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Original article

Obstetric violence as perceived by nurse-midwives: a qualitative study*

Violência obstétrica na percepção de enfermeiros obstetras: um estudo qualitativo

Violencia obstétrica en la percepción de enfermeros obstetras: un estudio cualitativo

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Abstract

Objective: to describe the conception of obstetric violence as perceived by nurse-midwives. **Method:** a descriptive-exploratory study with a qualitative approach, conducted with 60 nurse-midwives from all five regions of Brazil. Data collection took place between April and June 2024 through an electronic survey. The data were processed using the qualitative analysis software IRAMUTEQ and subjected to the thematic content categorization method. **Results**: 60 text segments were identified, representing units of registration organized into four classes and two categories: Obstetric violence as disrespect for women's autonomy and Obstetric violence as a result of violent practices in health care and Nursing. **Conclusion:** the results showed that, from the perspective of nurse-midwives, obstetric violence is represented by disrespect, the performance of unnecessary interventions and practices, and the limitation of women's autonomy.

Descriptors: Obstetric Violence; Nurse Midwives; Reproductive Rights; Health Advocacy; Parturition

Resumo

Objetivo: descrever a concepção sobre a violência obstétrica na perspectiva de enfermeiros obstetras. **Método:** estudo descritivo-exploratório, de abordagem qualitativa, realizado com 60 enfermeiros obstetras, contemplando as cinco regiões do Brasil. A coleta de dados ocorreu entre os meses de abril e junho de 2024, por meio de um *survey* eletrônico. Os dados foram processados pelo *software* de análise qualitativa IRAMUTEQ e submetidos ao método de

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categorização temática de conteúdo. **Resultados**: foram identificados 60 segmentos de texto, unidades de registro representadas em quatro classes, e duas categorias: Violência obstétrica como desrespeito à autonomia da mulher e Violência obstétrica como resultado de condutas violentas no cuidado em saúde e Enfermagem. **Conclusão:** os resultados evidenciaram que, na perspectiva dos enfermeiros obstetras, a violência obstétrica é representada por meio do desrespeito, da realização de intervenções e condutas desnecessárias e da limitação da autonomia feminina.
Descritores: Violência Obstétrica; Enfermeiros Obstetras; Direitos Sexuais e Reprodutivos; Advocacia em Saúde; Parto

Resumen

Objetivo: describir la concepción de la violencia obstétrica desde la perspectiva de los enfermeros obstétricos. **Método:** estudio descriptivo-exploratorio, de enfoque cualitativo, realizado con 60 enfermeros obstétricos, que abarca las cinco regiones de Brasil. La recopilación de datos tuvo lugar entre los meses de abril y junio de 2024, mediante una encuesta electrónica. Los datos se procesaron mediante el *software* de análisis cualitativo IRAMUTEQ y se sometieron al método de categorización temática del contenido. **Resultados:** se identificaron 60 segmentos de texto, unidades de registro representadas en cuatro clases y dos categorías: «La violencia obstétrica como falta de respeto a la autonomía de la mujer» y «La violencia obstétrica como resultado de conductas violentas en la atención sanitaria y la enfermería». **Conclusión:** los resultados pusieron de manifiesto que, desde la perspectiva de los enfermeros obstétricos, la violencia obstétrica se manifiesta a través de la falta de respeto, la realización de intervenciones y conductas innecesarias y la limitación de la autonomía de la mujer.
Descriptores: Violencia Obstétrica; Enfermeras Obstetrices**;** Derechos Sexuales y Reproductivos; Defensa de la Salud; Parto

Introduction

In Brazil, there has been an expansion of scientific production on Obstetric Violence (OV), accompanied by a diversity of concepts and terminologies used to address its different manifestations. In this context, understanding this phenomenon is a fundamental element in supporting the discussion and implementation of changes in care practices and the organization of health services, with a view to ensuring women's sexual and reproductive rights. This understanding also makes it possible to recognize the complexity and multidimensionality of OV, as well as its potential impacts on maternal health and women's experiences throughout the pregnancy and postpartum period.[1]

