

KNOWLEDGE OF POSTPARTUM WOMEN RECEIVING PRIMARY HEALTH CARE REGARDING OBSTETRIC VIOLENCE IN A MUNICIPALITY IN PARAÍBA, BRAZIL

 <https://doi.org/10.63330/aurumpub.058-021>

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Abstract

This study aimed to analyze knowledge about obstetric violence and its forms of manifestation among postpartum women receiving Primary Health Care in a municipality in the state of Paraíba, Brazil. This is an analytical study with a qualitative approach, conducted with 13 postpartum women who were users of Family Basic Health Units in Alagoinha, Paraíba, in October 2023. Data were collected through semi-structured interviews with audio recording and subjected to thematic content analysis, as proposed by Bardin. The results showed that most postpartum women did not receive adequate guidance during prenatal consultations regarding obstetric violence, which hindered the recognition of situations characterized as violence during labor and childbirth. It is concluded that the identified knowledge gaps reinforce the need to incorporate the topic of obstetric violence into health education activities developed during prenatal care. The importance of using specific educational strategies to increase pregnant women's knowledge about their rights and the different forms of obstetric violence is also highlighted, contributing to its prevention and to the recognition of possible situations of violence.

Keywords: Obstetrics, Obstetric Violence, Parturition, Postpartum Period, Pregnancy.

INTRODUCTION

Obstetric violence (violência obstétrica, OV) is understood as actions involving restrictions on the presence of a companion, the performance of medical procedures without consent, violations of privacy, refusal to administer analgesics, and violence in its various forms. The most common situations include neglect, physical violence, verbal violence, and psychological violence (Marinho et al., 2021).

Neglect occurs when a health professional fails to participate in family and reproductive planning, refuses to provide care, performs unnecessary procedures during labor, or prevents a pregnant woman from being accompanied by her partner or family members (Hakimi et al., 2025). Such conduct constitutes noncompliance with Federal Law No. 11,108/2005, which guarantees pregnant women the right to have a companion during labor and the postpartum period (Brasil, 2005).

In obstetric studies, physical violence refers to unnecessary interventions performed without the pregnant woman's consent. Practices contraindicated by the World Health Organization (WHO) include the administration of intravenous oxytocin, restrictions on fluid and food intake, excessive vaginal examinations, enemas, artificial rupture of the amniotic sac, pubic shaving, the imposition of birthing positions without considering the parturient woman's preference, denial of pain-relief methods, episiotomies, the use of forceps without clinical indication, limb immobilization, and application of the Kristeller maneuver (Brasil, 2017).

Within this context, a cesarean section may also constitute OV when performed without clinical indication or the woman's consent, as well as when her choice is denied, thereby preventing her from deciding how she will give birth. According to the WHO, Brazil has the second-highest percentage of cesarean births worldwide. Whereas the WHO recommends an ideal rate of between 25% and 30%, 55.6% of births in Brazil are performed by cesarean section. The percentage is even higher in private health services, where 85.5% of births are cesarean sections, according to data from the National Supplementary Health Agency (Marinho et al., 2021).

Furthermore, embarrassing, abusive, or derogatory comments about a pregnant woman that make her feel inferior because of her race, age, educational attainment, religion, beliefs, sexual orientation, socioeconomic status, number of children, or marital status, as well as sarcastic comments about her choice of birthplace, are associated with verbal obstetric violence (Menezes, 2022). Psychological violence, in turn, encompasses any word or action that makes a woman feel inferior, vulnerable, abandoned, frightened, emotionally unstable, or unsafe (Tordiman, 2022).

According to the study conducted by Lansky (2019), 12.7% of the pregnant women interviewed reported having experienced some form of OV, such as an episiotomy without clinical indication, the use of nonpharmacological methods, childbirth in a forced lithotomy position, prohibition of a companion during labor, and application of the Kristeller maneuver. This finding demonstrates that these women had

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not received sufficient information to recognize that the situations they experienced could be characterized as OV.

In response to this lack of information, the Ministry of Health (Ministério da Saúde, MS) implemented the Prenatal and Birth Humanization Program (Programa de Humanização no Pré-Natal e Nascimento, PHPN) in 2000. The program was intended to develop health promotion and prevention activities to support obstetric and neonatal care, as well as the organization and regulation of such care within the Unified Health System (Sistema Único de Saúde, SUS). The PHPN seeks to systematize good practices in the care of pregnant women, eliminate disrespect, and safeguard women's rights in obstetric care (Brasil, 2002).

