

Obstetric practices during the childbirth process experienced by postpartum women using Primary Health Care in Southern Brazil

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ABSTRACT

Objectives: to investigate the obstetric practices experienced by postpartum women using Primary Health Care during the childbirth process in the hospital context in Southern Brazil. **Methods:** a cross-sectional study, carried out in a health unit in the city of Porto Alegre. The non-randomized sample was composed of postpartum women who received prenatal care in a Primary Health Care unit, with a maximum period of one year elapsed since childbirth. **Results:** fifty postpartum women were included in the study, of whom 86.0% reported having been subjected to at least one harmful practice during labor and childbirth, including lithotomy birth, lack of freedom of choice for birthing position, and measures to expedite labor. All reported having experienced some type of best practice, mainly related to non-pharmacological pain relief measures. **Conclusion:** best practices coexist with a high rate of obstetric violence during childbirth, reported by women receiving Primary Health Care in a capital city in Southern Brazil. This demonstrates the incompleteness of the transition to the obstetric model that has been taking place in recent years.

Descriptors: Prenatal Care; Obstetric Violence; Nursing.

INTRODUCTION

The obstetric care model in Brazil has been based on the biomedical, hospital, and interventionist model⁽¹⁾. This model favors the medicalization of childbirth and the birth process, and the routine implementation of actions that are disconnected from best care practices and without scientific evidence⁽²⁾. In this scenario, there is a reduction in female leading role⁽¹⁾, with women being subjected to relationships of domination, limited autonomy, and freedom⁽²⁾, and interventions that disrespect their physical and mental integrity, feelings, choices, and preferences⁽³⁾.

Disrespectful actions during labor and childbirth are considered a human rights violation and negatively influence maternal and perinatal outcomes⁽⁴⁾. Such violations are a reality in most Brazilian hospitals⁽⁵⁾, where healthcare professionals consolidate different forms of violence when providing care to pregnant women and women in labor⁽⁶⁾. These include being confined to bed during labor, depriving of food and mobility, performing routine and unjustified vaginal exams, using oxytocin to speed up the birth process, performing the Kristeller maneuver and episiotomy, adopting positions that are not favorable for birth, and not having skin-to-skin contact with newborns, among others⁽⁷⁾.

These practices, legitimized by power relations and technical knowledge that naturalize their occurrence in childbirth care, characterize obstetric violence⁽⁶⁾. In this context, and to protect themselves from obstetric violence and behavior, Brazilian women tend to avoid a vaginal delivery and opt for a cesarean section⁽⁸⁾. Given this scenario, national public policies and international recommendations based

on scientific evidence have reconsidered obstetric practices. The goals are to provide qualified maternal and perinatal care, regardless of location or level of healthcare, impacting the reduction of obstetric violence^(4,9).

In Brazil, the Stork Network (In Portuguese, *Rede Cegonha*), established in 2011 by the Ministry of Health, deserves to be highlighted for having allowed the advancement and improvement of obstetric care offered in maternity hospitals⁽⁹⁾. However, a study that analyzed the implementation of best practices for labor and birth care in Brazilian maternity hospitals, as recommended by the Stork Network, found that a care model based on unnecessary interventions and little adequate practice still prevails in the country. More than 80.0% of maternity hospitals have inadequate implementation of non-pharmacological methods for pain relief and encouraging upright positions, with amniotomy (87.0%), episiotomy (55.6%), and the Kristeller maneuver (18.5%) being practiced in the healthcare services that comprised the sample⁽¹⁰⁾.

In this regard, preparing women for childbirth during prenatal care is one of the actions required to ensure successful obstetric care practices. On this occasion, healthcare professionals should provide health education, inform women of their rights, and encourage them to reclaim their leading role, thus reducing unnecessary interventions and obstetric violence⁽¹¹⁾. However, the Brazilian model of prenatal care does not appear to empower women to make informed decisions about the risks and benefits of the different care practices offered in hospitals⁽⁸⁾.

A cross-sectional study conducted in Pará, in the Northern region of Brazil, indicates that topics related to childbirth were addressed during one-third of prenatal appointments, and more than half of the participants were not encouraged to develop a birth plan addressing best practices⁽¹²⁾.

Another cross-sectional study, carried out with postpartum women in a public maternity hospital in Pernambuco, found that only 48.3% of them received guidance on best obstetric practices during prenatal care, and the majority experienced some conduct that was not recommended during the labor and birth process, such as methods to speed up labor, lack of identification of professionals, semi-sitting position for birth, and episiotomy⁽¹³⁾.

Considering that these studies were carried out taking as reference the national territory^(12,14) or healthcare services located in the North⁽¹²⁾ and Northeast⁽¹³⁾ regions, and considering the regional differences in culture, socioeconomic level, and level of education of the population in the different regions of Brazil, the present investigation was designed with the aim of shedding light on the context of the South region of the country.

Listening to women about the care provided during childbirth and postpartum can help identify situations of obstetric violence and guide the redirection of prenatal care toward best practices. Women should receive sufficient information to actively participate in the decision-making process regarding their bodies, childbirth, and neonatal care. Given the above, this study aimed to investigate obstetric practices during childbirth in the hospital setting as expe-

rienced by postpartum women receiving Primary Health Care in southern Brazil.

