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Epidemiology of obstetric violence: a narrative review of the Brazilian context

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Abstract *The aim of this review is to present the state of the art regarding obstetric violence in Brazil. The most commonly used terms are "obstetric violence," "disrespect and abuse," and "mistreatment". Concerning measurement, the most widely used instrument is based on the definition of "mistreatment," still in its early stages of evaluation and lacking adaptation to Brazil. The prevalence of obstetric violence varies widely in national studies due to methodological factors and the type of postpartum women considered. Regarding risk factors, adolescent or women over 35, non-white, with low education levels, users of the public health system (SUS), those who had vaginal birth or abortion, are at higher risk. Hierarchical relationships between the healthcare team and the family are also relevant, as well as inadequate hospital structures, bed shortages, and insufficient healthcare professionals, which contribute to obstetric violence. The consequences of this violence include an increased risk of postpartum depression and PTSD, reduced likelihood of attending postpartum and childcare consultations, and difficulties in exclusive breastfeeding. Interventions to mitigate obstetric violence should consider women's empowerment, healthcare professionals' training, monitoring obstetric violence, and legal support.*

Key word *Epidemiology, Obstetric violence, Women right*

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Introduction

Since the publication of the definition of "disrespect and abuse during childbirth" in 2010, researchers from around the world have been engaging in discussions and producing knowledge about violations of women's rights during pregnancy, childbirth, postpartum, and abortion care. In Brazil, the term "obstetric violence" is the most commonly used to describe such situations, so we have chosen to use it in this publication[1].

Obstetric violence is characterized by physical, verbal, and sexual violence, negligence, mistreatment, disrespect, non-evidence-based practices, and inadequacies in healthcare services[2]. Obstetric violence has three specific characteristics. It occurs exclusively in healthcare settings, including outpatient care, clinics, and maternity wards; the perpetrators are often healthcare professionals; and finally, it has a dual nature, combining interpersonal acts (physical/verbal violence) with institutional aspects (overloaded maternity wards with inadequate structure and human resources)[1].

In the Brazilian context, obstetric violence has gained visibility driven by two factors: the politicization and media coverage of the issue[3,4]. Regarding political issues, it is important to highlight that, during the period from 2018 to 2022, women faced challenges concerning their sexual and reproductive rights. One of the first was the release of a statement by the Federal Council of Medicine, endorsed by the Ministry of Health (Ministério da Saúde – MS), discouraging the use of the term "obstetric violence," arguing that the term is used inappropriately and "with an aggressiveness bordering on hysteria", being offensive to certain professional categories. Additionally, other actions adopted by the MS, such as the dismantling of the *Rede Cegonha* and the restriction of legal abortion services during the COVID-19[5] pandemic, were against women's rights.

On the other hand, all these events did not go unnoticed by the media, which reported stories of girls and women who were victims of obstetric violence. Among the articles released, the story of a 10-year old girl, pregnant as consequence of a rape and coerced to not exercise her right to legal abortion. In addition to that, audio files were disclosed regarding a digital influencer being verbally abused during childbirth, as well as the case of a woman who was raped by an anesthesiologist during a cesarean section. Such cases evidence that the obstetric violence is a reality in Brazil.

The media's interest in obstetric violence has increased the visibility of this issue in society at large. Furthermore, researchers worldwide have been publishing scientific studies demonstrating that obstetric violence is a public health issue and has a negative impact on the health of women and their newborns. In this context, this review aims to present the state of the art of obstetric violence in Brazil, addressing epidemiological aspects such as definition, measurement, prevalence, risk/protection factors, consequences, and interventions for its mitigation.

Definition and measurement

There is no consensus on the most appropriate term and definition to express acts related to obstetric violence. The most common terms are "obstetric violence," "disrespect and abuse", and "mistreatment during childbirth." Although these terms are often used interchangeably, in the scientific community they have distinct definitions, while sharing certain domains.

The term "obstetric violence" emerged from feminist movements that questioned childbirth care practices violating women's human rights[6]. Thus, discussions on autonomy, sexual and reproductive rights, and evidence-based medicine gained prominence in this context[7]. This term was initially defined in Venezuelan legislation in 2007[2] as "actions or omissions by healthcare teams, in the public or private sphere, that result in the "appropriation of women's bodies and reproductive processes by healthcare professionals through dehumanized care, abuse of medicalization, and pathologization of natural processes, leading to the loss of autonomy and the ability to freely decide about women's bodies and sexuality, negatively affecting their quality of life"[2].