Policies were therefore established to safeguard women's rights, including the Comprehensive Women's Health Care Program (Programa de Assistência Integral à Saúde da Mulher, PAISM), which proposed a comprehensive approach to women's health that encompassed family and reproductive planning services, as well as other health-related needs (Freitas et al., 2023).

The Stork Network (Rede Cegonha) was subsequently established by GM/MS Ordinance No. 1,459 of June 24, 2011, to ensure that women received comprehensive and humanized care during pregnancy, childbirth, and the postpartum period (Brasil, 2011). In 2022, this network was replaced by the Maternal and Child Health Care Network (Rede de Atenção Materna e Infantil, RAMI), established by GM/MS Ordinance No. 715 of April 4, 2022 (Brasil, 2022). The Stork Network was later reinstated in 2023 and restructured as the Alyne Network (Rede Alyne) in 2024 through GM/MS Ordinance No. 5,350 of September 12, 2024, which is currently in force (Brasil, 2024). The new structure seeks to improve maternal and child health care, strengthen comprehensive and humanized care, and promote equity, including by safeguarding women's autonomy and rights throughout the pregnancy-postpartum cycle.

Health professionals play a vital role in preventing obstetric violence by informing pregnant women about their rights during prenatal care so that they know how to respond if they encounter a situation involving OV (Silva et al., 2024).

The importance of the Primary Health Care (Atenção Primária à Saúde, PHC) team in prenatal care must therefore be emphasized, as it plays an essential role in health promotion and prevention throughout the pregnancy-postpartum cycle. During care, health professionals may identify signs of postpartum depression and other problems that could adversely affect both the postpartum woman and the newborn. It is therefore essential that the multidisciplinary PHC team recognize such risks and provide pregnant women with guidance on the progression of pregnancy and the childbirth process, thereby ensuring safe and health-promoting care (Ferreira et al., 2024).

Accordingly, this study aims to analyze knowledge of obstetric violence and its forms of manifestation among postpartum women receiving Primary Health Care in a municipality in Paraíba, Brazil.

METHODOLOGY

STUDY TYPE, SETTING, AND PERIOD

This was an analytical study with a qualitative approach. The research was conducted in October 2023 in the municipality of Alagoinha, Paraíba.

STUDY POPULATION AND ELIGIBILITY CRITERIA

The study population consisted of postpartum women who used the Family Health Basic Units (Unidades Básicas de Saúde da Família, UBSF) in the aforementioned municipality. The municipality has seven units, six of which are located in the urban area: 1) Manoel de Souza e Silva UBSF; 2) Miguel Severino Monteiro UBSF; 3) Dr. Antônio Ciraulo Barroso UBSF; 4) Flávio Gomes de Araújo UBSF; 5) José Borges Gondim UBSF; and 6) Gonçalo Joaquim de Andrade Silveira UBSF. One unit is located in the rural area: 7) Berenice Tibúrcio da Silva UBSF. Postpartum women aged 18 years or older who had received prenatal care at the municipality's UBSFs and remained actively registered with these units during the data-collection period were considered eligible and invited to participate.

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For this part of the study, the semi-structured interview guide was administered to 13 postpartum women. This number was determined according to the criterion of theoretical saturation, which was reached when the information obtained during the interviews began to recur and no new elements relevant to the subject under investigation emerged. Data collection was preceded by technical training for the lead researcher, conducted under the supervision of the study advisor, to ensure standardized procedures and the reliability of the information collected.

DATA-COLLECTION INSTRUMENTS AND PROCEDURES

Data were collected through audio-recorded interviews conducted using a semi-structured guide. Before each interview, sociodemographic information was collected through a questionnaire, including race, educational attainment, marital status, place of residence, number of pregnancies, number of prenatal consultations, number of children, mode of delivery, and place of delivery.

Before the study was conducted, a meeting was held with the municipal health secretary to present the study objectives and procedures. The municipal health department subsequently informed the nurses at the UBSFs about the study involving postpartum women affiliated with each unit. Together with the Community Health Workers (Agentes Comunitários de Saúde, ACS), the nurses determined the number of registered postpartum women and their respective catchment areas. With support from the ACS, the postpartum women were invited to participate and asked whether they were available to be interviewed in their homes.

