

Review

Analysis of the Concept of Obstetric Violence: A Combination of Scoping Review and Rodgers Conceptual Analysis Methodologies

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Abstract

(1) Background: Intrapartum obstetric violence has become increasingly visible and is portrayed as a cross-cutting and complex phenomenon. Despite numerous international debates and extensive reports in the literature, there is limited consensus on its definition, emphasizing the need to clarify the concept. The aim of this article is to analyze the concept of obstetric violence in the care of women in labor in health institutions; (2) Methods: Search and selection of studies using the scoping review methodology, based on the Joanna Briggs Institute guidelines and Rodgers' conceptual review method for data extraction and analysis; (3) Results: A sample of 49 studies provided a comprehensive understanding of the concept, revealing in its conceptualization attributes of physical, verbal, psychological, sexual, institutional and structural violence. Identification of antecedents of gender inequality and failure of relational, technical and structural standards at the level of health institutions and their professionals, as the main triggers of obstetric violence. Reporting of consequences with a negative impact on maternal and child health; (4) Conclusions: Conceptual analysis with important contributions to the paradigm shift in the work of health professionals. Multiple dimensions, cultural differences and variations in the concept should continue to be examined to improve its research and application.

Keywords: obstetric violence; woman; childbirth; hospitals



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1. Introduction

Childbirth clearly represents an event that has numerous social and cultural meanings, which has suffered profound transformations over time [1,2]. Historically, childbirth was considered a feminine mystery and exclusive to women, of which only they had special knowledge and understanding, taking place in the intimacy of their family and home sphere. Nowadays, however, it is an event that, hegemonically, takes place in hospital institutions under the supervision of health professionals [3,4]. Although the institutionalization of childbirth and scientific advances in maternity care have undoubtedly contributed to a sharp reduction in maternal and infant morbidity and mortality [5], the abusive

introduction of technology into labor has taken away the physiological nature of this process [6,7].

The female body has become a right of the professionals who assist childbirth and is often subjected to unnecessary and scientifically ineffective interventions, which can involve risks to maternal and fetal well-being [8], cause women to lose their autonomy [6,7] and consequently influence their perception of the acceptability, quality and satisfaction of intrapartum care [9,10].

The interactions involving the parturient woman and health professionals, with different powers and legitimacies, can lead to childbirth being perceived as a traumatic process following the dehumanization of care, particularly in the form of obstetric violence (OV) [11]. Several studies show that subjective factors in a negative childbirth experience include the fact that women do not feel respected by health professionals [12–15]. Growing evidence of violent behavior in hospital settings shows that certain maternal health services do not meet the standards of professional care in childbirth [9].

Labor and childbirth, permeated by various levels of violence, affect a significant number of women worldwide, with repercussions of various kinds [16,17]. In addition to physical damage [18,19], the impact of OV is linked to negative effects on women's mental health, through psychological trauma, postpartum depression and post-traumatic stress disorder (PTSD) [20–24]. Other collateral results indicate difficulties in the marital relationship [25] and the mother–baby bond [26], with detrimental effects on breastfeeding [27]. Negative memories of care during labor can also limit maternal desire for a new pregnancy, as well as reducing trust in accessing healthcare for hospital births [28,29].

In 2014, in the publication “Prevention and elimination of abuse, disrespect and mistreatment during childbirth in health institutions”, the World Health Organization (WHO) stated that physical and verbal mistreatment; humiliating and coercive practices; lack of information and interventions carried out without consent; lack of confidentiality and privacy; denial of pain relief; refusal of care; and discrimination and negligence against women in labor are forms of disrespect and abuse. This publication also stated that such practices constitute an unacceptable form of gender-based violence and a violation of sexual and reproductive rights [30].

The document “WHO recommendations: intrapartum care for a positive childbirth experience” focuses on the uniqueness of labor as a time of greater vulnerability for women, requiring the attention of health professionals to their dignified reception, with respect for their choices. It stresses that humanized care is fundamental to a positive and satisfactory perception of the birth experience [31].

International organizations [32] have recognized OV as a serious public health phenomenon, warning of its impact; some countries have legislated its occurrence as a form of violence against women [33,34] and activist movements for the humanization of childbirth continue to debate the relevance of this issue, showing its worldwide prevalence.