METHODS

This is a cross-sectional study conducted at a Basic Health Unit (Portuguese acronym Unidade Básica de Saúde – UBS) in the city of Porto Alegre, Rio Grande do Sul, from January to May 2022. The UBS is affiliated with the Pontifícia Universidade Católica do Rio Grande do Sul (PUCRS), with contracted services from the Porto Alegre Municipal Health Department. It includes faculty and students from the medicine, nursing, nutrition, pharmacy, and psychology programs, involved in practical teaching activities, supervised internships, and outreach activities at the aforementioned university, serving as an important link in the teaching-service-community integration.

Population and sample

The study population consisted of postpartum women attended the aforementioned USB who had their births in public maternity hospitals in Porto Alegre, accredited to the Stork Network.

The sample size was calculated using a 95% Confidence Interval, 80% expected power, 10% potential losses, and an estimated 50 postpartum women to statistically represent the study population. The non-probability sample included postpartum women who had given birth no more than one year previously and who received prenatal care at the unit. Postpartum women under 18 years of age were excluded.

Data collection

Recruitment of postpartum women was intentional, based on identification of postpartum women in the USB computerized system and verification of the date and time of their scheduled postpartum, pediatric, or gynecological appointments. Postpartum women were approached in the unit's waiting room while awaiting their appointments.

The interview took place in person, before or after participants' appointment, depending on availability, in a private area of the health unit. All postpartum women interviewed agreed to participate in the study after reading and signing the Informed Consent.

Data were collected using a structured questionnaire developed by the researchers. It contained questions regarding participant sociodemographic characteristics (skin color, age, education level, and family income), their past and current obstetric history, labor and childbirth during their most recent pregnancy, which occurred no more than one year previously, and information on the occurrence of violent practices and/or best birth care practices.

Statistical analysis

Data were analyzed using Statistical Package for the Social Sciences (SPSS) software (version 20.0; International Business Machines Corporation – IBM; United States). Discrete variables

were subjected to the Kolmogorov-Smirnov test to verify normality. Inferential analysis was performed using Pearson's chi-square test or Fisher's exact test. Statistical significance was considered at $p \leq 0.05$. To calculate the rate of obstetric violence, the sum of women subjected to at least one harmful practice was considered. Due to the lack of information on newborns' vital status at birth, practices such as "not breastfeeding within the first hour" and "not providing skin-to-skin contact" were not computed as harmful.

Ethical aspects

The research was approved by the Research Ethics Committee of the proposing institution and received the Certificate of Presentation of Ethical Consideration (In Portuguese, Certificado de Apresentação de Apreciação Ética – CAAE) 55415321.5.0000.5336.

RESULTS

At the USB, 56 postpartum women who met the inclusion criteria were identified, of who 50 agreed to participate in the study. Participants' mean age was 27 years. The majority (70.0%) identified themselves as brown or black, with a family income of less than one minimum wage and a complete elementary education (Table 1).

In relation to the number of prenatal appointments, 80.0% ($n = 38$) reported having attended more than six appointments. Of these women, 44.0% ($n = 22$) reported having been followed up by nurses, whose meetings were interspersed with a medical professional. Concerning the childbirth route, the most frequent was vaginal, occurring in 76.0% ($n = 38$) of cases. Among those who had a cesarean childbirth (24.0%; $n = 12$), 84.0% ($n = 10$) went through labor.

Best practices during labor and childbirth were reported by all postpartum women. Of these women, 54.0% ($n = 27$) had access to

non-pharmacological methods for pain relief, such as shower bath (52.0%; $n = 26$), obstetric ball (32.0%; $n = 16$), and freedom of walking (82.0%; $n = 41$). Skin-to-skin contact was performed in 78.0% ($n = 39$) of births, and 60.0% ($n = 39$) of newborns were breastfed in the first hour of life.

Regarding obstetric violence, 94.0% ($n = 47$) of women reported experiencing at least one harmful practice during labor and birth in the hospital setting. The most frequent was giving birth in the lithotomy position. For 38.0% ($n = 19$) of women, the right to a companion was denied. In 22.0% ($n = 11$) of births, skin-to-skin contact with the baby did not occur in the first hour, and 40.0% ($n = 20$) reported not having breastfed in the first hour after birth. Of the three women who reported not having been subjected to harmful practices, two underwent elective cesarean sections, and one had a vaginal delivery.

Of the 38 women who delivered vaginally, 95.0% ($n = 36$) reported being in the lithotomy position during the expulsive stage of labor. The remaining women ($n = 2$) reported receiving encouragement and adopting upright positions. When asked about their choice of birthing position, half of those who delivered in the lithotomy position reported that they had no freedom to choose.

The harmful practices during labor and childbirth most frequently cited by participants were amniotomy, use of oxytocin to speed up labor, food restriction, and restriction on companionship (Table 2).

No relationship was found between obstetric violence and age, race, level of education, family income, childbirth route, number of prenatal appointments, appointments carried out by a nurse and presence of a companion during labor and childbirth (Table 3).