The term “OV”, also referred to as violence during childbirth, institutional or structural violence in childbirth care, was first used in 2007, in Venezuela, to define and legislate on the subject, through the *Ley orgánica sobre el derecho de las mujeres a una vida libre de violência*.[2] In 2009, Argentina advanced the protection of women's rights

with the enactment of the *Ley de Protección Integral a las Mujeres*, reinforcing the recognition of OV as an expression of gender-based violence.[3]

Research conducted in the United States has demonstrated that OV is embedded in a context of structural and institutional inequalities that sustain gender-based violence.[4] This scenario is aggravated by social markers such as race/color and socioeconomic status, which make certain groups more vulnerable. Women exposed to these and other forms of social vulnerability are more susceptible to experiencing this type of violence.[5-6]

Brazilian obstetric care is grounded in the technocratic model, characterized by an excess of procedures and interventions, often unnecessary and performed without women's informed consent, compromising their autonomy and right to information and favoring the occurrence of OV.[7] Thus, Brazil has sought to transform the obstetric model, with a commitment to reducing unnecessary interventions, such as cesarean sections without clinical indication, addressing OV, and overcoming practices historically and culturally marked by medicalization and disregard for women's protagonism.[8]

In this respect, there is resistance among professionals to recognizing reproductive rights due to the normalization of routine obstetric practices, making advocacy for women's health a major challenge. OV goes beyond categorization, as it constitutes structural violence (multicausal and multidimensional) that is socially normalized, evidenced by the oppression of gender-based violence, the violation of human rights, and violations of the rights to reproductive health.[7]

To recognize childbirth as an exercise of female sexuality and modify this paradigm, it is necessary to reflect on the cultural and social processes associated with this phenomenon, as well as to validate public policies and how they are reflected in women's health daily. Such policies should provide theoretical and reflective support for professionals to minimize inappropriate interventionist practices.[8]

In this context, Nursing has positioned itself alongside Law and Medicine and acts as an advocate for the parturient to prevent inappropriate practices, promote comfort, safety, and empowerment actions during childbirth, which, despite demonstrating vulnerability, involves humanity in relationships, based on ethical principles, bonding, and responsibility for continuity of care.[9]

The political and social movements of the profession, such as the Nurse Manifest and Nursing Now, mobilize nurses toward greater political engagement, which can be strengthened through innovative advocacy actions in defense of women's health. To this end, leadership, an active voice, and the presence of nurses in social spaces, as well as the development of innovation projects in women's health, can contribute not only to the Sustainable Development Goals, including gender equality, but also to the growth of the profession in society.[10]

This study is justified by the need to integrate different concepts to recognize and analyze OV, considering the multiple factors and physical, biological, social, and cultural aspects involved. Thus, the objective is: to describe the conception of OV from the perspective of nurse-midwives.

Method

This is a descriptive-exploratory study with a qualitative approach linked to the research macroproject entitled: Strategies for addressing OV in Brazilian public maternity hospitals from the perspective of human rights and health advocacy.

The non-probability sample was composed using the snowball sampling technique, initiated through referrals of Nurse-Midwives (NM) by the presidents of the regional sections of the *Associação de Obstetrizes e Enfermeiros Obstetras* (ABENFO), who then referred other participants. This strategy, which uses referral networks, can be applied in research involving restricted groups or sensitive topics, making it possible to obtain the sample.[11]

The inclusion criterion was professional practice as an NM for a minimum period of one year in labor and childbirth care. NM who worked exclusively in other settings of obstetric care, such as prenatal care, postpartum care, or other areas of women's health care, without experience in childbirth care throughout their professional practice, were excluded. Those who did not complete the research instrument were considered losses.