The term "obstetric violence" has a broad definition, being advantageous for the implementation of specific legislation on the subject. However, the concept lacks a more precise definition that could be used for measurement in epidemiological surveys. Having this in mind, Bowser & Hill[8] (2010) proposed the term "disrespect and abuse in childbirth." Their definition encompasses seven dimensions: 1) Physical abuse; 2) Care assistance without consent; 3) Non-confidential care assistance; 4) Undignified care assistance, which includes verbal abuse; 5) Discrimination; 6) Abandonment of patients; 7) Detention in healthcare facilities. This term and its definition were the first to bring visibility to the issue at a

global level, forming the basis for an important publication by the World Health Organization in 2015, titled "*The prevention and elimination of disrespect and abuse during facility-based childbirth*"[9]. Based on this proposal, there was a significant increase in publications on this theme, representing an important milestone in this area of knowledge.

In 2015, Bohren *et al.*[6] (2015) proposed a new definition based on the proposal by Bowser and Hill, as well as on data from qualitative and quantitative research. The term used was "Mistreatment in childbirth," and their definition was also presented in seven dimensions: 1) Physical abuse; 2) Sexual abuse; 3) Verbal abuse; 4) Stigma and discrimination; 5) Inadequate healthcare practices; 6) Poor healthcare professional-patient relationship; 7) Healthcare system inadequacies and constraints[6]. This proposal included a questionnaire to measure mistreatment in childbirth care and an attempt to validate this instrument. This is an important advancement as it has stimulated research and allowed for comparisons between different locations around the world. Additionally, it has contributed to the recognition of mistreatment in childbirth care as a public health issue.

Although all the expressions presented show similarities and share domains, there is much controversy surrounding them. One point to mention is that none of these definitions explicitly include women undergoing abortions as a target group. Consequently, it is common for research studies on this theme to focus only on women giving birth, leaving a significant portion of women who are also victims of obstetric violence invisible.

Another aspect that incurs in constant conflict is the term "obstetric violence." Many healthcare professionals feel uncomfortable with its use, arguing that the word "violence" assumes intentionality, making it inappropriate for all situations encompassed by obstetric violence[10]. A second argument against the use of this term is the lack of recognition by some professionals that obstetric violence is indeed a public health issue in Brazil. Many believe that the cases highlighted in the media are extreme and isolated. Thus, labeling and defining these acts as obstetric violence would be disproportionate.

However, there are healthcare professionals and researchers who advocate for the use of the term. The main argument is that women's social movements chose this expression because they consider it the most appropriate to describe situations of violence, abuse, or mistreatment experienced during pregnancy, childbirth, postpartum, or abortion. Therefore, supporting the use of this term is a way to give voice to the victims. The term "violence" conveys a violation of women's human and reproductive rights. In turn, the term "obstetric" highlights that this violence occurs during the pregnancy cycle, including women undergoing abortions. Additionally, the term emphasizes that obstetric violence is a combination of gender-based violence and mistreatment in healthcare services[10].

The measurement of obstetric violence is a challenge linked to the discussion about the lack of consensus on this matter. As mentioned above, this construct is still under development. In this context, the assessment of the issue at acceptable levels of validity and reliability is impaired and subject to bias due to the lack of an objective definition[11]. According to Reichenheim & Bastos (2021), the validation of a measurement instrument ultimately implies the validation of the very theory that encompasses the construct the instrument is intended to measure.

Given this gap, much of the research on this theme has used a different set of questions related to the construct of obstetric violence, which complicates the comparison of findings. It is worth mentioning that, to date, only three instruments developed for measuring obstetric violence have had some of their psychometric properties evaluated, one of which was developed in Brazil by Paiz et al. (2022)[12]. The authors developed two instruments: one for women who were in labor and another for a broader group. Another instrument whose psychometric properties were evaluated is the one proposed by Dewkat et al. (2021)[13], which includes 11 items and was developed in the West Bank. The third and final instrument that had its psychometric properties assessed[14,15] is the one developed by Bohren et al. in 2015[6]. Initially developed for use in research studies conducted in African and Asian countries[16,17], this instrument has been widely used in epidemiological studies and applied in various countries. It is important to note that most existing psychometric evaluations focus on the reliability and the analysis of the instrument configural structure. Thus, it underscores the need for more studies addressing these and other psychometric properties that have not been previously evaluated in other populations and contexts, in order to consolidate knowledge around the development and/or cross-cultural adaptation of instruments for measuring obstetric violence.

