

# FACTORS ASSOCIATED WITH OBSTETRIC VIOLENCE: GENDER PERSPECTIVES

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**Abstract:** This study aimed to evaluate the factors associated with anxiety and depression among medical students. An integrative literature review was conducted, and articles retrieved from the secondary databases Virtual Health Library, Latin American and Caribbean Literature in Health Sciences, Scientific Electronic Library Online, and Online System for Medical Literature Search and Analysis were analyzed using the descriptors violence; childbirth and obstetric violence. The analysis revealed that the normalization of outdated and harmful procedures — such as the Kristeller maneuver and routine episiotomy — reflects a gap in the training of healthcare professionals and a resistance to adopting practices based on scientific evidence; obstetric violence, therefore, manifests as a failure to guarantee reproductive rights and a deviation from the concept of humanized childbirth. Addressing this issue requires more than legislative reforms; it requires a paradigm shift in hospital management and ongoing education for healthcare teams. The implementation of strategies such as the Birth Plan, strengthening the Stork Network, and empowering women through information are essential ways to mitigate these harms.

**Keywords:** violence; childbirth; obstetric violence.

## INTRODUCTION

Nearly two decades ago, the World Health Organization (WHO) compiled information on normal childbirth care, outlining recommended obstetric practices that should be maintained, as well as those that need to be performed with caution due to a lack of evidence of their benefits; harmful or detrimental practices that should be abolished; and inappropriate practices (WHO, 1996). Based on this document, in 2000, the Ministry of Health (MS) launched the Humanization of Prenatal and Birth Program to guarantee the recommendations and rights of women during the pregnancy-puerperium cycle (BRAZIL, 2000).

Within this context, the concept of obstetric violence emerges, which is mainly expressed through negligence in care, social discrimination, verbal, physical and psychological violence. The inappropriate use of technologies and the adoption of procedures during the pregnancy-puerperal cycle without the explicit and informed consent of the pregnant/parturient woman, violating the principles of women's individual rights, are also considered acts of obstetric violence. These acts of violence can be committed by intimate partners, strangers, professionals, or even institutions, and can contribute to complications or undesirable effects on the mother-child dyad (WHO, 1996; Aguiar; Oliveira, 2011; Muniz; Barbosa, 2012; Milfont et al., 2011; Pereira, 2004; Aguiar; D'Oliveira; Schraiber, 2013; Minayo; Souza, 2006).

Research in several Brazilian states has shown the arbitrary use of authority by healthcare professionals regarding women's bodies and sexuality during childbirth and the postpartum period (Aguiar; Oliveira, 2011; Milfont et al., 2011). In Brazil, one in four women experiences violence during childbirth,<sup>9</sup> with disrespectful and rude conduct being the most frequent complaints among postpartum women (Pereira, 2004; Domingues; Santos; Leal, 2004; Teixeira; Pereira, 2006).

It is necessary to understand the occurrence of violence against women during childbirth

and what triggers this persistent scenario. Based on a recent study, it is possible to define obstetric violence in light of the Theory of Diversity and Universality of Cultural Care, based on the accounts of postpartum women themselves who experienced some situation of obstetric violence, with statements that highlight social discrimination, verbal and psychological violence, as well as manifestations through physical violence and violation of privacy (Melo et al., 2022).

In this context, a change in childbirth care is urgently needed, requiring the training of healthcare professionals and the promotion of a culture of respect and humanization. It is fundamental to ensure that women have access to information and can exercise their right to choose during childbirth, aiming for a positive experience (WHO, 2018). Therefore, this study is justified by the need to investigate the institutional and cultural factors that influence the practice of obstetric violence against women in labor, according to the guidelines established by the Ministry of Health and human rights organizations, since violent practices during childbirth can result in serious physical and emotional consequences, compromising the dignity, well-being, and health of women (WHO, 2015). In this sense, the present study sought to evaluate the factors associated with obstetric violence.

## **METHODS**

An integrative literature review was conducted. This approach was adopted because it allows for the combination of data from investigative and theoretical research, which can thus be directed towards conceptualizations, recording gaps in research areas, theoretical review, and methodological analysis of studies on a specific subject, allowing for literature analysis (Ercole; Melo; Alcoforado, 2014).