Data collection took place from April to June 2024, with 60 NMs, through an electronic survey made available via Google Forms, whose link was sent to participants through the WhatsApp messaging application. The data collection instrument was structured into three parts: presentation of the research, ethical aspects, and Free and

Informed Consent Term (FICT); biographical characterization of the participants; and six open-ended questions about the concept of OV, its manifestations, examples experienced in the daily routine of health services, contributing factors, practices of OV by nurses, and prior knowledge about OV.

Data organization began with the pre-analysis, through a floating reading of each response, based on the report generated with all responses in a Microsoft Excel file, and subsequently transferred to a file in txt format, to constitute the textual corpus to be processed by the qualitative analysis software *Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionaires* (IRAMUTEQ).[12]

After this process, the material was explored: the corpus was created and classified into 64 Text Segments (TS), of which 60 were used, corresponding to a utilization rate of 92.3%. The relationship can be visualized through the dendrogram generated by the Descending Hierarchical Classification (DHC) provided by the software IRAMUTEQ.

During the material exploration phase, the textual corpus was processed using IRAMUTEQ, making it possible to identify, in the 60 TS, the units of registration, the identification of lexical forms, frequency, and relationships among the relevant terms: harm, aggression, practice, institutional violence, intervention, unnecessary, autonomy, process, consent, right, and dignity.

To classify the TS, the DHC method was chosen to divide the words present in the TS according to their frequency. The DHC created a dendrogram showing the hierarchical divisions of the classes, indicating how the text segments are thematically related.

Based on the results provided by IRAMUTEQ, the researchers revisited the TS and their respective contexts, seeking to identify the meanings attributed by the participants to the phenomenon under investigation. The lexical classes and the co-occurrence relationships were interpreted in conjunction with the units of registration, supporting the process of constructing the analysis categories in light of the study objectives, the original corpus, and the theoretical framework adopted.[2,8] The categories were constructed and interpreted by the researchers based on the convergence between the textual evidence and the lexical results provided by IRAMUTEQ.

Based on this analysis, the meanings supported the construction of the two thematic categories:[13] Obstetric violence as disrespect for women's autonomy and Obstetric violence as a result of violent practices in health care and Nursing.

The study was approved by the Research Ethics Committee of Universidade Federal de Santa Catarina (UFSC) under substantiated opinion No. 6,744,764, dated April 4, 2024, and CAAE: 77506024.0.0000.0121, and complied with all ethical and legal aspects established by Resolutions No. 466/2012 of the Brazilian National Health Council (CNS), Ministry of Health, and the National Research Ethics Commission, and No. 510/2016, which regulate research involving human beings. The anonymity, privacy, and confidentiality of the participants were guaranteed through the use of the letters NM followed by a number in ascending order (NM 01, NM 02, and so forth), in addition to signing the FICT.

The study was conducted in accordance with the topics of the Consolidated Criteria for Reporting Qualitative Research (COREQ) to assist the researchers in reporting the information obtained with quality and transparency.

Results

the majority of participants were employed by public institutions, reflecting the greater representation of NM and midwives in public obstetric care services, as shown in Table 1.

Table 1 - Characterization of participants according to employment status and professional practice. Florianópolis, Santa Catarina, Brazil. 2026

Employment Status	n=60	**%**
Public institutions	45	75
Self-employed	10	17
Private institutions	05	8
Workplace		
Hospitals/maternity hospitals	24	40
Normal Birth Center	02	3
Universities	15	25
Self-employed service	12	20
Health Department	02	3
Retired	03	5
Regional Nursing Council	02	3

Regarding the geographical distribution of the participants, the data show the participation of professionals from all Brazilian regions, with greater representation from the Southern Region, as shown in Table 2.

Table 2 - Characterization of participants according to the regions of the country. Florianópolis, Santa Catarina, Brazil. 2026

Brazilian Regions	n=60	%
North	08	13
Northeast	11	18
Central-West	07	12
Southeast	09	15
South	25	42

Regarding the length of postgraduate training in Obstetrics, a relatively homogeneous distribution was observed among the categories.