Prevalence of obstetric violence

Women in labor

There are many studies on the prevalence of obstetric violence in Brazil. However, it is worth noting that some research studies stand out due to their coverage. In this regard, four studies deserve attention: 1) Perseu Abramo Foundation, 2) Nascer no Brasil 2011/2012; 3) 2015 Pelotas Cohort; 4) Ribeirão Preto Cohorts of 1978/79 and 94.

The first national survey that covered obstetric violence is named "Brazilian Women and Gender in Public and Private Spaces.", conducted by the Perseu Abramo Foundation. This study included 1,466 women who reported having had at least one previous pregnancy. Obstetric violence was measured through 10 items that assessed physical, psychological, and sexual abuse, as well as neglect, estimating a prevalence of 25%[18]. Despite the innovative theme for a national survey, it is important to mention its limitations, such as the limited number of women for a national sample and the lack of a validated measurement instrument.

The second national survey that also addressed the theme was the study "Nascer no Brasil I", conducted in 2011/2012. Approximately 24,000 women across the entire national territory were interviewed in this hospital-based study, representing 80% of the births that occurred in the country[19]. Regarding obstetric violence, the study contributed to a better understanding of the matter in the country through publications that addressed disparities, the prevalence of acts of obstetric violence, and their impact on the health of the woman and her newborn.

The findings of the study "Nascer no Brasil I" showed that 11.1% of women felt disrespected throughout the entire childbirth process[20]. Regarding the presence of a companion during childbirth, 24.5% of women reported the complete absence of a companion, while 56.7% mentioned the partial absence of a companion[21]. Among women with usual obstetric risk, 56.1% reported having undergone an episiotomy, and 37.3% reported having experienced the Kristeller maneuver[22]. About 45% of the interviewees reported having experienced at least one act of obstetric violence during childbirth, including physical or psychological violence, disrespectful treatment, lack of information, privacy, and communication with the healthcare team, impossibility to ask questions, and loss of autonomy[23].

Similarly to the study conducted by the Perseu Abramo Foundation, the study "Nascer no Brasil I" also has its limitations. Obstetric violence was not measured using a validated measurement instrument. In this study, the measurement of this issue was conducted through seven questions from a questionnaire which assess the satisfaction with the care received. The combination of these questions via latent classes was considered an indicator of the occurrence of obstetric violence. It should be noted that at the time the study was conducted, there was no consensus on the definition and measurement of obstetric violence. Regarding the strengths of this research study, the large sample size and its high representativity stand out.

Another study that should be mentioned when addressing obstetric violence in Brazil is the 2015 Pelotas (RS) Birth Cohort. This is a population-based study that collected information on obstetric violence three months after delivery. The sample included 4,275 postpartum women and showed that 10% of them suffered verbal abuse, 5% physical abuse, 6% were subjected to inappropriate or undesirable procedures, and 6% had some type of care service denied. In total, 18.3% of the women reported some form of mistreatment during their last childbirth[24]. As with the two previously mentioned studies, measurement of obstetric violence also represents a limiting aspect of this research study. The strengths of this study include its large sample size and population coverage.

Finally, another relevant study in the context of obstetric violence is the Ribeirão Preto (SP) Cohort. In this study, women from two cohorts (1978/79 and 1994) who had experienced at least one childbirth were interviewed. The questionnaire was administered by phone during the 5th and 3rd follow-ups of the respective cohorts. A total of 632 women were interviewed, representing 68% of the total women in the cohorts[25]. In addition to addressing the occurrence of obstetric violence, this study also investigated women's perceptions of obstetric violence. The results showed a significant disparity. While 62.2% of the women reported experiencing at least one act of obstetric violence, only 8.3% perceived themselves as victims of any form of violence, abuse, or mistreatment. A notable limitation of this study is the number of eligible women considered as losses to follow-up. The limitation of the instrument used should also be mentioned. Chart 1 provides a summary of the results and methods of the abovementioned studies.

Chart 1. Prevalence and methodological aspects of national research studies on obstetric violence against women during childbirth .