Table 1 - Sociodemographic profile of postpartum women ($n = 50$) users of Primary Health Care who gave birth in public maternity hospitals, Porto Alegre, Rio Grande do Sul, Brazil, 2022

Variables	n	%
Age		
18 to 35 years	44	88.0
≥ 36 years	6	12.0
Skin color		
White	15	30.0
Brown or black	35	70.0
Education		
Complete elementary education	31	62.0
Complete high school	14	28.0
Complete higher education	5	10.0
Family income (Minimum wage R\$ 1,212.00)		
< 1 minimum wage	24	48.0
1 minimum wage	17	34.0
> 1 minimum wage	9	18.0

Table 2 - Practices of obstetric violence in the hospital context during the childbirth process experienced by users of Primary Health Care, Porto Alegre, Rio Grande do Sul, Brazil, 2022

Obstetric violence practices among postpartum women who progressed to vaginal delivery ($n = 38$)		
Variables	n	%
Birth in the lithotomy position	35	95.0
Did not choose the birth position	19	50.0
Episiotomy	13	34.0
Enema	4	10.5
Trichotomy	2	5.3
Forceps	1	2.7
Obstetric violence practices among postpartum women who went through labor ($n = 47$)		
Amniotomy	30	63.8
Oxytocin to speed up labor	28	59.6
Food restriction	20	42.5
Companion restriction	19	40.4
Suppression of feelings of fear or screaming	7	14.9
Verbal abuse	7	14.9
Inability to walk	5	10.6

Table 3 - Analysis of possible factors related to obstetric violence practices during childbirth in the hospital context experienced by Primary Health Care users (n = 47). Porto Alegre, Rio Grande do Sul, Brazil, 2022

Variable	Report of obstetric violence		
	n	%	p-value
Childbirth route			
Cesarean	10	21.3	0.074
Vaginal	37	78.7	
Age			
18 to 35 years	41	87.2	0.509
≥ 36 years	6	12.7	
Color			
White	14	29.7	0.897
Brown and black	33	70.3	
Education			
Elementary school	29	61.8	0.834
High school	13	27.6	
Higher education	5	10.6	
Family income (Minimum wage R\$ 1,212.00)			
< 1 minimum wage	22	46.8	0,668
1 minimum wage	16	34.1	
> 1 minimum wage	9	19.1	
Prenatal care			
> 6 appointments	37	78.7	0.372
≤ 6 appointments	10	21.3	
Nurse participation in prenatal care	42	89.4	0.551
Presence of a companion during labor and childbirth	33	70.2	0.897

Likewise, no statistical difference was found in the prevalence of episiotomy, lithotomy childbirth, use of oxytocin to accelerate labor, and amniotomy in relation to the sociodemographic characteristics of postpartum women (Table 4).

No relationships were found between the types of obstetric violence and prenatal characteristics. The lithotomy position was more common among postpartum women who had a companion present during the birth process ($p = 0.018$). Furthermore, the absence of a companion was associated with the restriction of their presence ($p < 0.001$) (Table 5).

DISCUSSION

This study identified a high prevalence of reports of obstetric violence among postpartum women treated at USB during childbirth in public maternity hospitals. The prevalence of harmful practices found in this study, approximately 86.0%, contrasts with the results of Brazilian population-based studies. A nationwide study conducted in Brazil identified a prevalence of reports of disrespect and abuse in 45.2% of participants treated at public maternity hospitals and in 30.3% of those treated at private maternity hospitals⁽¹⁴⁾. In a cohort in the city of Pelotas (Rio Grande do Sul), this contingent was 18.3%⁽¹⁵⁾.

Epidemiological studies on obstetric violence in Brazil, taking municipalities in different states as references, are scarce. Furthermore, there is a lack of consensus regarding the term used. Some studies^(14,15) cite disrespect and abuse to describe practices referred to as situations of obstetric violence in other studies^(7,11), as well as in the present investigation. Additionally, it is important to highlight the absence of a validated measurement instrument. Con-

Table 4 - Analysis of possible relationships between sociodemographic characteristics and types of obstetric violence experienced in the hospital context by Primary Health Care users during the childbirth process, Porto Alegre, Rio Grande do Sul, Brazil, 2022

Variables	Obstetric violence							
	Lithotomy (n = 35)		Episiotomy (n = 13)		Oxytocin (n = 28)		Amniotomy (n = 30)	
	n (%)	p-value	n (%)	p-value	n (%)	p-value	n (%)	p-value
Age (years)								
18 to 35 years	31 (88.5)	0.536	10 (76.9)	0.690	24 (85.7)	0.755	26 (86.7)	0.936
≥ 36 years	4 (11.5)		3 (23.1)		4 (14.3)		4 (13.3)	
Color								
White	10 (28.6)	0.350	3 (23.1)	0.571	10 (35.7)	0.556	12 (40.0)	0.059
Brown and black	25 (71.4)		10 (76.9)		18 (64.3)		18 (60.0)	
Education								
Elementary school	23 (65.7)	0.432	11 (84.6)	0.336	15 (53.6)	0.316	18 (60.0)	0.440
High school	9 (25.7)		1 (7.7)		8 (44.5)		10 (33.3)	
Higher education	3 (8.6)		1 (7.7)		5 (17.9)		2 (6.7)	
Family income (Minimum wage R\$ 1,212.00)								
< 1 minimum wage	17 (48.6)	0.877	4 (30.8)	0.363	10 (35.7)	0.247	15 (50.0)	0.747
1 minimum wage	12 (34.9)		7 (53.8)		12 (42.8)		9 (30.0)	
> 1 minimum wage	6 (17.5)		2 (15.4)		6 (21.5)		6 (20.0)	