Regarding the type of training in Obstetrics, lato sensu specialization predominated. These data reflect the diversity of participants' educational backgrounds in Obstetrics, as shown in Table 3.

Table 3 - Characterization of participants according to their educational background. Florianópolis, Santa Catarina, Brazil. 2026

Training period	n=60	**%**
11 years	24	40
21 years	22	37
Between 6 and 10 years	08	13
Up to 5 years	06	10
Postgraduate training in Obstetrics		
More than 21 years	15	25
Between 11 and 20 years	14	23
Between 6 and 10 years	15	25
Up to 5 years	16	27
Type of postgraduate training		
Specialization	44	73
Residency in Obstetrics	15	25
Residency in Women's Health	01	2

The textual *corpus* was processed by IRAMUTEQ, which classified the TS according to their respective words and divided them according to the frequency of reduced forms. Based on the processing of the corpus, the TS presented in each class were obtained from the most recurrent words, an aspect that enabled the identification of themes. The processing of the *corpus* was completed in zero hours, zero minutes, and 45 seconds, during which 64 TS were classified, of which 60 were used, corresponding to a utilization rate of 92.3%. The relationship can be visualized in the dendrogram generated through the DHC provided by the software IRAMUTEQ, as presented in Figure 1.

Figure 1 - Dendrogram of the classes provided by the software IRAMUTEQ. Florianópolis, Santa Catarina, Brazil. 2024

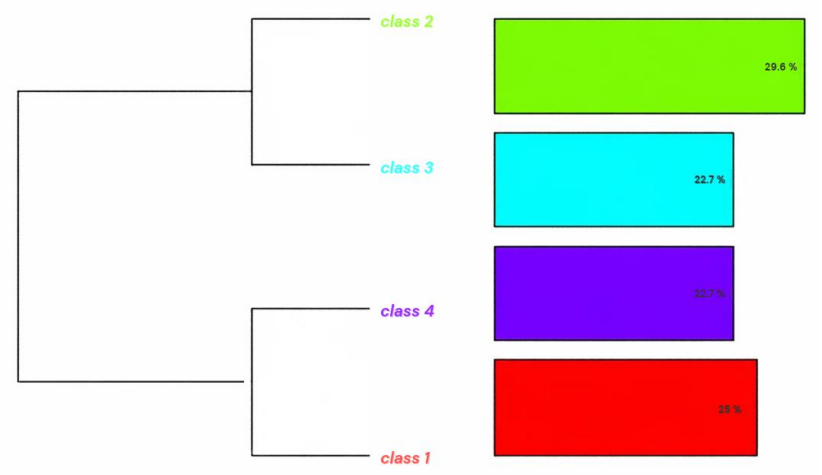
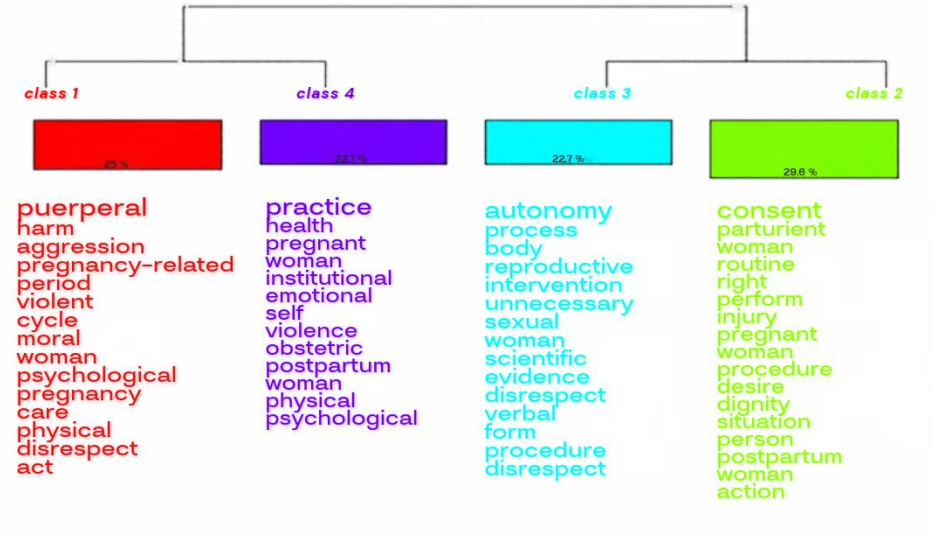