After each participant had confirmed her participation, a schedule was prepared containing the date and time of the interviews. On the scheduled dates and at the appointed times, the researcher traveled to the respective UBSFs and, with support from the ACS, proceeded to the participants' homes. At each home, the researcher introduced herself and explained the study objectives. This was followed by the reading and signing of the Informed Consent Form (Termo de Consentimento Livre e Esclarecido, TCLE) and the Voice Recording Authorization Form (Termo de Autorização para Gravação de Voz, TAGV).

Once this stage had been completed, the sociodemographic questionnaire was administered, followed by the semi-structured interview.

DATA ANALYSIS

The data collected were organized and tabulated using Microsoft Office Excel and were subsequently analyzed and presented in tables to report the results and structure the discussion. Bardin's content analysis, using thematic categorization, was employed to analyze the content of the participants' statements.

ETHICAL CONSIDERATIONS

The study was approved by the Research Ethics Committee (Comitê de Ética em Pesquisa, CEP) of UNIFACISA University Center under approval No. 6,453,034. The postpartum women's participation was preceded by the signing of the TCLE and TAGV, both of which were presented and read in full by the lead researcher before data collection, in compliance with the ethical criteria governing research involving human participants established by Resolution No. 466/2012.

RESULTS

Thirteen postpartum women participated in the study, of whom 62% ($n = 8$) were multiparous and 38% ($n = 5$) were experiencing the postpartum period for the first time. Of these women, 38% ($n = 5$) had experienced only one pregnancy, 31% had experienced more than four pregnancies ($n = 4$), and 23% had experienced two pregnancies ($n = 3$). Regarding prenatal consultations, 84% ($n = 11$) reported attending more than seven consultations during pregnancy, whereas 8% ($n = 1$) attended six consultations and 8% ($n = 1$) attended four. It was found that 31% ($n = 4$) of the interviewees had more than four children, 31% ($n = 4$) had two children, 31% ($n = 4$) had one child, and 7% ($n = 1$) had three children. Regarding mode of delivery, most participants' most recent birth was vaginal, 46% ($n = 6$); 39% ($n = 5$) underwent an

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emergency cesarean section; and 15% (n = 2) underwent a planned cesarean section. All postpartum women reported giving birth in a public hospital, 100% (n = 13) (Table 1).

Table 1

Obstetric characteristics of postpartum women. Alagoinha, Paraíba, Brazil, 2026.

Variable	Frequency (n)	Percentage (%)
First childbirth		
Yes	5	38
No	8	62
Number of pregnancies		
None	0	0
1	5	38
2	3	23
3	1	8
More than 4 pregnancies	4	31
Number of prenatal appointments attended		
None	0	0
1	0	0
2	0	0
3	0	0
4	1	8
5	0	0
6	1	8
More than 7 appointments	11	84
Number of children		
None	0	0
1	4	31
2	4	31
3	1	7
More than 4 children	4	31
Mode of delivery		
Vaginal birth	6	46
Forceps-assisted vaginal birth	0	0
Planned cesarean section	2	15
Emergency cesarean section	5	39
Place of delivery		
Public hospital	13	100
Private hospital	0	0
Other location	0	0
Total	13	100

Source: Prepared by the authors.

Analysis of the interviewees' statements led to the creation of four thematic categories: 1) Lack of information about obstetric violence, childbirth, and labor; 2) The concept of obstetric violence as perceived by postpartum women; 3) Failure to recognize obstetric violence during one's own labor; and 4) Consequences of obstetric violence. These categories are presented below.

CATEGORY 1: LACK OF INFORMATION ABOUT OBSTETRIC VIOLENCE, CHILDBIRTH, AND LABOR

When asked whether they had received information during prenatal care about the different modes of delivery and the differences between them, the postpartum women made it clear that the health care teams had not provided them with guidance on this subject. They also reported that they had not been informed of their rights during labor, as illustrated by the following statements:

“No, I wasn’t given any guidance.” (P1)

“No, no one told me about that.” (P5)

“No, no, they didn’t tell me anything, you understand!?” (P13)

“No, I wasn’t informed about this subject.” (P10)

The lack of information and guidance places women in a vulnerable position because they do not understand the labor process, the childbirth options to which they are entitled, or the forms of social, emotional, and psychological support available to them. This situation is consistent with the absence of guidance concerning the phenomenon of obstetric violence. The participants’ statements also indicate that the postpartum women were not informed about the meaning of OV by the health professionals who cared for them during their prenatal consultations.