Table 5 - Analysis of possible relationships between aspects of prenatal care, presence of a companion during childbirth, and types of obstetric violence in the hospital context during the childbirth process, experienced by users of Primary Health Care, Porto Alegre, Rio Grande do Sul, Brazil, 2022

Obstetric violence	Variables					
	Prenatal appointments		Nurse care during prenatal care		Companion present during the birth process	
	> 6	≤ 6	Yes	No	Yes	No
Lithotomy (n = 35)						
n (%)	28 (80.0%)	7 (20.0%)	33 (94.3)	2 (5.7)	25 (71.4)	10 (28.5)
p-value	0.626		0.210		0.018	
Episiotomy (n = 13)						
n (%)	13 (100.0)	0.0	12 (92.3)	1 (7.7)	8 (61.5)	5 (38.5)
p-value	0.109		0.677		0.471	
Oxytocin (n = 30)						
n (%)	21 (75.0)	7 (25.0)	25 (89.3)	5 (10.7)	20 (66.7)	10 (33.4)
p-value	0.399		0.316		0.968	
Amniotomy (n = 28)						
n (%)	25 (83.4)	5 (16.6)	26 (86.7)	2 (13.3)	23 (82.4)	5 (16.6)
p-value	0.470		0.336		0.208	
Diet restriction (n = 20)						
n (%)	15 (75.0)	5 (25.0)	17 (85.0)	3 (15.0)	15 (75.0)	5 (25.0)
p-value	0.470		0.336		0.529	
Companion restriction (n = 19)						
n (%)	16 (84.2)	3 (15.7)	17 (89.5)	2 (10.5)	8 (42.1)	11 (57.9)
p-value	0.560		0.923		< 0.001	

sequently, there is diversity in the interpretation and classification of obstetric practices as violence, which makes the investigations complex and difficult to compare⁽¹⁶⁾.

Although there is currently no validated instrument for measuring obstetric violence, in the current Brazilian health system, the number of women reporting having suffered obstetric violence has increased, whether during prenatal care, childbirth, the postpartum period, or abortion situations⁽⁷⁾. It is important to note that the childbirth care model is still excessively technocratic, abusive, and guided by unnecessary interventions⁽¹⁻³⁾. It is crucial to invest in health education to empower these women and empower them to better exercise their autonomy in making decisions about their care during prenatal, labor, and childbirth. Furthermore, it is important to train healthcare professionals to change disrespectful practices and prevent violence against women.

Coping with obstetric violence impacts not only women, but also the healthcare professionals involved in care, since ethical and evidence-based practices need to be adequately structured and based on harmonious and non-hierarchical working relationships⁽¹⁷⁾.

In Brazil, obstetric violence is still not specified or criminalized by Federal Law, making it difficult to protect women's rights⁽¹⁸⁾. Several measures have been implemented to reduce and prevent practices that are harmful to women. Among them, prenatal care stands out as an important strategy for supporting pregnant women and

their families, strengthening their bond with the healthcare team, and providing education and guidance regarding the labor and birth process⁽¹⁹⁾. The inclusion of nurses in prenatal care is a powerful factor in preventing obstetric violence, as these professionals are able to guide pregnant women regarding their rights and build a care plan based on best care practices⁽²⁰⁾.

In this study, although approximately 90.0% of participants reported encounters with nurses during prenatal care, and 80% of them had more than six appointments, this was not enough to prevent obstetric violence during labor and childbirth. The presence of a companion was also not a protective factor for the lithotomy position during childbirth, which may be related to the lack of preparation of women and their family members during prenatal care, or to a structure of power and hegemony that is not minimized simply by the presence of a companion.

These findings are in line with the results of a Brazilian investigation in which attendance at prenatal appointments in a number greater than or equal to that recommended by the Ministry of Health (six), as well as participation in nursing consultations, was not synonymous with active participation of women in pre-childbirth and childbirth⁽²¹⁾. Prenatal care is an important time to educate pregnant women about their rights during labor and childbirth. However, it is not necessarily sufficient to empower them to play a leading role in decision-making during labor and childbirth. Best practices are still

applied partially, with little or no participation by women in choosing the childbirth route⁽¹²⁾.

The childbirth route should be a factor analyzed in the scenario of violence. In Brazil, the rate of surgical childbirth in several healthcare services exceeds the number of vaginal deliveries⁽²¹⁾, which makes this procedure abusive in the country⁽²²⁾. In the present investigation, the cesarean section rate among participants was 24.0%, similar to the findings of another study carried out in healthcare services in the city of Porto Alegre, in which a cesarean section rate of 23.4% was identified⁽²³⁾. The rates of this surgical practice as a childbirth route correspond to 21.0% worldwide⁽²²⁾, and in Brazil, approximately 55.3% of births occur through this route⁽²⁴⁾.