Figure 2 represents the dendrogram with the subdivisions performed in the textual *corpus* until the final classes were reached. The classes should be read from left to right, based on the analysis of the relationship proposed between them, in which the divisions of the TS present vocabulary with similar frequency within each class and divergent frequencies between the classes.

Figure 2 - Dendrogram of the classes generated by the software IRAMUTEQ through Descending Hierarchical Classification. Florianópolis, Santa Catarina, Brazil. 2026



The description of the classes was based on the analysis of the words individually, in the context of the TS and their relationship with the previously selected concepts (reproductive and sexual rights and advocacy). The excerpts taken from the textual *corpus* were indexed after the segmentation, according to the fragments established by the software IRAMUTEQ after data processing, which generated two categories, namely:

In the category Obstetric Violence as disrespect for women's autonomy, represented by classes 3 and 2, situations were identified in which procedures and care practices are performed without the woman's consent, disregarding her participation in decisions concerning her own body and the birth process. The findings reveal violations of the right to autonomy, agency, and informed decision-making, fundamental principles for humanized and rights-based obstetric care.

The most frequent words in this category were “autonomy” and “consent”, associated with the performance of interventions and the maintenance of care routines, often unnecessary, during labor, childbirth, and birth, without the woman's active participation or authorization.

> *Appropriation of the woman's body and her reproductive processes by a health professional, disregarding her autonomy and her ability to decide about her own body and sexuality. (NM3)*
> *Disrespect for the woman's autonomy, represented by statements, invasive procedures, procedures without consent. (NM7)*
> *Any action that disrespects the woman as the protagonist of her pregnancy process. Actions without shared decision-making with the woman that do not respect her autonomy over her own body. (NM20)*
> *It is everything that is done to the woman's body without her consent and without information [...] thinking that you know what is best for the woman without explaining and without talking to the woman to decide on a procedure or intervention. (NM59)*
> *Disrespect for the woman, not including her in decisions about the care to be provided or performing procedures without her consent or against her will. (NM9)*
> *It is any action without the woman's consent, involving disrespect, negligence, or abuse that occurs during obstetric care. (NM11)*

In the category Obstetric Violence as a result of violent practices in health care and Nursing, represented by classes 1 and 4, practices related to physical, verbal, moral, and psychological violence perpetrated by health professionals during obstetric care were identified.

This category encompasses actions and behaviors that may cause suffering, embarrassment, physical or emotional harm to women in the context of care. The most prominent words were “aggression”, “violent”, and “harm”, associated with the expressions “physical harm” or “psychological harm”, highlighting different forms of disrespect and violations of women's rights during labor, childbirth, and birth.

> *Not acting respectfully [...] causing physical, emotional, symbolic, or sexual injury. (NM10)*
> *Disrespect, abuse, and violent acts against the woman during her reproductive process, which may cause irreversible mental, physical, and sexual harm. (NM45)*
> *Obstetric violence can occur in physical, psychological, patrimonial, moral, and institutional forms. (NM47)*
> *It is when a woman suffers mistreatment, disrespect, and verbal, psychological, or physical aggression during pregnancy, labor, childbirth, and the postpartum period, with her human rights and dignity being violated. (NM46)*

In addition to explicit manifestations of violence, participants associated violent practices with outdated care practices, interventions without scientific evidence, and actions that cause physical and emotional suffering during obstetric care. Such situations reveal a disregard for the woman's individuality, compromising her dignity, autonomy, and the full exercise of her sexual and reproductive rights.