The incidence rates of mistreatment or abuse of women during labor range from 33% in Mexico and 49.4% in the remainder of Latin America to over 70% in some countries on the African continent [35]. The research results also point to a high prevalence in Europe [36–38]. The differences presented must take into account the complexity and lack of consensus about the concept itself, since it has strong connotations and is rejected by health professionals and often not perceived by the women themselves [39].

The subjectivity inherent in childbirth and the naturalization of violence, due to social or cultural aspects, as well as factors inherent in health systems, make it difficult to define the concept of OV, with different terminologies being used [40].

Although a number of studies have addressed the issue of OV, namely assessing its prevalence and predictive factors, there is a need for the concept to be analyzed, contributing

to its understanding, precisely by those women who experience it and who, being victims, may not identify it, by health professionals who, conditioned by a multiplicity of factors, may trigger it and by researchers who investigate it.

The aim of this study was to analyze the concept of OV in the care of women undergoing labor in health institutions. More specifically, it aimed to analyze how the term OV is perceived by women who have given birth in health institutions, so that the evidence can raise awareness among health professionals of the effective implementation of good practices in care during labor and delivery.

2. Materials and Methods

2.1. Study Design

In this study, the search and selection of relevant publications followed the methodology of a scoping review, while the conceptual review method, according to Rodgers' evolutionary model, guided the extraction and analysis of data for the refinement of the concept of OV.

The scoping review through a methodical and rigorous process makes it possible to examine the quantity, variety and nature of the available and most pertinent evidence, limiting bias in the choice of articles for the clarification of key concepts [41]. Although it provides guidelines on extracting data from the publications identified, it does not detail a method for extracting data to analyze concepts [42].

The concept analysis methodology ascertains the current state of knowledge of a concept and presents structural criteria for the data to be collected from the literature [43]. However, it lacks a systematic procedure for identifying and screening the relevant publications to be included in the review [42].

In the field of health sciences, both scoping reviews and conceptual analyses have strengths and weaknesses in their methods for clarifying the meaning of concepts [42]. It was therefore decided to combine methodological elements from both approaches in order to overcome their respective limitations and enable a better interpretation of the concept of OV.

The choice of the scoping review methodology for mapping the evidence on the characteristics and dimensions of the conceptual term of OV in labor was related to the fact that it is considered the best choice in situations where there is an interest in identifying concepts, analyzing them, reporting on them or discussing them [44,45]. It provides broad and in-depth information on the existing literature in a particular field of research, in order to clarify and refine a complex concept [46,47].

This scoping review study followed the guidelines proposed by the Joanna Briggs Institute (JBI) [44], integrating the following research stages: (1) outlining the research question; (2) identifying relevant studies; (3) selecting studies; (4) extracting data; and (5) compiling, summarizing and reporting results. The review protocol was designed in accordance with the guidelines of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) [48] and registered on the Open Science Framework Registries platform, under the following Digital Object Identifier: <https://doi.org/10.17605/OSF.IO/U46B5>.

For extract and categorize the theoretical data that made up the corpus for the analysis of the concept of OV, we chose, as previously mentioned, for the theoretical framework of Rodgers' evolutionary model [49,50]. It is characterized by being an inductive and descriptive model, applied to the investigation of a given concept, in which three fundamental aspects are distinguished: its meaning, use and application. The meaning of the concept is understood in the context of its application and from a dynamic perspective, as it can change and evolve over time, according to contextual conditions [51].

The application of the model involved different phases: (1) identification of the concept of interest, substitute terms and relevant uses; (2) selection of the data collection method; (3) collection of relevant data for the analysis of the concept’s attributes; (4) analysis of the contextual basis of the concept (antecedents and consequences); (5) identification of related concepts; (6) presentation of an example of the concept’s applicability (construction of a model case); and (7) determination of possible implications for future research into the concept [50].

2.2. Search Strategy

Following the scoping review methodology, the research question was derived from the PCC mnemonic (Population, Concept, Context) [44]: How is the concept of obstetric violence (Concept) characterized in women’s care (Population) in the context of hospital labor (Context)?