Pesquisa	Perseu Abramo	Nascer no Brasil I	Pelotas (RS) Cohort	Ribeirão Preto (SP) Cohort
Prevalence of obstetric violence	25% throughout life	44% in the last childbirth	18% in the last childbirth	62,2% throughout life
Coverage	National (however, the text is not clear regarding the representativeness of the sample for those questions involving obstetric violence)	National – Hospital-based	Local – Population-based	Local – Population-based
Sample Size	1,466	24,000	4,275	745
Questions used to measure obstetric violence	During childbirth, any healthcare professional: 1) performed painful vaginal exams? 2) denied or failed to offer any type of pain relief? 3) yelled at you? 4) did not inform you about a procedure being performed? 5) refused to assist you? 6) cursed or humiliated you? 7) pushed you? 8) restrained you? 9) hit you? 10) sexually harassed you?	During your childbirth hospitalization: 1) Do you consider yourself to have been a victim of mistreatment or any other form of violence by the professionals, such as verbal violence, psychological violence, or physical violence? 2) How do you evaluate the respect shown by the professionals when receiving you and speaking with you? 3) How do you evaluate the manner in which your privacy was respected during the physical examination and care? 4) In your opinion, how were the care and guidance you received from childbirth until discharge from the maternity ward? 5) How would you rate the clarity with which the healthcare professionals explained things to you? 6) How would you rate the amount of time available for you to ask questions about your health or treatment? 7) How do you evaluate the opportunity to participate with the healthcare team in decisions about your labor and delivery?	During your hospitalization for childbirth: 1) Did any professional ever push, hurt, hit, hold you forcefully, or conduct any examination in a rude or disrespectful manner? 2) Was any professional rude to you, insulted or yelled at you, humiliated or threatened not to assist you?; 3) Did any professional refuse to give you something you requested, such as water or a painkiller? 4) Did any professional ever perform a procedure against your will, without explaining the necessity of it, such as an episiotomy or medication to induce labor?	During my childbirth care: 1) I was not allowed to have the companion of my choice with me; 2) I was not allowed to eat or drink; 3) They yelled at me; 4) They threatened to interrupt the assistance being provided to me; 5) I was subjected to several vaginal exams without being consulted; 6) The healthcare team in charge of assisting me did not explain to me what was happening; 7) I was forced to have a vaginal delivery against my will; 8) I was forced to have a cesarean section against my will; 9) They pushed on my abdomen to help the baby be born; 10) The healthcare team did not allow me to walk when I wanted to; 11) The healthcare team cut my vagina without consulting me or against my will; 12) The healthcare team cut my vagina without anesthesia; 13) The healthcare team took a long time to show or take the baby.

Source: Authors.

Women undergoing abortion

Few national studies have estimated the prevalence of obstetric violence among women undergoing abortion, revealing the invisibility of this issue in these women. Additionally, the main terms and definitions on the theme emphasize childbirth, leaving gaps concerning situations related to abortion.

The most recent systematic review on the theme in Latin America identified only three publications that addressed the issue in Brazil[26].

The oldest study, already mentioned, was conducted in 2010 by the Perseu Abramo Foundation. In this research study, specific questions were asked to women who reported having had at least one induced abortion in their lifetime. The estimated prevalence was 53.6%, double that found for women in labor in the same study (25%)[18]. Despite the innovation, caution is necessary when using these data to reference prevalence and make comparisons with women in labor due to the small sample size (n = 100).

Another study that addressed obstetric violence among women undergoing abortion was conducted by Aquino et al, 2012[27]. This was a cross-sectional study conducted in seven hospitals in four capitals of Northeast Brazil. The target population consisted of women hospitalized due to abortion. A total of 2,804 participants were interviewed using a validated questionnaire on the quality of the care received during abortion. The results showed that 5.6% of the women felt judged and treated with suspicion for having induced the abortion, while 1.8% of the women reported having their requests for analgesia denied. Combining these two indicators, 8.4% of the women reported some type of obstetric violence.

This study stands out for being conducted with women hospitalized specifically due to abortion and for having a large sample size considering the said target group. However, a limitation is that the study was designed to evaluate the quality of the care received during abortion. Thus, although some questions concerns obstetric violence, there is no specific instrument related to this topic in the research study. Although related, these topics consist of different constructs.