> *It is disrespect for the woman, her autonomy, her body, and her reproductive processes, which may manifest through verbal, physical, or sexual violence and through the adoption of unnecessary interventions and/or procedures without scientific evidence. (NM26)*
> *They are outdated, contraindicated, and harmful obstetric practices that cause physical, emotional, and psychological harm to the person experiencing miscarriage and to the woman during pregnancy, childbirth, and the postpartum period. (NM17)*

The findings reinforce the importance of obstetric care grounded in scientific evidence, respect for autonomy, qualified communication, and shared decision-making, recognizing women as rights-bearing individuals and protagonists in decisions related to their reproductive process.

Discussion

The study reveals that, in the participants' perception, OV is understood as a violation of women's autonomy and as an inappropriate appropriation of women's bodies and reproductive processes by health professionals.[7,10]

The perceptions reveal that violent practices are not restricted to the performance of invasive procedures but also involve, above all, the exclusion of women from decision-making processes, causing a rupture with the principles of rights-based care.[10]

Care for women in labor and childbirth is permeated by asymmetric power relations, in which technical and professional knowledge may be exercised hierarchically, placing women in a passive position in decision-making and thus favoring the appropriation of the childbirth process and establishing care models that understand the female body as an object of intervention, rather than as a space of autonomy, individualities, and rights.[14]

The NM highlight informed consent as a central element in characterizing OV and associate OV with the performance of procedures without prior explanation, without the woman's participation, or without her authorization, including invasive procedures that are ultimately performed even without consent. In this sense, the absence of effective communication and shared decision-making transforms a technically indicated intervention into a potentially violating experience, since it disregards the woman's right to understand, accept, or refuse practices related to her care.[15]

It should be noted that shared decision-making is valued among the participants as an essential component of respectful obstetric care. The statement by NM20 reinforces that any action that removes the woman's protagonism from the pregnancy process represents a violation of her autonomy: actions that do not involve shared decision-making with the woman and that do not respect her autonomy over her own body. This finding demonstrates that professionals recognize autonomy not merely as the formal possibility of giving consent, but as a continuous process of active participation, effective communication, relationship building, and joint decision-making.[16]

OV may occur subtly through the normalization of professional practices based on the idea that the professional “knows what is best” for the woman, as identified by NM59. This conception reveals a paternalistic model of care, in which technical authority overrides the woman's ability to make decisions about her body.[14] Although scientific knowledge is fundamental to obstetric practice, it should not replace women's autonomy, but rather support informed and shared decisions.

Participants also associated OV with situations involving disrespect, negligence, and abuse during care, broadening their understanding beyond physical acts to include ethical and relational dimensions and communication failures.

In this context, OV should be understood as a multidimensional phenomenon, related both to individual actions by professionals and to the structural and organizational characteristics of health services. Hierarchical relationships, medicalized care models, and the normalization of certain practices may favor the perpetuation of practices that restrict women's autonomy and limit their participation in decisions regarding their own bodies and the birth process.

For NM, these findings reinforce the importance of a practice grounded in respect, attentive listening, effective communication, and shared decision-making. Ethical obstetric care presupposes recognizing women as protagonists of the childbirth experience, ensuring adequate information, free and informed consent, and active participation in choices related to the care received.[16]

This study's findings corroborate the persistence of a hegemonic model of care for labor and childbirth in Brazil, in which the institutional context and care practices may favor the reproduction of OV. The predominance of a technocratic model is evident, marked by the excessive use of hard technologies, the medicalization of the childbirth process, and the adoption of interventions aimed at accelerating labor, often at the expense of women's individuality, autonomy, and protagonism.[17]

In a study conducted in the southern region of the state of Minas Gerais with health professionals who provide care during labor and childbirth, it was identified that, among the many forms of violence, one of the most recurrent is verbal violence, in addition to the trivialization of routinized, mechanized practices used to accelerate the birth process.[16] The aggressions recognized here by the participants as verbal violence, including words or comments that ridicule women during labor and childbirth, were also identified in other studies on OV, commonly occurring in Brazilian maternity hospitals, which may cause serious psychological impacts and postpartum depression, in addition to lasting emotional scars.[18]