It is known that cesarean sections can save lives in serious situations. However, they present risks like any surgical procedure, and when performed without the appropriate clinical indication, they can be harmful to the health of both the woman and the newborn⁽²¹⁾. In the present study, more than half of the postpartum women who underwent cesarean section were already in labor at the time the surgery was indicated, without discussion with patients about this choice.

Regarding the obstetric violence practices reported in this study, they occurred regardless of the childbirth route. The main harmful practices cited by women during the birth process were amniotomy, use of oxytocin to speed up labor, and restricted access to food. During the second stage of labor, harmful practices were identified, such as birth in the lithotomy position, lack of participation by women in choosing the position they would like to adopt for birth, and the use of episiotomies. These findings reinforce the results of other studies and also highlight the lack of consent for such procedures and the lack of knowledge about their performance^(14,25).

Amniotomy and the use of oxytocin are practices used to speed up labor and/or prevent its delay, although they are not recommended due to the lack of scientific evidence to support them^(4,26). Although the present study did not analyze the factors that led to the indication for amniotomy, as this was not part of the objective, this procedure is still performed in clinical practice, despite the lack of scientific evidence. A study on the use of synthetic oxytocin in Brazilian obstetrics showed that narco-acceleration labor does not serve postpartum women's interests, but rather contributes to the increased medicalization of the process⁽²⁷⁾.

The dietary restriction reported by postpartum women is also a practice not recommended by national and international protocols for childbirth care in low-risk pregnancies^(4,26). The risk of aspiration of gastric contents is low, as is the indication for general anesthesia in cesarean sections⁽²⁸⁾.

The performance of episiotomy, reported in the setting of this investigation, is a practice with divergent indications in the literature. According to the National Guideline for Care in Normal Childbirth of the Brazilian Ministry of Health⁽²⁶⁾, episiotomy is indicated when there is a risk of severe perineal laceration, fetal distress, difficulty in performing instrumental childbirth, and shoulder dystocia, and is not routinely recommended. However, internationally, this practice is not recommended by the World Health Organization⁽⁴⁾.

A meta-analysis found that performing a selective episiotomy did not demonstrate any difference compared to not performing this procedure in severe perineal lacerations or anal sphincter injuries, perineal trauma, instrumental childbirth, duration of the second stage of labor, perineal pain, and postpartum hemorrhage⁽²⁹⁾.

The high rate of this procedure in Brazil may indicate obstetric violence, as it exceeds the World Health Organization-recommended frequency. Its clinical indication is inconsistent, disrespecting female autonomy and the physiological process of childbirth, and causing more harm than good⁽³⁰⁾.

In relation to lithotomy birth and the inability to choose a position during the expulsive stage of labor, as cited by the postpartum women participating in this study, these are discouraged practices and should not be imposed. On the contrary, it is important to support women in choosing the position they find most comfortable^(4,26). It is known that vertical positions during the expulsive period of labor offer greater perineal protection, i.e., a lower risk of laceration and a greater chance of an intact perineum⁽³¹⁾.

Given the high rates of harmful practices during labor in public maternity hospitals in Porto Alegre reported by the postpartum women participating in this study, it is necessary to understand which models offer potential advances to improve the care offered to pregnant and postpartum women and help reduce rates of obstetric violence in healthcare institutions.

National research^(32,33) indicates that nurse-midwives' work in maternity wards, supported by public policies, has represented a powerful transformative agent of obstetric practices in recent years. It has led to a decrease in harmful practices, such as episiotomy, amniotomy, lithotomy birth, and use of oxytocin to accelerate labor, and an increase in the proportion of best practices, including freedom of position and movement, provision of diet, the presence of a companion, and use of non-pharmacological techniques for pain relief^(32,33). These results demonstrate the inclusion of nurse-midwives as a possible measure to be taken to reduce the rates of obstetric violence in the context of the childbirth process.

Best practices coexist with harmful practices, which denote obstetric violence. Best practices were offered, especially during labor before the expulsive stage. During this period, freedom of walking and the use of some non-pharmacological measures for pain relief, such as showers, the use of a ball, and breathing techniques, were offered. At the same time, harmful practices occurred, such as restricting the presence of a companion and restricting feeding. In the postpartum period, best practices included skin-to-skin contact and breastfeeding within the first hour of life. These findings are supported by another study⁽³⁴⁾ and represent advances in the care provided during childbirth.

Non-pharmacological pain relief measures are known to promote relaxation and comfort, reducing maternal anxiety and the length of the latent and active phases. They are also associated with a lower risk of drug interventions during labor and contribute to a positive birth experience⁽³⁵⁾.

The implementation of best obstetric practices in maternity hospitals across different Brazilian states is partial. Changes in the

care model, based on scientific evidence and a humanization perspective^(34,36,37), are still in the process of consolidation. Therefore, it is understood that the obstetric care model offered to postpartum women in this study does not yet fully meet the best practices recommended by national and international public policies^(4,26).