Finally, the research study conducted by Madeiro et al, 2017[28] in Teresina (PI), involved women who underwent illegal and unsafe abortions and were hospitalized in a referral hospital for uterine curettage. The results revealed that 33% of the women experienced at least one act of obstetric violence, considering dimensions such as discrimination, neglect, undignified clinical care, lack of confidentiality or privacy, physical violence, and non-consensual procedures. Despite having design and questionnaire specific for obstetric violence, the study included only 78 women, which hindered the conduction of robust statistical analyses.

It is important to highlight that the measurement instrument is a significant methodological issue to be overcome. None of the studies used a questionnaire specifically validated for the target group in order to assess the occurrence of obstetric violence. However, to date, there is no specific instrument to evaluate obstetric violence in women undergoing abortion in Brazil.

Considering the current panorama and the absence of nationally representative studies, we do not have robust evidence on the prevalence of obstetric violence among women undergoing abortion in Brazil. However, the cited studies suggest that the prevalence may be higher compared to women who have gone through childbirth. Additionally, we may also hypothesize that women who have undergone induced abortion may be at a higher risk of experiencing obstetric violence compared to women who have had miscarriages.

In summary, when analyzing national studies on the prevalence of obstetric violence, there is a wide range, varying from 25% to 62% for women who have given birth, and from 8% to 54% for women undergoing abortion. This variation can be explained by different factors: 1) differences in the questionnaires used to measure obstetric violence; 2) type of prevalence considered, whether point prevalence (prevalence during the last childbirth/abortion) or lifetime prevalence (considering all childbirths/abortions of the woman); 3) location where the women are interviewed; 4) method of interview (face-to-face or by phone); 5) geographical location. Regarding this last aspect, some studies suggest that the South region has a lower prevalence of obstetric violence compared to the other regions[20]. Therefore, when analyzing information regarding this issue in Brazil, caution is necessary due to the different methodological approaches used in the studies, as observed in Chart 2.

Risk and protective factors for obstetric violence

Obstetric violence results from an interaction of various factors, including individual, relational, socioeconomic, cultural, and environmental aspects. The ecological approach developed by Bronfenbrenner and presented in the 2002 World Report on Violence and Health helps us understand the multicausal etiology of violence. The model encompasses four levels: 1) individual, 2) relational, 3) community, and 4) society (macro level)[29], according to Figure 1.

This ecological model can be adapted to obstetric violence. Thus, the first level seeks to identify women's characteristics that may increase or decrease the likelihood of experiencing obstetric violence. Adolescents or women over 35 years old, non-white women, immigrants, and those

Chart 2. Prevalence and methodological aspects of national research studies on obstetric violence against women undergoing abortion and spontaneous abortion.

Study	Aquino et al., 2012	Venturi et al., 2013	Madeiro et al., 2017
Prevalence	8,4% (spontaneous abortion and abortion)	53,6% (abortion)	33% (abortion)
Coverage	Local – Salvador (BA), Recife (PE) and São Luís (MA)	National	Local - Teresina (PI)
Sample Size	2,804 women	100 women	78 women
Questions used to measure obstetric violence	The questions used included those regarding the moral judgment of abortion, as well as requests for denied analgesia.	1) They persistently asked if you had an abortion and treated you like a suspect; 2) they did not inform you about the procedure they would be performing; 3) they said you had committed a crime and threatened to report you to the police; 4) they left you hospitalized without giving you any explanations; 5) they showed you the remains of the fetus and said something like "Look at what you did?"	The questions addressed included those regarding moral judgment on the practice of abortion, long wait times for performing uterine curettage, and the absence of a companion during the wait for the curettage; threats and reports to the police; use of harsh and rude language, reprimands or yelling; joint hospitalization with postpartum mothers; interviews and physical examinations conducted in the presence of other patients; disclosure of medical history without consent; lack of pain management and refusal to offer painkillers; vaginal exams performed without prior explanation; blood transfusion performed without prior explanation; and hysterectomy performed without prior explanation.

Source: Authors.

from lower socioeconomic backgrounds are more vulnerable to experiencing obstetric violence compared to women between 20-34 years old, white, Brazilian nationals, and those with higher socioeconomic status. These data highlight the existing social and racial inequalities in our country[22].