For NM, public policies aimed at strengthening qualified and humanized childbirth care practices have been progressively developed and consolidated. Although this movement has its roots in the 20th century, it gained greater visibility from the 1990s onward, with the publication by the WHO of the Practical Guide for Normal Birth Care in 1996, a document that proposed reviewing interventionist practices and encouraging the adoption of practices based on scientific evidence.[18] Subsequently, in 2018, the WHO updated its recommendations in view of the global scenario of a significant increase in cesarean section rates, growing medicalization of birth, and the persistence of high maternal mortality rates, especially in low- and middle-income countries.[19]

Despite advances in maternal and neonatal health policies, maternal mortality remains a major global public health problem. Approximately 260,000 women died in 2023 from causes related to pregnancy, childbirth, or the postpartum period, corresponding to approximately 712 deaths per day, most of which resulted from causes that could be prevented through timely access to qualified care and evidence-based care.[20] Health systems must ensure obstetric care grounded in respect, dignity, and women's rights through clear policies, professional training, and support for healthcare professionals.[21] In this context, successful experiences of respectful care should be strengthened and disseminated, together with continuous monitoring of the quality of care.[22]

In this context, the role of NM assumes strategic importance in transforming the model of care for labor and childbirth, contributing to the implementation of practices grounded in the physiology of childbirth, respect for women's autonomy, reduction of unnecessary interventions, and promotion of safe, ethical, and person-centered care.

To recognize, address, and eradicate obstetric violence, it is necessary to establish legal and institutional frameworks, as well as to recognize and legitimize the term "OV" in the health field. However, there is resistance among professionals, whose rejection is often related to interpretations based on personal experiences and historically constructed sociocultural conceptions of the female body and childbirth. These forms of resistance may hinder the questioning of normalized practices and the identification of situations that constitute disrespect, abuse, or violations of rights.[17]

Participants highlighted the lack of consent and disrespect by healthcare professionals during labor and childbirth, expressed through inhumane attitudes and verbal abuse, demonstrating that procedures and interventions performed without the woman's active participation violate her autonomy and rights. Moreover, they emphasized the insufficient information provided to women, which compromises conscious and shared decision-making regarding their own bodies, sexuality, and reproductive process.[23]

In this context, the role of NM in transforming the care model stands out, recognizing that childbirth care should be centered on women, their needs, choices, and individualities. As professionals committed to ethical and humanized care, NM act as advocates for women's rights, interests, and needs. This practice is grounded in the principles of health advocacy, autonomy, respect for human dignity, and the guarantee of sexual and reproductive rights, which are essential elements for safe, rights-based obstetric care.[24]

The study conducted in Minas Gerais with Nurses Residents in Obstetrics, in which participants recognized the occurrence of OV in different forms during their training experiences, including verbal and physical manifestations, psychological violence, negligence, omissions, and coercion, corroborates this study's results, in which participants reported experiencing or witnessing care practices marked by unnecessary interventions during labor and childbirth. Such practices may negatively affect the birth experience, causing suffering, trauma, and negative memories related to childbirth.[25]

The convergence between these studies reveals the need to strengthen educational and institutional processes that promote evidence-based care. In this context, the training of NM assumes a strategic role in deconstructing unnecessary interventionist practices and consolidating a model of care centered on women and grounded in human rights. The 2021 report by the United Nations Population Fund (UNFPA) indicates that the presence of this professional during childbirth directly reduces obstetric violence, demonstrating that the practice of these professionals reduces unnecessary procedures and the number of cesarean sections and also increases biopsychosocial satisfaction throughout the childbirth process.[25-26]

