07];24(11):1466-1480. Available from: https://doi.org/10.1080/13691058.2021.1970812

7. Ministério da Saúde (BR). Programa humanização do parto: humanização no pré-natal e nascimento. Brasília: Ministério da Saúde; 2000 [citado 07 fev 2025]. Disponível em: http://bvsms.saude.gov.br/bvs/publicacoes/parto.pdf

8. World Health Organization. WHO recommendations: intrapartum care for a positive childbirth experience. Geneva: WHO; 2018[cited 2025 fev 07]. Available from: https://apps.who.int/iris/bitstream/handle/10665/260178/9789241550215-eng.pdf?sequence=1

9. Bockorni BRS, Gomes AF. A amostragem em snowball (bola de neve) em uma pesquisa qualitativa no campo da administração [Internet]. Rev Ciênc Emp UNIPAR. 2021 [citado 07 fev 2025];22(1):105-117. Disponível em: https://doi.org/10.25110/receu.v22i1.8346

10. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 14. ed. São Paulo: Hucitec; 2014.

11. Conceição RGS, Simões AV, Rodrigues VP, Machado JC, Penha JMN, Balbinote FS. Assistência qualificada no pré-natal como prevenção da violência obstétrica: revisão integrativa [Internet]. Resear Soc Development. 2021[citado 07 fev 2025];10(8):1-9. Disponível em: https://doi.org/10.33448/rsd-v10i8.17505

12. Oliveira MRR, Elias EA, Oliveira SR. Mulher e parto: significados da violência obstétrica e a abordagem de enfermagem [Internet]. Rev Enferm UFPE. 2020[citado 07 fev 2025];14:1-8. Disponível em: https://doi.org/10.5205/1981-8963.2020.243996

13. Pascoal KCF, Carvalho MA, Candeia RMS, Pereira, JB, Cruz RAO, et al. Violência obstétrica na percepção de puérperas [Internet]. Nursing. 2020[citado 07 fev 2025]; 23(265):4221-4226. Disponível em: https://doi.org/10.36489/nursing.2020v23i265p4221-4232

14. Escobal APL, Andrade APM, Matos GC, Giusti PH, Cecagno S, et al. Relações de poder e saber na escolha pela cesárea: perspectiva de puérperas [Internet]. Rev Bras Enferm. 2022[citado 07 fev 2025];75(2):1-8. Disponível em: https://doi.org/10.1590/0034-7167-2020-1389

15. Kloch LL. A percepção das mulheres sobre violência obstétrica [Dissertação na internet]. Portugal: Escola Superior de Enfermagem de Coimbra; 2021 [citado 07 fev 2025]. Disponível em: https://pesquisa.bvsalud.org/portal/resource/pt/biblio-1366933

16. Organização das Nações Unidas para a Educação, Ciência e Cultura. Declaração universal sobre bioética e direitos humanos [Internet]. Lisboa: Comissão Nacional da Unesco Portugal; 2006 [citado 07 fev 2025]. Disponível em: https://unesdoc.unesco.org/ark:/48223/pf0000146180_por

17. Reis J, Junqueira LS, Azevedo MJS. Episiotomia e complicações associadas: uma revisão de literatura [Internet]. Research Soc Development. 2024[citado 07 fev 2025]; 13(5):1-17. Disponível em: https://doi.org/10.33448/rsd-v13i5.45718

18. Machado LO, Said M Neto. Uso do fórceps: uma revisão de literatura [Internet]. Rev Patol Tocantins. 2018[citado 07 fev 2025];5(3):56-59. Disponível em: https://doi.org/10.20873/uft.2446-6492.2018v5n3p56

19. Ministério da Saúde (BR). Diretrizes nacionais de assistência ao parto normal. Brasília: Ministério da Saúde; 2017 [citado 07 fev 2025]. Disponível em: https://bvsms.saude.gov.br/bvs/publicacoes/diretrizes_nacionais_assistencia_parto_normal.pdf

20. Goes CS, Almeida JS, Silva PA, Lopes GS, Rodrigues MEA, Santos AM. Percepções de puérperas acerca da violência obstétrica em uma maternidade de Manaus [Internet]. Reser Soc Development. 2021[citado 07 fev 2025];10(15):1-11. Disponível em: https://doi.org/10.33448/rsd-v10i15.22670