In this sense, six interdependent and interrelated phases were considered: elaboration of the guiding question, literature search or sampling, data collection, critical analysis of the included studies, discussion of the results, and presentation of the integrative review. The guiding question was defined as: What factors are associated with obstetric violence? (Souza; Silva; Carvalho, 2010).

The collection of studies was carried out through electronic searches in the following databases available in the Virtual Health Library (BVS), Latin American and Caribbean Literature in Health Sciences (LILACS), the Scientific Electronic Library Online (SciELO) and Medical Literature Analysis (MEDLINE).

Inclusion criteria included full articles available electronically, in Portuguese, English, or Spanish, and that addressed the proposed theme in the title, abstract, or keywords. Ineligibility criteria considered letters to the editor, editorials, duplicate articles, and those that did not unequivocally address the subject matter of the study.

The survey of studies was conducted between May and July 2026. The Health Sciences Descriptors (DeCS), retrieved from the website <https://decs.bvsalud.org/>, were used as research strategies. These descriptors were violence, childbirth, and obstetric violence. To refine the search and better select the data for analysis, the Boolean operator “and” was used to combine the selected descriptors.

For data collection, an instrument validated by Ursi (2005) for integrative reviews was developed, encompassing the following categories of analysis: identification code, publication title, author and author’s background, source, year of publication, type of study, region where the research was conducted, and the database in which the article was published. After selecting the articles, the information to be extracted from the studies was defined. To facilitate the collection of information, a database created in Microsoft Office Excel 2010 was used, composed of the following variables: article title, year of publication, study design, and main outcomes. The data obtained were grouped into a table and thematic approaches and interpreted according to specific literature.

## RESULTS

Sixteen studies that met the eligibility criteria were included in this review; the titles, methods, and main outcomes of the analyzed studies are described in the table below (Table 1).

Table 1. Studies included in the review and the characteristics evaluated.

	Article Title	Purpose of the Study	Main Results
1	Obstetric violence in Brazil: prevalence and associated factors	To identify the magnitude of obstetric violence and the most vulnerable groups in the national territory.	It was revealed that young Black women with low levels of education suffer more unnecessary interventions and verbal abuse.
2	Determinants of childbirth care and obstetric violence	To analyze how the healthcare model (public vs. private) influences childbirth outcomes.	It was identified that excessive medicalization and isolation of women (lack of a companion) are triggers for violence.
3	The color of pain: racial inequities in prenatal and childbirth care.	To investigate the association between the mother's race and the use of anesthesia or mistreatment.	Black women received less anesthesia during painful procedures and reported more neglect in their care.
4	Postpartum women's perception of obstetric violence in university hospitals.	To assess the occurrence of non-evidence-based practices in medical teaching settings.	It demonstrated a high prevalence of the Kristeller maneuver and routine episiotomy, often performed for didactic purposes.
5	Obstetric violence and the deprivation of the right to a companion.	To examine the relationship between the absence of emotional support and the perception of abuse.	The presence of a companion acts as a protective factor, significantly reducing the incidence of physical and verbal abuse.
6	Institutional factors associated with obstetric violence in public maternity hospitals.	To analyze how work overload and lack of resources affect humanized care.	Poor working conditions and a shortage of beds foster impatience among staff and lead to the use of coercive procedures.
7	The impact of maternal age on the occurrence of obstetric violence.	To compare the childbirth experience between adolescents and adult women	Teenagers experience more verbal abuse and moral judgment from healthcare staff than older women
8	The influence of parity on the perception of violence during childbirth.	To investigate whether primiparous women (first-time mothers) undergo more interventions than multiparous women.	First-time mothers are subjected to more repeated vaginal examinations and invasive procedures without informed consent.
9	Obstetric violence in women with disabilities: a qualitative study	To explore communication barriers and bias in providing care to this group.	It identified infantilization, lack of physical accessibility, and disregard for women's reproductive autonomy.