Recognizing NM as essential professionals in obstetric care is aligned with Brazilian public policies that encourage their integration and establish them as key actors in health education actions throughout the pregnancy and postpartum period. This recognition strengthens the premise of the woman-professionals-managers triad, in which all are active agents in the construction and transformation of the Brazilian obstetric model.[25]

Although NM receive training based on the best evidence to ensure a childbirth process free from OV, hierarchical and institutional barriers prevent them from making decisions to advocate on behalf of women, which also constitutes a restriction on professional practice grounded in the beneficence of humanized care, highlighting institutional violence. The absence of robust legislation criminalizing violent practices, the weaknesses in the academic training of health professionals, combined with parturient women's superficial knowledge of their rights, contribute to OV.[25]

Humanized practices should constitute a central axis of NM's practice, guiding care grounded in professional legislation, recommendations based on scientific evidence, and Good Practices in Labor and Childbirth Care. In this context, their practice should be permeated by the principles of health advocacy, whose premise is the promotion of equity, the defense of rights, and the provision of woman-centered care.[21,23]

Furthermore, NM should contribute to overcoming the biomedical model, historically centered on professional authority and the medicalization of the reproductive process, favoring the consolidation of a humanized model of obstetric care. This model recognizes women as protagonists of the pregnancy, labor, and birth process, ensuring their active participation in decision-making, respect for their choices, autonomy, and sexual and reproductive rights.

In this study, disrespect, negligence, and abuse during obstetric care were widely observed by NM. It is evident that, to eradicate OV, it is necessary to recognize these obstetric practices that have become normalized in health services, as well as to raise awareness and promote reflection on such unnecessary, abusive, and violent practices.

Beyond health services, OV should be widely discussed as a constitutional right to health and to the best possible care. According to the NM reports, in this study, legislation on this issue in Brazil remains very weak, and the term is little known. The oldest law was approved in 2017 in the state of Paraíba, followed by Minas Gerais, Paraná, Amazonas, Tocantins, Rondônia, Goiás, Pernambuco, Mato Grosso do Sul, and Rio de Janeiro, with the most recent one enacted in 2024 in the Federal District.[27]

In Santa Catarina, the law currently in force includes a chapter specifically addressing OV within the law on violence against women (Chapter V); the other states do not have approved laws or are still in the initial stages of discussion in their legislative assemblies.[27]

It is worth highlighting that, for this study, NM from all five regions of Brazil were invited, as indicated by ABENFO, so that different realities could be evidenced, and the results corroborate recent studies showing the fragility of recognition, debate, and existing legislation.

This study's limitations include the identification of VO, which may have been hindered by the normalization of certain practices in the context of obstetric care, influencing how participants recognize and describe such situations.

Regarding this study's contributions, it is possible to give visibility and voice to NM in recognizing OV, highlighting the daily identification of normalized practices in the care context. By problematizing these practices, this study promotes critical reflection on the current model of labor and childbirth care and points to the need to consolidate a care model grounded in practices based on scientific evidence.

Conclusion

The perceptions attributed by NM to OV revealed that it is represented through disrespect, unnecessary interventions, and the limitation of women's autonomy. Such manifestations reaffirm a technocratic, physician-centered, and hierarchical care model that hinders the consolidation of good obstetric practices and woman-centered care. Despite the restriction of these professionals' autonomy, there is a concurrent recognition of parturient women's rights and good practices grounded in scientific evidence. On this matter, the study provided NM with an opportunity to reflect on their role as professionals trained to provide care during labor and childbirth. This contradiction revealed the need to strengthen continuing health education and organizational conditions that ensure practices based on evidence and respect for sexual and reproductive rights.

Addressing OV goes beyond the individual actions of professionals, requiring structural changes in health services, training and continuing education processes, management, and public policies. Thus, collaboration among professionals, managers, and institutions is essential to consolidate an interdisciplinary care model centered on women, committed to equity, the guarantee of human and reproductive rights, and the elimination of unnecessary, coercive, and violent practices in the context of labor and childbirth care.

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