The initial search for scientific evidence was carried out by three of the authors (AF, MSS and MZ) in June 2023 and then refined with the guidance of two experienced librarians in early January 2024. As a first step, a search of the health databases MEDLINE Complete with Full Text (via PubMed) and CINAHL Complete with Full Text (via EBSCOHost) was carried out to identify the keywords usually included in the titles and abstracts of relevant studies on the topic of interest, as well as the indexed Medical Subject Headings (MeSH terms) to describe the articles. Subsequently, the keywords “obstetric violence”, “woman”, ‘childbirth’ and “hospital” were combined with the synonyms and indexing terms identified, to carry out the formal literature search strategy in the following databases: MEDLINE Complete with Full Text (via PubMed), CINAHL Complete with Full Text (via EBSCOHost), Web of Science (via Clarivate), Scopus (via Elsevier), Science Direct (via b-on) and Virtual Health Library (via BIREME), as described in Table 1. Finally, the list of references of each selected study was analyzed to include potential additional studies, but no others were considered for the final sample.

Table 1. Search strategy in different databases.

Database	Complete Search Equation
MEDLINE Complete with full text (PubMed)	“obstetric violence” OR “labor room violence” OR “labour room violence” OR “dehumanization during delivery” OR “violation of birth integrity” OR ((abus* OR disrespect* OR mistreatment OR “disrespect and abuse”) AND (childbirth OR “labor process” OR “labour process” OR parturition OR delivery OR birth)) NOT abortion
CINAHL Complete with full text (EBSCOHost)	“obstetric violence” OR “labor room violence” OR “labour room violence” OR “dehumanization during delivery” OR “violation of birth integrity” OR ((abus* OR disrespect* OR mistreatment OR “disrespect and abuse”) AND (childbirth OR “labor process” OR “labour process” OR parturition OR delivery OR birth)) NOT abortion
Web Of Science (Clarivate)	“obstetric violence” OR “labor room violence” OR “labour room violence” OR “dehumanization during delivery” OR “violation of birth integrity” OR ((abus* OR disrespect* OR mistreatment OR “disrespect and abuse”) AND (childbirth OR “labor process” OR “labour process” OR parturition OR delivery OR birth)) NOT abortion
SCOPUS (Elsevier)	“obstetric violence” OR “labor room violence” OR “labour room violence” OR “dehumanization during delivery” OR “violation of birth integrity” OR ((abus* OR disrespect* OR mistreatment OR “disrespect and abuse”) AND (childbirth OR “labor process” OR “labour process” OR parturition OR delivery OR birth)) AND NOT abortion
Science Direct (b-on)	“obstetric violence” AND ((women AND (perspective OR perception)) AND hospital
Biblioteca Virtual em Saúde (BIREME)	(“violência obstétrica” OR “violência no parto”)

We opted for a restricted selection of articles for the analysis sample, justifying this criterion by the fact that studies published in scientific journals are more qualified and accessible publications than gray literature. The limitations of using gray literature are: lack of clarity in the status of peer review, with a greater likelihood of biased evidence, greater difficulty in systematic and transparent research and restricted dissemination [52].

2.3. Eligibility Criteria

In order to improve the accuracy of the conceptual analysis and answer the research question, eligibility criteria were defined (Table 2), in terms of population, concept and context [53], as well as type of evidence [54].

Table 2. Inclusion and exclusion criteria.

PCC	Inclusion Criteria	Exclusion Criteria
Population	Studies whose target population included only women with labor experience.	Studies that explore the topic of OV, according to the perception of health professionals, community agents, family members and significant others. Studies that did not deal with theoretical aspects of the concept of OV and/or whose research focus was on other key concepts.
Concept	Studies addressing the dimensions of the concept of OV (terminology, typology; causes; predisposing factors and consequences).	Investigations into the effects of programs in the field of OV. Studies that presented the process of construction and/or validation of OV assessment instruments.
Context	Studies that explored labor care in public and/or private hospitals, regardless of size, clinical conditions and geographical location.	Studies investigating the use of mouth-to-mouth in situations of miscarriage, prenatal surveillance and postpartum check-ups. Research into home birth care in birthing centers.
Types of evidence	Peer-reviewed scientific articles containing primary data. Research with a qualitative, quantitative or mixed methods design. Published in English, Spanish and Portuguese, between 2012 and 2023. Articles with $\geq 75\%$ of the quality criteria of the JBI tools.	Secondary studies such as systematic literature reviews and meta-analyses; theses and dissertations; books; editorial supplements; opinion articles; commentaries and conference papers. No full text available in databases and/or not made available by the authors after contact via ResearchGate.