Considering the physiological aspects of childbirth, it is observed that primiparous women, women who were in labor and had a vaginal delivery are more likely to be victims of obstetric violence compared to multiparous women, women who did not go into labor and had a cesarean section[20]. Available evidence indicates that situations extending the duration of interaction between the woman and the healthcare team during the pre-labor period increase the risk of obstetric violence.

Still concerning the first level, it is important to highlight the reason for admission in the maternity ward/hospital, whether due to childbirth or abortion. Although the literature does not allow for a direct comparison between these different experiences, our hypothesis is that the prevalence of obstetric violence is higher among women who have undergone an abortion compared to those who have experienced childbirth. This difference is due to the moral judgment associated with this practice in our society. Women undergoing abortion often report being repeatedly questioned about their decision to induce the abortion, as well as experiencing neglect in healthcare services as a result[18].

The second level of the ecological model explores how close social relationships can influence the risk of obstetric violence. This level takes into account the relationship between the healthcare team and the patients. Hierarchical relationships, with limited opportunities for women to ask questions and little autonomy to make decisions about their own bodies, can increase the likelihood of obstetric violence[23]. In the case of abortion, judgment, discrimination, and distrust from the healthcare team regarding the woman's intention to induce an abortion are additional factors.

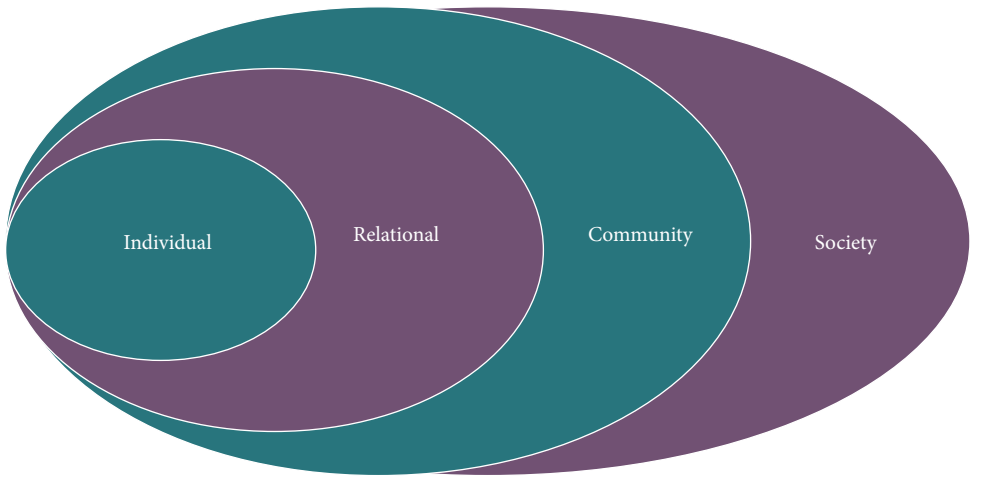

Figure 1. Ecological model explaining the multicausal factors for the occurrence of violence.

Source: Authors, adapted from Krug, 2002.

In turn, studies have shown that the presence of a companion throughout the hospitalization for childbirth/abortion is an important protective factor against obstetric violence[21,23]. Regarding doulas, there is no evidence indicating a positive or negative effect on the occurrence of obstetric violence. It is noteworthy that resistance to the presence of doulas from other healthcare professionals is high in our country, turning the presence and performance of these professionals during childbirth into a potential risk factor in some contexts.

The third level of the ecological model regards the community context in which violence occurs. Considering that 99% of births in Brazil take place in healthcare institutions, we can highlight that inadequate hospital structures, lack of beds, an insufficient number of healthcare professionals, medicalization of childbirth care, and a culture that favors cesarean sections can contribute to the occurrence of obstetric violence[30]. In case of abortion, the access to healthcare services is also an issue, even in legal cases[31].

At the last level, the social level, structural and cultural factors that favor the occurrence of obstetric violence are included. At this level, we can mention legal issues that violate women's reproductive rights, the lack of autonomy for pregnant women to refuse any type of treatment that the doctor deems necessary, the criminalization of abortion, the lack of public policies for the prevention of violence during the pregnancy and postpartum cycle, as well as the lack of legal support for reporting and punishing aggressors. In cases of abortion, it is also important to consider the cultural issues of a predominantly Catholic and Evangelical country, where there is a moral and religious consensus that condemns the act, which supports the existence of restrictive and punitive laws[32]. The influence of these religious beliefs on legislation and public policies related to abortion can create significant barriers to accessing reproductive healthcare services. These restrictions can result in serious impacts on women's health and rights, making access to safe and legal abortion a challenge in our country.