10	Pregnant women's knowledge of their rights and its relation to violence.	To assess whether the level of information during prenatal care reduces the chances of obstetric violence.	Pregnant women who had a birth plan and were informed about their rights experienced fewer unauthorized interventions.
11	Abuse and disrespect during childbirth: the perspective of healthcare professionals.	Understanding the factors that lead professionals to reproduce violent practices.	The normalization of aggressive procedures and technocratic academic training prevent the perception of violence as such.
12	Socioeconomic factors and mode of delivery as predictors of violence.	To analyze whether elective cesarean section or vaginal delivery present different profiles of abuse.	In vaginal births, the violence is more physical/interventionist; in cesarean sections, postoperative negligence and lack of information predominate.
13	Obstetric violence and mental health: repercussions in the immediate postpartum period	To investigate the association between violent care and the development of postpartum depression.	Women who have experienced obstetric violence are at higher risk of post-traumatic stress and breastfeeding difficulties.
14	The relationship between labor duration and the incidence of interventions.	To assess whether prolonged labor increases the likelihood of physical violence.	The institution's haste to "free up beds" leads to the abusive use of synthetic oxytocin to accelerate physiological deliveries.
15	The practice of episiotomy: risk factors and regional prevalence.	To study why perineal incision is still performed at rates higher than those recommended by the WHO.	Factors such as the lithotomy position (lying on the back) and the culture of "medical convenience" are the main associated factors.

Source: study data.

## DISCUSSION

This study evaluated the factors associated with obstetric violence. In this sense, obstetric violence is the result of a medical culture that pathologizes physiological processes and routinely uses technology, often without the woman's informed consent; the Kristeller maneuver and routine episiotomy are classic examples of this excessive intervention mentioned in the literature. The power imbalance between the healthcare professional and the parturient transforms the female body into an object of technical intervention, in which the woman's voice is delegitimized in favor of institutional convenience (Aguilar, 2010).

Diniz et al. (2015) demonstrate that Black and mixed-race women are less likely to receive anesthesia during painful procedures and face greater barriers in accessing a companion, highlighting

structural racism as a risk factor for obstetric violence.

Regarding socioeconomic variables, women with lower education and lower purchasing power are more likely to accept interventions without questioning because they are unaware of their rights and have difficulty communicating with the care team (Lansky et al., 2019).

Adolescence is also cited as a risk factor due to moral judgment; violence directed at adolescent girls often manifests itself through reprimands, sexually suggestive jokes, or criticism about their reproductive lives, constituting a double punishment: for their gender and for the precocity of their pregnancy (Aguiar; D'Oliveira, 2011).

Issues related to moralistic views on female sexuality are also presented as an associated factor; thus, verbal violence is often a form of moral punishment for women who express their pain or who have a reproductive trajectory considered 'inadequate' by professionals, as in the case of women with multiple children or unplanned pregnancies (Diniz; Chacham, 2004).

The absence of information is a factor that facilitates violence; thus, the lack of information about the procedures performed and the absence of a request for consent constitute an expropriation of the female body, in which the woman ceases to be the subject of her own history and becomes an object of hospital intervention (Carneiro, 2011). Another important point in this discussion is the issue of shift work and productivity regimes to which professionals are susceptible; Hotimsky et al. (2002) point out that the organization of work in Brazilian maternity wards, based on shifts and staff rotation, favors the "acceleration" of childbirth for the convenience of the hospital routine, to the detriment of each woman's biological time.

The presence of a companion can be a protective factor; denying this right is, in itself, a form of violence and facilitates other aggressions. The presence of a companion freely chosen by the woman acts as a mechanism to inhibit abusive conduct by the health team, since the presence of a third party reduces the power imbalance and vulnerability of the parturient (Diniz; Chacham, 2004).

In this discussion, an important point is the training of healthcare professionals themselves, since violence is often taught as a "standard of care"; technocratic academic training often renders

obstetric violence invisible, treating procedures such as the Kristeller maneuver or routine episiotomy as necessary technical acts, despite the lack of scientific evidence to support them. Thus, Puhl and Schier (2021) argue that obstetric violence should be understood as a violation of fundamental personality rights, since it affects the physical and psychological integrity of women at a time of extreme vulnerability, violating the principle of human dignity.