2.4. Selection of Sources of Evidence

After searching the databases, all the articles identified were transferred to the electronic tool Rayyan[®] in order to organize the results and remove duplicates. The articles were then selected by reading the titles and abstracts by two independent reviewers (AF and MSS), meeting the eligibility criteria. In the full-text screening stage, the articles were also analyzed independently by two researchers (AF and VA) and excluded if they did not meet the inclusion criteria. During the selection process, any conflicts between the two reviewers were resolved through discussion until consensus was reached. When disagreements prevailed, they were resolved by a third reviewer (MSS or MZ). The results of the search, as well as the study selection process, are presented in the PRISMA-SCR 2020 flowchart [55] (Figure 1).

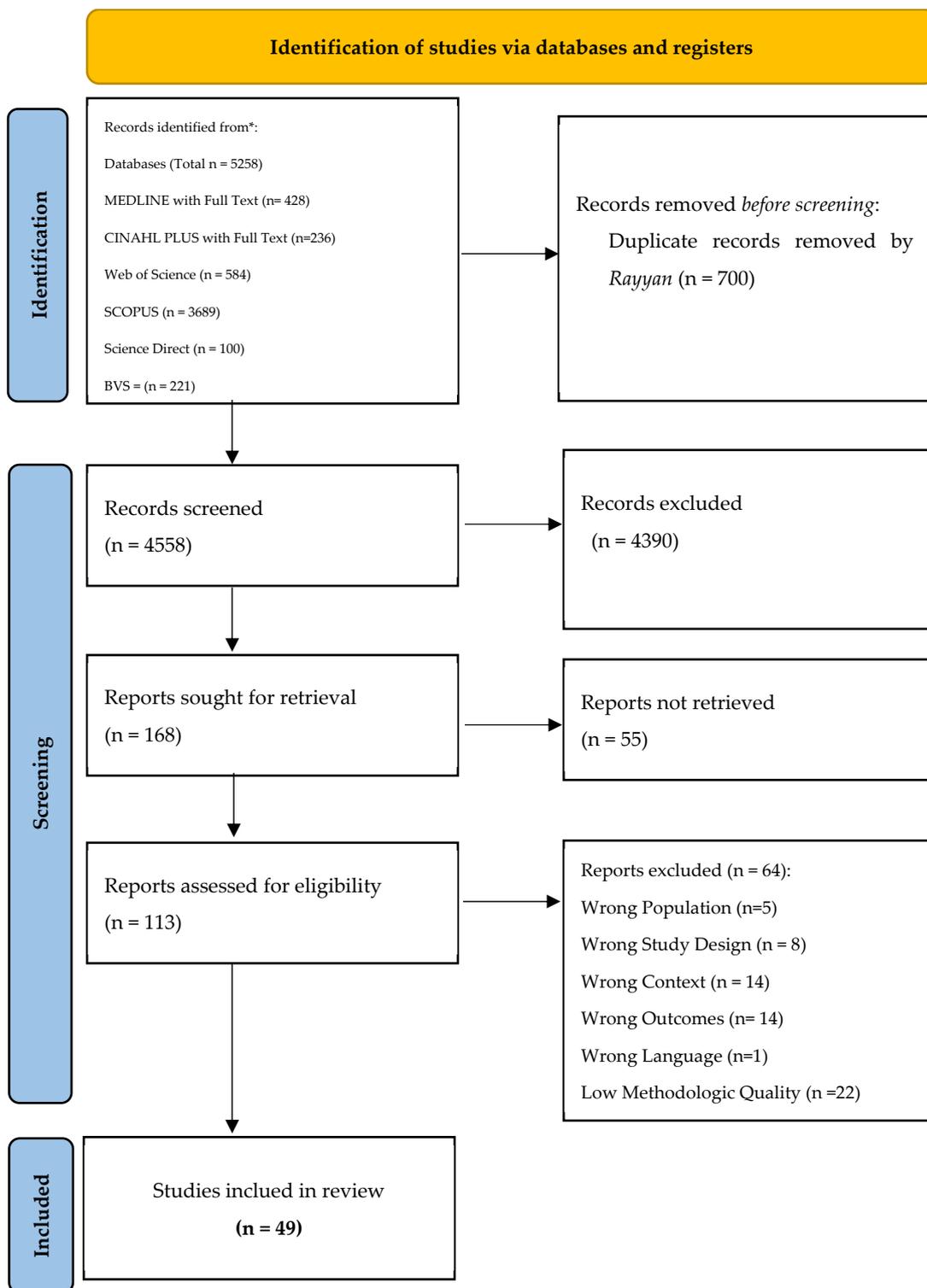


Figure 1. PRISMA-ScR flowchart. * PRISMA: Preferred Reporting Items for Scoping Reviews and Meta-Analyses.

2.5. Quality Appraisal

Assessing the methodological quality of primary studies using standardized instruments is not a mandatory indication in a scoping review [48]. However, reviewers can decide to assess the reliability and rigor of the methodology of the primary studies gathered [56], considering the purpose of the review [44].

The critical analysis of the methodological design of each study took into account the JBI instruments [57], specifically checklists for qualitative, cross-sectional, prevalence, cohort and case-control studies. The classification of items for assessing qualitative research is similar to that for quantitative studies, whereby scores less than or equal to 6 suggest a weak classification of scientific evidence with methodological limitations, between 7 and 8 indicate a moderate level of quality and between 9 and 10 strong or high [58,59]. In order to make the process clearer and free of subjectivity, all the reviewers defined the acceptance of moderate to high quality studies with a score of 75% or more.

The Mixed Methods Appraisal Tool (MMAT) was used to assess primary mixed methods studies. In its structure, in addition to two prior questions that are common to all types of research, each study is submitted to the evaluation of five specific criteria, depending on its methodological design [60,61]. For all mixed research to be considered of good quality, both strands of the study need to meet the criteria of scientific rigor [60].

Two reviewers (AF and MSS) independently carried out preliminary assessments of each study. Disagreements were mediated through analysis and discussion with a third researcher (MZ or VA). The assessment of the methodological quality of the studies included in the review can be seen in Supplementary Material Table S1.