Consequences of obstetric violence

In the past five years, there has been an increase in academic research on the consequences of obstetric violence on the health of women and newborns. Initial studies on the matter explored the effects of obstetric violence on maternal mental health, focusing on postpartum depression and post-traumatic stress disorder (PTSD).

Regarding depression, Brazil stood out as a pioneer by publishing the first manuscript on the

relationship between obstetric violence and postpartum depression in 2018[33]. This study revealed that the experience of wandering and physical violence during childbirth were associated with a higher occurrence of postpartum depression. This association was even stronger among Black women and adolescents. Another study, using data from the 2015 Pelotas Birth Cohort, also found a causal relationship between obstetric violence and postpartum depression[34]. The authors of this study observed a dose-response relationship, showing that the risk of postpartum depression increased with the number of acts of obstetric violence experienced.

Another national study that has also investigated this relationship used data from the "Nascer no Brasil I" research study. The study explored whether the mode of delivery or the payer for the hospitalization influenced the magnitude of the relationship between obstetric violence and postpartum depression. The researchers did not find differences, showing that the increased risk of postpartum depression due to obstetric violence occurs similarly among all women, regardless of whether they had a vaginal delivery or a cesarean section, or whether they received care assistance in public or private services[23].

Publications that evaluate the relationship between obstetric violence and PTSD are relatively recent in the literature. These studies indicate that a woman may perceive her childbirth experience as traumatic when events during labor, delivery, or the postpartum period put her life or the life of her newborn at risk. Additionally, situations where there is a disruption of the imagined expectations for the childbirth process have been mentioned in the literature as factors that can amplify the perception of trauma[35]. Thus, the experience of obstetric violence can be traumatic, as it is not expected for the healthcare team to treat women violently, especially during a moment of vulnerability[36].

Although most of the literature on the impact of obstetric violence focuses on mental health outcomes, other consequences have also been studied. A study using data from the "Nascer no Brasil I" research study revealed that women who experienced obstetric violence were less likely to seek postnatal healthcare services, both for themselves and for their babies, especially among women who used the SUS (Unified Health System)[37]. The authors explain that a breakdown of trust in the healthcare service as a whole can drive families away from primary care. This disruption in the relationship has the potential to harm care assistance continuity, which includes everything from family planning to monitoring the child's growth and development during the first year of life.

Another consequence of obstetric violence is the difficulty in establishing and maintaining breastfeeding. A recent study showed that women who experienced obstetric violence during hospitalization for childbirth were less likely to be discharged with their baby exclusively breastfeeding and less likely to be breastfeeding two months after delivery[38]. This effect was observed primarily in women who had vaginal deliveries. The authors proposed several hypotheses to explain this relationship. Obstetric violence often occurs at a critical moment, such as labor and delivery, which can cause stress and result in irreversible changes in milk production physiology, reducing the likelihood of breastfeeding after childbirth. Additionally, women who experienced obstetric violence may receive less support from the healthcare team in establishing breastfeeding[38]. Finally, another possibility is that the negative effect of obstetric violence on breastfeeding is related to the increased risk of depression and other mental health disorders in the postpartum period.

Lastly, considering neglect as one of the components of obstetric violence, it is possible to suggest that neglect may increase the likelihood of near misses and maternal and neonatal mortality[39]. In different contexts from Brazil, particularly in some African countries where there is resistance from women regarding hospital childbirths, the fear of obstetric violence and cesarean sections is the major reason for preferring home childbirths. In these countries, mitigating obstetric violence has been adopted as a strategy to increase the proportion of hospital childbirths and reduce maternal mortality.

Interventions

Obstetric violence is a complex phenomenon, and its risk and protective factors are broad and distributed across various micro- and macrostructural levels, as outlined in the ecological model. Therefore, strategies aimed at its mitigation should intervene at these levels, seeking to modify the structures that allow for the perpetuation and normalization of this form of violence against women.

Thus, the empowerment of women (individual level); training and education of healthcare professionals (relational level); epidemiological

surveillance and reporting (community level); and legal support (macro level) are the four essential pillars for mitigating obstetric violence.