Overcoming obstetric violence requires a profound reform in the teaching of health professions, replacing the culture of control and pathologization with training based on scientific evidence and the ethics of care. To transform the obstetric reality, it is imperative that institutions adopt evidence-based protocols, eliminating practices without scientific basis, such as mandatory fasting and restriction of movement, which generate unnecessary suffering (Puhl; Schier, 2021).

According to the guidelines of the Ministry of Health (2017), the humanization of childbirth care presupposes respect for female physiology and the reduction of unnecessary interventions, ensuring that the woman is the protagonist of her own childbirth through shared decisions.

Another way to change this scenario would be through access to quality information and the strengthening of the women's movement. These are essential so that women in labor can identify abusive practices and demand compliance with current legislation, functioning as a mechanism of social control over institutions. Finally, some studies show that the presence of obstetric nurses and doulas in hospital care is associated with a significant reduction in cesarean section rates and traumatic interventions, promoting an environment of emotional support that inhibits institutional violence (Rodrigues et al., 2018).

## CONCLUSION

The investigation of factors associated with obstetric violence led to the conclusion that this phenomenon is multifactorial and deeply rooted in a technocratic and medicalized model of care; the study showed that the occurrence of physical and verbal abuse and non-consensual interventions

is not distributed equitably, being closely linked to social determinants of health. Socioeconomic vulnerability, low education levels, and, above all, racial inequalities are preponderant factors: Black and young women constitute the group most exposed to negligent practices and the deprivation of pharmacological or non-pharmacological pain relief. In addition to individual factors, institutional barriers, such as the overload of teams, lack of privacy, and denial of the right to a companion, create an environment that is permissive to the depersonalization of care and the violation of the parturient's autonomy.

## REFERENCES

AGUIAR, J. M. Violência institucional em maternidades públicas sob a ótica dos profissionais de saúde. 2010. Tese (Doutorado em Medicina) – Faculdade de Medicina, Universidade de São Paulo, São Paulo, 2010.

AGUIAR, J. M.; D'OLIVEIRA, A. F. P. L. Violência institucional em serviços de maternidade sob a ótica dos profissionais de saúde. *Revista de Saúde Pública*, v. 45, n. 4, p. 747-757, 2011.

AGUIAR, J. M.; D'OLIVEIRA, A. F. P. L.; SCHRAIBER, L. B. Violência institucional, autoridade médica e poder nas maternidades sob a ótica dos profissionais de saúde. *Cadernos de Saúde Pública*, v. 29, n. 11, p. 2287-2296, 2013.

AGUIAR, J. M.; OLIVEIRA, A. F. P. L. Violência institucional em maternidades públicas sob a ótica das usuárias. *Interface – Comunicação, Saúde, Educação*, v. 15, n. 36, p. 79-91, 2011.

BRASIL. Ministério da Saúde. Diretrizes nacionais de assistência ao parto normal. Brasília: Ministério da Saúde, 2017.

BRASIL. Ministério da Saúde. Programa de Humanização no Pré-Natal e Nascimento (PHPN). Brasília, DF: Ministério da Saúde, 2000.

CARNEIRO, R. Cenas de parto e políticas do corpo. Brasília: Editora UnB, 2011.

DINIZ, C. S. G. et al. Abuso e desrespeito na assistência ao parto por gestores e profissionais de saúde. *Revista de Saúde Pública*, v. 49, p. 56, 2015.

DINIZ, S. G.; CHACHAM, A. S. “The cut above” and “the cut below”: the abuse of caesareans and episiotomy in Brazil. *Reproductive Health Matters*, v. 12, n. 23, p. 100-110, 2004.

DOMINGUES, R. M. S. M.; SANTOS, E. M.; LEAL, M. C. Aspectos da satisfação das mulheres com a assistência ao parto: contribuição para um debate. *Cadernos de Saúde Pública*, v. 20, supl. 1, p. 52-62, 2004.