2.6. Data Charting Method

Data extraction was also carried out by two researchers (AF and VA), using an instrument built in table format, in accordance with the JBI guidelines [44]. In identifying and characterizing the selected publications, the following data was extracted: author(s)/year/country, type of study; objective(s); population/sample; methodology; results; and main conclusions and findings (Supplementary Material Table S2). Data congruent with Rodgers' method [51] was also compiled using a Microsoft Excel[®] tool (table). Each article was coded based on antecedents, attributes, consequents and alternative and/or related terminology. When mapping the information to be collected, whenever doubts or disagreements arose, a third-party reviewer (MZ) was used.

2.7. Data Synthesis

A narrative approach accompanied the reporting of the data, in order to align the main results with the question and objective formulated for this review. The information was transcribed into a table format to summarize the results.

3. Results

The search of the selected databases identified 5258 potentially relevant studies. After removing duplicates, 4558 articles were considered eligible for screening by title and abstract. This selection resulted in 168 studies, of which 113 were retrieved for evaluation through full-text reading. A total of 49 studies met the inclusion criteria for the main analysis, as shown in the PRISMA-SCR 2020 flowchart (Figure 1).

3.1. Characteristics of the Included Studies

Among the studies included ($n = 49$), the years of publication ranged from 2012 to 2023, with the highest scientific production being evident in 2022 with 11 publications. The sample included research from different continents such as North ($n = 2$) and South America ($n = 5$), Africa ($n = 26$), Asia ($n = 10$) and Europe ($n = 6$). In line with the United Nations (UN) classification, these studies collected data that ranged from developed countries with advanced technological and economic infrastructure, to mostly underdeveloped countries with a low level of industrialization, an average to low standard of living, with unequal distribution of wealth and where birth and mortality rates are higher [62].

As for the type of research, quantitative studies stood out ($n = 32$), followed by qualitative studies ($n = 15$) and, finally, mixed methods studies ($n = 2$). The quantitative studies included analytical prevalence studies ($n = 21$), descriptive cross-sectional studies ($n = 7$), cohort studies ($n = 3$) and case-control studies ($n = 1$). The qualitative studies included exploratory and descriptive methodology ($n = 13$) and a phenomenological design ($n = 2$).