Regarding women, the primary intervention that can be implemented is the dissemination of high-quality, evidence-based information about the processes of pregnancy, childbirth, postpartum period, and situations involving abortion. In addition to that, it is crucial to raise awareness among women about their legal rights. This information should be provided during prenatal care, as well as during visits to familiarize oneself with the maternity ward, at admission for childbirth, and during postpartum consultations. It is also important to provide information about obstetric violence so that women can recognize harmful and disrespectful practices.

Regarding healthcare professionals (second level), it is important that they receive training and ongoing education to adopt practices based on scientific evidence and have knowledge about human and reproductive rights, as well as the several forms of violence prevention that can occur in healthcare services. The promotion of a non-hierarchical and respectful relationship between the healthcare team and the woman is also necessary. Currently, many health decisions may and must be made considering the patient's context, opinion, and culture. Thus, it is essential to encourage shared decision-making between the healthcare team and the woman.

Still concerning the second level, interventions aimed at mitigating obstetric violence must also consider important aspects of healthcare workers in our country, addressing issues such as exhausting work hours, overcrowding of the healthcare system – especially in the public sector, precarious working conditions, and mental health problems triggered by the work process. It is important to ensure that professionals working in maternal and postpartum care have dignified working conditions and are assisted, receiving psychosocial support when necessary.

Regarding the third level, it is essential that hospitals/maternity wards conduct epidemiological surveillance on indicators related to obstetric violence and satisfaction with the care received, following the example of what is done for some maternal and perinatal health indicators. Furthermore, reporting is an important way for women to unveil acts of obstetric violence that have occurred at any stage of the reproductive cycle. Therefore, it is essential that healthcare facilities encourage women, family members, and other healthcare professionals to report the practice of obstetric violence, providing communication channels for this purpose. Finally, at the last level, it is important to have specific laws that classify obstetric violence as a crime and establish punishments for its perpetrators.

It is worth mentioning that a growing number of studies evaluating interventions to mitigate obstetric violence within the hospital environment have been published[40]. These studies focus both on evaluating actions to minimize the occurrence of obstetric violence and on promoting respectful maternal care. This approach encompasses a set of actions aimed at ensuring a positive childbirth experience, valuing autonomy, dignity, and women's rights.

The most recent systematic review, published in 2023, identified 7 studies that evaluated interventions in maternity wards aimed at mitigating obstetric violence[40]. All of these studies were conducted in African countries. In general, these interventions were multi-component, covering more than one level of the aforementioned ecological model. The interventions included the dissemination of information to women through illustrations, pamphlets, and videos. Additionally, training sessions and workshops were conducted for healthcare teams, addressing topics such as obstetric violence, human rights, women's rights, ethics, and quality of healthcare services. Technical training was also offered to the teams. Some studies also focused on community-level actions, such as disseminating information about sexual and reproductive rights to the community and providing legal counseling for reporting and conflict mediation. The results of these studies revealed that the implemented interventions reduced the occurrence of obstetric violence.

However, future studies are necessary to develop and evaluate interventions that address obstetric violence more comprehensively and effectively. These studies could contribute to the adoption of evidence-based strategies targeted at various levels of the ecological model, aiming to promote a more respectful and violence-free maternal and infant care.

Conclusion

This review underscores the importance of understanding the current state of knowledge on obstetric violence in the national context. The evidence presented highlights the urgency of addressing this public health issue, which affects women's physical and emotional integrity as well

as their rights during the pregnancy-puerperal cycle.

The review revealed significant gaps in the literature on obstetric violence, emphasizing the need for more studies on the negative consequences for the health and well-being of women and newborns in different contexts. It is crucial to expand the researches scope in order to include women undergoing abortion, acknowledging that obstetric violence is a reality faced by this group. Another identified gap relates to the lack of consensus in terminology, definition, and consequently, in the absence of an accurate instrument to measure the issue. Additionally, the lack of studies addressing interventions to mitigate obstetric violence is also a gap that should be addressed in future research.

Investing in structured and representative epidemiological studies is essential for understanding and deepening the problem. These studies will provide important information for the development of public policies better suited to the national context, promoting effective transformation in healthcare services and ensuring respect for women's reproductive rights and dignity.

Collaborations

TH Leite and ES Marques: conception and design, drafting of the article. RG Corrêa, MC Leal, BC Olegário and RM Costa: critical review, approval of the version to be published. MA Mesenburg: conception and design, approval of the version to be published.

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