Given the above, the vulnerability of pregnant women during labor and birth must be considered. Although no relationship was found between the types of violence and the sociodemographic characteristics of postpartum women in the present investigation, a study found disparities in the care offered by healthcare services to this population. Sociodemographic characteristics of postpartum women were a determining factor⁽³⁸⁾. Racism and inequities present in Brazilian society negatively impact the provision of care in healthcare services, and cause black (black and brown) and poor women to experience this type of situation more during motherhood compared to other women⁽³⁹⁾.

In this regard, it is necessary to implement continuing education initiatives aimed at training healthcare professionals in best practices in obstetrics, so they can provide quality and impartial care. Furthermore, women's access to health information must also be expanded to empower them to make informed decisions during labor⁽³⁸⁾. Therefore, it is suggested that further studies be carried out in different Primary Health Care contexts to better understand which actions can improve user perinatal education.

Although this study provided information that allows for a better understanding of the reality of obstetric care in the public health sector in Southern Brazil, it has some limitations that should be considered. The design used did not include an analysis of women's medical records regarding the birthing process in maternity hospitals. This approach would have contributed to triangulating data collection and increased the possibility of identifying best practices, obstetric violence, the professionals involved, and possible indications for procedures such as cesarean section. Despite this, the results were based on a sample composed of almost all postpartum women treated at a healthcare service that is part of the Maternal Health Care Network, highlighting both the negative experiences and best practices experienced by these women during the birthing process.

CONCLUSION

Best labor and childbirth care practices coexist with high rates of obstetric violence experienced by postpartum women in public maternity hospitals in a Brazilian capital. Measures to accelerate labor (amniotomy and oxytocin) were the most common harmful practices. Best practices were related to the provision of non-pharmacological pain relief methods and the presence of a companion. Most women who delivered vaginally remained in the lithotomy position and received an episiotomy during the second stage of labor.

No statistically significant relationship was found between obstetric violence and the variables age, level of education, family income, and skin color.

The results allowed us to understand the scenario of obstetric practices to which postpartum women were subjected while giving

birth, having the potential to collaborate with the construction of a prenatal care plan aimed at women's health education regarding these practices, while also providing important data for continuing health education processes for professionals working in maternity hospitals, and raising awareness among local managers.

Perinatal education should be guided by information and actions that empower women regarding their physiological capacity to give birth without interventions, but also regarding their rights to safe, respectful, and consensual obstetric care, based on scientific evidence.

REFERENCES

1. Leal NP, Versiani MH, Leal MC, Santos YRP. Práticas sociais do parto e do nascer no Brasil: a fala das puérperas. *Ciênc. saúde coletiva*. 2020 June 13;26(3):941-50. <https://doi.org/10.1590/1413-81232021263.13662020>
2. Nicida LRA, Teixeira LAS, Rodrigues AP, Bonan C. Medicalização do parto: os sentidos atribuídos pela literatura de assistência ao parto no Brasil. *Ciênc. saúde coletiva*. 2019 Jan 30;25(11):4531-46. <https://doi.org/10.1590/1413-812320202511.00752019>
3. Lansky S, Souza KV, Peixoto ERM, Oliveira BJ, Diniz CSG, Vieira NF, et al. Violência obstétrica: influência da Exposição Sentidos do Nascer na vivência das gestantes. *Ciênc. saúde coletiva*. 2019 Aug 5;24(8):2811-23. <https://doi.org/10.1590/1413-81232018248.30102017>
4. World Health Organization (WHO). WHO recommendations: intrapartum care for a positive childbirth experience [Internet]. Geneva: World Health Organization (WHO); 2018 Feb 7 [cited 2025 July 29]. 200 p. Available from: <https://www.who.int/publications/i/item/9789241550215>
5. Nogueira NV. O reconhecimento da violência obstétrica no Brasil e sua repercussão sociolégislativa por intermédio do movimento feminista. *InSURgência: revista de direitos e movimentos sociais*. 2021 July 31;7(2):261-86. <https://doi.org/10.26512/insurgencia.v8i2.38447>
6. Jardim DMB, Modena CM. Obstetric violence in the daily routine of care and its characteristics. *Rev. Latino-Am. Enfermagem*. 2018;26:e3069. <https://doi.org/10.1590/1518-8345.2450.3069>
7. Branco MA, Meucci RD, Paludo SS. Práticas associadas à violência obstétrica no parto vaginal: estudo de base populacional em município do Sul do Brasil. *Cad. Saúde. Colet*. 2024 Oct 14;32(2):e32020020. <https://doi.org/10.1590/1414-462X202432020020>
8. Fabbro MRC, Wernet M, Baraldi NG, Bussadori JCC, Salim NR, Souto BGA, et al. Antenatal care as a risk factor for caesarean section: a case study in Brazil. *BMC Pregnancy Childbirth*. 2022 Sep 25;22:731. <https://doi.org/10.1186/s12884-022-05008-z>
9. Leal MC, Szwarcwald CL, Almeida PVB, Aquino EML, Barreto ML, Barros F, et al. Saúde reprodutiva, materna, neonatal e infantil nos 30 anos do Sistema Único de Saúde (SUS). *Ciênc. saúde coletiva*. 2018 June;23(6):1915-28. <https://doi.org/10.1590/1413-81232018236.03942018>
10. Bittencourt SDA, Vilela MEA, Marques MCO, Santos AM, Silva CKRT, Domingues RMSM, et al. Atenção ao parto e nascimento em Maternidades da Rede Cegonha/Brasil: avaliação do grau de implantação das ações. *Ciênc. Saúde Coletiva*. 2021 Mar 15;26(3):801-21. <https://doi.org/10.1590/1413-81232021263.08102020>
11. Sousa MPV, Santos LSA, Caldas GRF, Batista FAM, Silva CRL. Violência obstétrica: fatores desencadeantes e medidas preventivas de enfermagem. *Revista Nursing*. 2021 Aug 2;24(279):6015-9. <https://doi.org/10.36489/nursing.2021v24i279p6015-6024>
12. Spinola MCR, Oliveira AS, Maciel TJS, Figueira TPC, Santos LA. The importance of approach the birth plan during prenatal care in basic health units Amazon. *Población y Salud en Mesoamérica*. 2024 Nov 13;22(1). <https://doi.org/10.15517/psm.v22i1.56680>
13. Monteiro BR, Souza NL, Silva PP, Pinto ESG, França DF, Andrade ACA, et al. Health care in the prenatal and childbirth context from puerperal