21. Rocha NFF, Ferreira J. A escolha da via de parto e a autonomia das mulheres no Brasil: uma revisão integrativa [Internet]. Saúde Debate. 2020[citado 18 jun 2025];44(125):556–568. Disponível em: https://doi.org/10.1590/0103-1104202012521

22. Brasil. Lei n° 11.108, de 7 de abril de 2005. Altera a Lei no 8.080, de 19 de setembro de 1990, para garantir às parturientes o direito à presença de acompanhante durante o trabalho de parto, parto e pós-parto imediato, no âmbito do Sistema Único de Saúde – SUS [Internet]. Brasília: Presidência da República; 2005[citado 07 fev 2025]. Disponível em: http://www.planalto.gov.br/ccivil_03/_Ato2004-2006/2005/Lei/L11108.htm

23. Bitencourt AC, Oliveira SL, Rennó GM. Significado de violência obstétrica para os profissionais que atuam na assistência ao parto [Internet]. Enferm Foco. 2021[citado 18 jun 2025];12(4):787-793. Disponível em: https://doi.org/10.21675/2357-707X.2021.v12.n4.4614

24. Ribeiro DO, Gomes GC, Oliveira AMN, Alvarez SQ, Gonçalves BG, Acosta DF. A violência obstétrica na percepção das multíparas [Internet]. Rev Gaúcha Enferm. 2020[citado 18 jun 2025];41:1-6. Disponível em: https://doi.org/10.1590/1983-1447.2020.20190419

25. Fagundes CS, Marques EFS, Souza IS, Souza LS, Tourinho LOS. Violência obstétrica e a subjugação feminina: uma análise a partir da interseccionalidade gênero, raça e classe social [Internet]. Rebesbe. 2023[citado 18 jun 2025];1(2):1-21. Disponível em: https://doi.org/10.29327/2335218.1.2-10

26. Jardim DMB, Modena CM. Obstetric violence in the daily routine of care and its characteristics. Rev Latino Am Enfermagem [Internet]. 2019[cited 2025 Feb 07];26:1-12. Available from: https://doi.org/10.1590/1518-8345.2450.3069

27. Gonzalez PR, Prates LA, Schmalfuss JM, Lipinski JM, Escobal APL, Silva MLC. Práticas de atenção ao parto na experiência de puérperas: análise à luz da humanização [Internet]. Rev Enferm UFSM. 2020[citado 07 fev 2025];11:1-23. Disponível em: https://doi.org/10.5902/2179769253146

28. Nascimento EM, Machado JC, Vilela ABA, Rodrigues VP. Análise estrutural das representações sociais de mulheres sobre a violência obstétrica [Internet]. Physis. 2025[citado 18 jun 2025];35(1):1-17. Disponível em: https://doi.org/10.1590/S0103-73312025350117pt

29. Tesser CD, Knobel R, Andrezzo HFA, Diniz SG. Violência obstétrica e prevenção quaternária: o que é e o que fazer [Internet]. Rev Bras Med Fam Comunidade. 2015[citado 18 jun 2025];10(35):1-12. Disponível em: https://doi.org/10.5712/rbmfc10(35)1013

30. Yalley AA, Jarašiūnaitė-Fedosejeva G, Kömürcü-Akik B, Abreu L. Addressing obstetric violence: a scoping review of interventions in healthcare and their impact on maternal care quality. Front Public Health [Internet]. 2024[cited 2025 Jun 18];12:1-39. Available from: https://doi.org/10.3389/fpubh.2024.1388858

31. Leal MC. Parto e nascimento no Brasil: um cenário em processo de mudança [Internet]. Cad Saúde Pública. 2018[citado 18 jun 2025];34(5):1-3. Disponível em: https://doi.org/10.1590/0102-311X00063818

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How to cite: Vilaverde FA, Lipinski JM, Prates LA, Moraes CL, Escobal APL, Tier CG, et al. Women's knowledge about obstetric violence and its implications: the pain they try to silence. **Rev Bras Promoç Saúde**. 2025;38: e15775. htpps://doi.org/10.5020/18061230.2025.15775