CATEGORY 2: THE CONCEPT OF OBSTETRIC VIOLENCE AS PERCEIVED BY POSTPARTUM WOMEN

When asked about the concept of OV, some postpartum women mentioned aspects of direct physical or psychological violence. One woman specifically mentioned episiotomy as a manifestation of obstetric violence, as shown in the excerpts below:

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“It means when the doctor climbs on top of the woman’s belly. To me, that is violence.” (P2)

“It’s beating someone!” (P5)

“To me, obstetric violence is when you aren’t treated well and they make you suffer.” (P1)

“To me, there are several types, even the way they speak to you, the way they treat the patient as a whole. That is obstetric violence, right? The laceration, which is the cut, I think that’s absurd, but we know that many women go through it.” (P4)

Other postpartum women described OV as the absence of choice regarding the mode of delivery, a lack of information, and the suffering associated with the imposition of a particular mode of delivery or other care processes, as illustrated below:

“To me, it’s when we can’t give birth normally, but they force us to keep trying even though there isn’t enough room for the baby to pass. They don’t perform a cesarean right away. They let the person suffer a great deal and only then perform the cesarean, when the baby is already at the end of its strength, right?!” (P3)

“It’s everything the professionals do to you without explaining what they’re doing. They do everything, how can I put it? Everything they want, and the person doesn’t know what is happening at the time.” (P13)

“In my mind, the only thing I knew about obstetric violence was that it happened when we couldn’t decide what kind of birth it would be, right? Whether it would be vaginal or cesarean. That’s all I know about it.” (P10)

In addition to these accounts, some postpartum women did not know what obstetric violence was, as revealed by the following statements:

“I don’t know.” (P6)

“I don’t even know what that is.” (P7)

“I don’t even know what that is.” (P9)

CATEGORY 3: FAILURE TO RECOGNIZE OBSTETRIC VIOLENCE DURING ONE’S OWN LABOR

Despite describing OV as involving disrespect and the absence of choice, some postpartum women denied having experienced violence when asked whether they had been victims of this phenomenon or had encountered any form of disrespect. This finding shows that although these

postpartum women understood the meaning of obstetric violence, they did not identify themselves as victims, as demonstrated by the following responses to the question of whether they had experienced OV:

“No, I don’t think I experienced it.” (P6)

“No, I didn’t experience any violence. Besides, when I gave birth and was there in labor, my mother was with me the entire time.” (P1)

Conversely, other women stated that they had not experienced OV because of the way the health care team had treated them, as illustrated by the following statement:

“No, I didn’t experience any type of violence, because I received very good care, right? From the moment I entered the hospital until I left, the team was very humane and respectful. They were incredibly attentive to me and my son, so I have nothing negative to report about anything or anyone. It truly was a blessing.” (P4)

CATEGORY 4: CONSEQUENCES OF OBSTETRIC VIOLENCE

Analyzing the consequences of OV remains challenging. In this study, one postpartum woman identified factors that may have been influenced by experiences of violence, as shown in the account below:

“Regarding breastfeeding him, the staff from the human milk bank would come by, and one person would say that I really wasn’t producing milk, while another would come and say that I did have milk. So your mind is left wondering: ‘Why can’t I breastfeed my child? Why can’t I do it?’” (P10)

DISCUSSION

OV is regarded as an obstacle to women’s health and is complex to analyze, as it encompasses far more than medical practices. It also includes the cultural and social dimensions surrounding childbirth care and may affect groups of women who differ in several respects. Nevertheless, it appears to be particularly prevalent among women experiencing multiple vulnerabilities, such as those living in

poverty, those with low educational attainment, and those belonging to ethnic minority groups (Ralli et al., 2021).

The study found that most postpartum women identified as brown or mixed race, a characteristic that may be understood in light of Brazil's racial and cultural diversity resulting from racial admixture. In most cases, these women have less access to information and high-quality health services, making them more vulnerable to violent practices during childbirth because of multiple factors, including social inequalities, which are compounded by incomplete primary education (Farias et al., 2021).