women's perspective. *Rev. Bras. Enferm.* 2020 June 24;73(4):e20190222. <https://doi.org/10.1590/0034-7167-2019-0222>

14. Leite TH, Pereira APE, Leal MC, Silva AAM. Disrespect and abuse towards women during childbirth and postpartum depression: findings from Birth in Brazil Study. *J Affect Disord.* 2020 May 11;273:391-401. <https://doi.org/10.1016/j.jad.2020.04.052>

15. Mesenburg MA, Victora CG, Jacob Serruya SJ, Ponce De León R, Damaso AH, Domingues MR, et al. Disrespect and abuse of women during the process of childbirth in the 2015 Pelotas birth cohort. *Reprod Health.* 2018 Mar 27;15:54. <https://doi.org/10.1186/s12978-018-0495-6>

16. Leite TH, Marques ES, Esteves-Pereira AP, Nucci MF, Portella Y, Leal MC. Desrespeitos e abusos, maus tratos e violência obstétrica: um desafio para a epidemiologia e a saúde pública no Brasil. *Ciênc. saúde coletiva.* 2020 Jan 31;27(2):483-91. <https://doi.org/10.1590/1413-8123202272.38592020>

17. Katz L, Amorim MM, Giordano JC, Bastos MH, Brillhante AVM. Who is afraid of obstetric violence? *Rev. Bras. Saúde Mater. Infant.* 2020 Aug 5;20(2):623-6. <https://doi.org/10.1590/1806-93042020000200017>

18. Marques SB. Violência obstétrica no Brasil: um conceito em construção para a garantia do direito integral à saúde das mulheres. *Cad. Ibero-amer. Dir. Sanit.* 2020 Apr 1;9(1):97-119. <https://doi.org/10.17566/ciads.v9i1.585>

19. Pardin EP, Retroz FF, Queiroz HF, Haag A, Semaan KM, Liz HS, et al. Pré-Natal como estratégia de prevenção à violência obstétrica. *Braz. J. Implantol. Health Sci.* 2023;5(4):872-82. <https://doi.org/10.36557/2674-81692023v5n4p872-882>

20. Santos LHS, Oliveira NCS, Coelho NS, Moura WEA, Verde RMV. O papel do enfermeiro na prevenção da violência obstétrica: revisão integrativa. *Revista Científica FacMais [Internet].* 2023 May 5 [cited 2025 July 29];20(1):128-47. Available from: <https://revistas.facmais.edu.br/index.php/revistacientificafacmais/article/view/88>

21. Betran AP, Ye J, Moller A-B, Souza JP, Zhang J. Trends and projections of caesarean section rates: global and regional estimates. *BMJ Global Health.* 2021 June;6(6):e005671. <https://doi.org/10.1136/bmjgh-2021-005671>

22. Silva ATCSG, Campos RLO, Silva NCDL, Souza LN, Santana MR, Silva AEG, et al. O papel do enfermeiro na humanização do parto normal. *Revista Eletrônica Acervo Saúde.* 2021 Jan 8;13(1):e5202. <https://doi.org/10.25248/reas.e5202.2021>

23. Campos PM, Gouveia HG, Strada JKR, Moraes BA. Skin-to-skin contact and breastfeeding of newborns in a university hospital. *Rev Gaúcha Enferm.* 2020 Apr 30;41(spe):e20190154. <https://doi.org/10.1590/1983-14472020.20190154>

24. Dias BAS, Leal MC, Esteves-Pereira AP, Nakamura-Pereira M. Variações das taxas de cesariana e cesariana recorrente no Brasil segundo idade gestacional ao nascer e tipo de hospital. *Cad Saúde Pública.* 2022 July 15;38(6):e00073621. <https://doi.org/10.1590/0102-311XPT073621>