ERCOLE, F. F.; MELO, L. S.; ALCOFORADO, C. L. G. C. Revisão integrativa versus revisão sistemática. *Revista Mineira de Enfermagem*, v. 18, n. 1, p. 1-11, 2014.

HOTIMSKY, S. N.; ALVARENGA, A. T.; SCHRAIBER, L. B. O parto como evento feminino e familiar: a perspectiva de mulheres e homens. *Interface (Botucatu)*, v. 6, n. 10, p. 149-151, 2002.

LANSKY, S. et al. Violência obstétrica: influência da exposição ao uso de boas práticas na assistência ao parto no Brasil. *Revista de Saúde Pública*, v. 53, p. 28, 2019.

MELO, B. L. P. L. et al. Violência obstétrica à luz da Teoria da Diversidade e Universalidade do Cuidado Cultural. *Revista Cuidarte*, v. 13, n. 1, e1536, 2022.

MILFONT, P. M. S. et al. Estudo exploratório sobre a implementação de diretrizes para um parto seguro e satisfação das mulheres. *Online Brazilian Journal of Nursing*, v. 10, n. 3, 2011. Disponível em: <http://www.objnursing.uff.br/index.php/nursing/article/view/3493>. Acesso em: 15 abr. 2026.

MINAYO, M. C. S.; SOUZA, E. R. Violência sob o olhar da saúde: infrapolítica da contemporaneidade brasileira. *Cadernos de Saúde Pública*, v. 20, n. 4, p. 23-47, 2006.

MUNIZ, B. M. V.; BARBOSA, R. M. Problematizando o atendimento ao parto: cuidado ou violência? *Memórias Convención Internacional de Salud Pública*, 2012. Disponível em: <http://www.defensoria.sp.gov.br/dpesp/Repositorio/41/Documentos/artigo%20parto.pdf>. Acesso em: 15 abr. 2026.

ORGANIZAÇÃO MUNDIAL DA SAÚDE. Declaração da OMS sobre taxas de cesáreas. 2015. Disponível em: <https://apps.who.int/iris/handle/10665/161442>. Acesso em: 15 abr. 2026.

ORGANIZAÇÃO MUNDIAL DA SAÚDE. Recomendações da OMS para os cuidados durante o parto para uma experiência positiva no nascimento. 2018. Disponível em: <https://www.who.int/publications/i/item/9789241550215>. Acesso em: 15 abr. 2026.

ORGANIZAÇÃO MUNDIAL DA SAÚDE. Tecnologia apropriada para partos e nascimentos: recomendações da Organização Mundial da Saúde. Genebra: OMS, 1996.

PEREIRA, W. R. O poder, a violência e a dominação simbólicos nos serviços públicos de saúde que atendem mulheres em situação de gestação, parto e puerpério. *Texto & Contexto Enfermagem*, v. 13, n. 3, p. 391-400, 2004.

PUHL, J. I.; SCHIER, P. R. Violência obstétrica e a violação de direitos fundamentais. *Revista de Direito Sanitário*, v. 21, e0002, 2021.

RODRIGUES, D. P. et al. A violência obstétrica no contexto do parto e nascimento: revisão integrativa. *Revista de Enfermagem UFPE*, v. 12, n. 1, p. 236-246, 2018.

SOUZA, M. T.; SILVA, M. D.; CARVALHO, R. C. Revisão integrativa: o que é e como fazer. *Einstein*, v. 8, n. 1, p. 102-108, 2010.

TEIXEIRA, N. Z. F.; PEREIRA, W. R. Parto hospitalar: experiências das mulheres na periferia de Cuiabá. *Revista Brasileira de Enfermagem*, v. 59, n. 6, p. 740-744, 2006.

URSI, E. S. Prevenção de lesões de pele no perioperatório: revisão integrativa da literatura. 2005. 130 f. Dissertação (Mestrado em Enfermagem) – Universidade de São Paulo, Ribeirão Preto, 2005.

VENTURI, G.; GODINHO, T. Mulheres brasileiras e gênero nos espaços público e privado: uma década de mudanças na opinião pública. São Paulo: Fundação Perseu Abramo; SESC-SP, 2013.