This factor warrants analysis because educational attainment may directly influence the knowledge acquired by these postpartum women. Compared with women who have attained higher levels of education, the latter appear more likely to seek information on various topics involving pregnancy, childbirth, and the postpartum period and therefore possess a broader body of knowledge. Seeking such knowledge provides greater autonomy when planning and making decisions involving labor, helps create a humanized environment, reduces unnecessary interventions, and promotes respect for the mother's decisions (Lacerda; Mariano; Passos, 2022).

A lack of information leads postpartum women to believe that all procedures to which they are subjected during labor are simply hospital routines intended to facilitate the birth of their child (Annborn; Finnbogadóttir, 2022).

Limited understanding of OV practices therefore leads to the regrettable situation in which women are treated as mere objects during obstetric procedures, including episiotomy, forceps use, excessive medication, the imposition of inappropriate birthing positions, and even cesarean sections performed without consent. Such practices constitute disrespect toward these women (Mena-Tudela et al., 2021).

From this perspective, intervention is needed to address the dehumanization of childbirth. This may be achieved through guidance provided by PHC professionals, who should also undergo training to continuously learn new health care approaches outside a model that fails to recognize women as the protagonists and coordinators of their own childbirth. One such strategy is to develop a birth plan jointly

with the team responsible for the woman's prenatal care. This plan takes her wishes into account during this significant event and carries legal weight in supporting those wishes and serving as a standard against which noncompliance resulting in any characteristic of OV may be assessed (Silva et al., 2023).

Women should also be advised that they may report the abuse they have experienced, without fear of retaliation, to the health authorities responsible for the facility where they received care. They may do so through a reporting hotline or by initiating proceedings with the Public Prosecutor's Office against the institution, thereby demonstrating that their wishes were disregarded even though the team was aware of the plan that had been developed (Silva et al., 2023).

Within this context, many women are unaware that they have experienced obstetric violence, a problem that particularly affects Black and low-income women. It is important to emphasize that this form of violence may result in physical and psychological complications, including postpartum depression and emotional trauma (Silva et al., 2023).

It is essential to underscore that OV not only compromises women's physical health but also profoundly affects their emotional and psychological health, potentially resulting in trauma and reduced self-esteem, self-confidence, and connection with their bodies and the experience of motherhood. Negative effects on breastfeeding and the establishment of the emotional bond between mother and infant are also evident (Agrawal; Mehendale; Malhotra, 2022).

OV has lasting consequences for maternal and child health because such traumatic experiences may trigger emotional disorders and negatively affect breastfeeding and the bond between mother and infant. Furthermore, the unnecessary use of medical interventions during childbirth may increase the risk of complications. It is therefore essential to address this issue professionally, ensuring awareness and protecting the health of everyone involved (Moreira et al., 2022).

In light of the foregoing, health professionals must take care to provide pregnant women with appropriate guidance about their rights during health care consultations throughout pregnancy. They must explain what constitutes OV and the settings and practices in which it may occur, with a view to

safeguarding women in the event of any undesirable occurrence and fostering their autonomy throughout the pregnancy-postpartum cycle (Mena-Tudela et al., 2023).

FINAL CONSIDERATIONS

It became evident that most postpartum women interviewed had not received adequate guidance during prenatal consultations regarding the meaning of obstetric violence and the different forms it may assume. This lack of guidance made it difficult for them to recognize whether they had experienced any form of obstetric violence during labor.

In this regard, PHC professionals play a crucial role in disseminating information during prenatal care, not only by fulfilling their expected professional and technical responsibilities but also by acting as health educators. The lack of knowledge about OV underscores the importance of these professionals in guiding pregnant women and preparing them for a humanized childbirth experience by informing them of their rights and decision-making autonomy, given that these professionals form part of a longitudinal care network grounded in an ongoing relationship with patients.

Health professionals must also work with pregnant women to prepare a birth plan, a tool that may help prevent abusive and unnecessary procedures. This situation highlights the need to provide health professionals with continuing education on obstetric violence and on developing birth plans in accordance with individualized therapeutic plans. Such measures can ensure high-quality, comprehensive care for women and, consequently, serve as a preventive instrument for combating this phenomenon.

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