25. Paiz JC, Souto AS, Martins ACM, Ahne SMS, Baréa M, Giugliani C. Violência obstétrica: entre a percepção das mulheres e as práticas de assistência ao parto. *Rev Bras Med Fam Comunidade.* 2024 Nov 28;19(46):3852. [https://doi.org/10.5712/rbmf19\(46\)3852](https://doi.org/10.5712/rbmf19(46)3852)

26. Ministério da Saúde (BR), Secretaria de Ciência, Tecnologia e Insumos Estratégicos, Departamento de Gestão e Incorporação de Tecnologias em Saúde. Diretriz nacional de assistência ao parto normal [Internet]. Brasília: Ministério da Saúde (BR). 2017 [cited 2025 July 29]. 51 p. Available from:

https://www.gov.br/conitec/pt-br/midias/protocolos/diretrizes/diretrizes_partonormal_versoareduzida_final.pdf

27. Nucci M, Nakano AR, Teixeira LA. Ocitocina sintética e a aceleração do parto: reflexões sobre a síntese e o início do uso da ocitocina em obstetrícia no Brasil. *Hist ciênc saúde-Manguinhos.* 2018 Oct-Dec;25(4):979-98. <https://doi.org/10.1590/S0104-59702018000500006>

28. Alhafez L, Berghella V. Evidence-based labor management: first stage of labor (part 3). *Am J Obstet Gynecol MFM.* 2020 July 21;2(4):100185. <https://doi.org/10.1016/j.ajogmf.2020.100185>

29. Sagi-Dain L, Kreinin-Bleicher I, Bahous R, Arye NG, Shema T, Eshel A, et al. Is it time to abandon episiotomy use? A randomized controlled trial (EPITRIAL). *Int Urogynecol J.* 2020 May 24;31:2377-85. <https://doi.org/10.1007/s00192-020-04332-2>

30. Murena AO, Pereira AN, Evaristo GLO, Santos LG, Barbosa BJP, Cossia T, et al. A prática da episiotomia no Brasil. *Arq. Ciênc. Saúde Unipar [Internet].* 2023 Sep 6 [cited 2025 July 29];27(9):4865-92. Available from: <https://revistas.unipar.br/index.php/saude/article/view/10183>

31. Rocha BD, Zamberlan C, Pivetta HMF, Santos BZ, Antunes BS. Posições verticalizadas no parto e a prevenção de lacerações perineais: revisão sistemática e metanálise. *Rev Esc Enferm USP.* 2020 Sep 14;54:e03610. <https://doi.org/10.1590/S1980-220X2018027503610>

32. Ritter SK, Gonçalves AC, Gouveia HG. Práticas assistenciais em partos de risco habitual assistidos por enfermeiras obstétricas. *Acta Paul Enferm.* 2020;33:eAPE20180284. <https://doi.org/10.37689/acta-ape/2020A00284>

33. Gama SGN, Viellas EF, Medina ET, Angulo-Tuesta A, Silva CKRT, Silva SD, et al. Atenção ao parto por enfermeira obstétrica em maternidades vinculadas à Rede Cegonha, Brasil – 2017. *Ciênc. saúde coletiva.* 2020 Aug 5;26(3):919-29. <https://doi.org/10.1590/1413-81232021263.28482020>

34. Nakata TN, Colombiano IMC, Rodrigues RMS. Análise das boas práticas de atenção ao parto em maternidade pública de Roraima. *Femina [Internet].* 2022 [cited 2025 July 29];50(6):360-6. Available from: <https://pesquisa.bvsalud.org/portal/resource/pt/biblio-1380718>

35. Cabral BTV, Rocha MCS, Almeida VRM, Petrônio CCAD, Azevedo IC, Martins QCS, et al. Non-pharmacological measures for pain relief in childbirth: a systematic review. *Rev Bras Saude Mater Infant.* 2023 June 5;23:e20210439. <https://doi.org/10.1590/1806-9304202300000439-en>

36. Carvalho EMP, Amorim FF, Santana LA, Gottens LBD. Avaliação das boas práticas de atenção ao parto por profissionais dos hospitais públicos do Distrito Federal, Brasil. *Ciênc. saúde coletiva.* 2019 June 27;24(6):2135-45. <https://doi.org/10.1590/1413-81232018246.08412019>

37. Nicolotti CA, Lacerda JT. Avaliação da organização e práticas de assistência ao parto e nascimento em três hospitais de Santa Catarina, Brasil. *Cad Saúde Pública?* 2022 Nov 28;38(10):e00052922. <https://doi.org/10.1590/0102-311XPT052922>

38. Aragão TEB, Santos ANS. Percepção de puérperas negras sobre os cuidados recebidos no parto. *Rev baiana enferm.* 2023 Oct 26;37:e46421. <https://doi.org/10.18471/rbe.v37.46421>

39. Saraiva VCS, Campos DS. A carne mais barata do mercado é a carne negra: notas sobre o racismo e a violência obstétrica contra mulheres negras. *Ciênc. saúde coletiva.* 2023 May 29;28(9):2511-7. <https://doi.org/10.1590/1413-81232023289.05182023>

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