3.2. Characteristics Identified in the Conceptual Analysis

The concept of interest was analyzed in terms of its name, uses and contexts of application, substitute terminology, attributes, antecedents, consequents, related concepts, model case and implications for clinical practice. The review of all included studies [63–111] and the summary extraction of the main characteristics identified through the applicability of Rodgers' evolutionary approach, can be consulted in Supplementary Material Table S3.

3.3. Naming the Concept of Interest

In 1996, with the publication of the Care in Normal Birth manual, the WHO compiled recommendations on low-risk obstetric care for normal childbirth, encouraging scientifically proven practices and calling for the elimination of others considered harmful [67,87]. However, with obstetric care far from ideal, in the mid-2000s, in association with feminist movements and activists for the humanization of childbirth, the concept of OV emerged in Latin America and the Caribbean, bringing legal and investigative discussions about the biomedical model of childbirth in certain clinical environments [67,97,107].

As a legal milestone, in 2007 Venezuela became the first country in the world to officially define OV, as well as to regulate and criminally sanction those responsible for its practice. The literature review identified that the concept of OV was described in the country's Organic Law on Women's Rights to a Life Free of Violence as the appropriation of women's bodies and reproductive processes by health professionals, through dehumanized treatment, abusive medicalization of labor without maternal consent and pathologization of the physiological process of childbirth, causing a loss of autonomy in decisions involving their bodies and sexuality, as well as a negative impact on their quality of life [66,67,87,97,107,109]. Similar legislation has been passed in countries such as Argentina and Mexico, defining and prohibiting this form of violence. In Brazil, legislation has been passed demanding humanized care in childbirth [76,87].

Only seven of the studies analyzed directly adopted the concept of OV, presenting its definition [66,67,81,87,97,107,109] even though they sometimes used substitute terminology throughout the text. In these studies, it became clear that the concept refers to violent and abusive acts, behaviors or attitudes in the interpersonal relationship between caregivers and care recipients, triggered by health professionals or even inadequate conditions in institutions [67,81,97,107,109]. In their definition, some of these studies mentioned the WHO's categorization of OV, covering the lack of active listening and support for women; inhuman mistreatment; negligence and humiliating acts in care; socio-demographic, economic, religious, ethnic and cultural discrimination; verbal, physical and psychological violence; the routine and excessive use of interventions and technologies without authorization, infringing on the fundamental rights of equality, freedom of choice and physical and mental integrity [66,67,81,87,97,107,109].

3.4. Contexts and Uses of the Concept

Research on the concept of OV takes place in the humanities, social sciences and medical sciences. In the review, the following contexts of applicability of the concept were identified: (1) in the field of Medicine and Public Health where it describes and addresses inadequate practices in intrapartum care [63–111]; (2) in the field of human sciences related to women's

rights to receive respectful care [65,69,71,73–75,77–81,84–86,88–93,95,96,99,102–110]; and (3) in relation to the social sciences, focusing on their influence by sociocultural norms on the role of women and medical authority [63,68,71,76,85,94,95,97,111].

As for the uses of the concept, three domains were recognized: (1) health legislation and policies (used in the formulation of laws and guidelines to protect women in childbirth, interventions to strengthen the quality of maternal health services and accountability mechanisms, allowing for the reporting and legal treatment of OV) [63–77,79–86,88,90,92,94–97,99–108,110,111]; (2) education and training of health professionals (integrated into the training process, in order to rethink their care practices and promote humanized and respectful interventions) [64–68,70,73–75,77,82,84–91,93,94,96,98–105,107,110,111]; and (3) advocacy and activism (used by lawyers and women’s rights groups to raise awareness and bring about social change) [68,78,87,96].

3.5. Surrogate Terms

Substitute terms are ways of naming the concept that differ from the word or expression selected by the researcher [51]. They can express similar ideas and characteristics, using different terminology to represent the chosen concept [49,51].

The analysis revealed that the most commonly used substitute term was disrespect and abuse [63–65,68–74,76–80,83,84,86,89–93,96,99,104–108,111], which was mentioned in most studies (63%; *n* = 31). The other substitute terms included: mistreatment [75,78,85,95,100–103,107,108,110]; traumatic childbirth and/or negative birth experience [63,82,97,98,101,103]; dehumanization of childbirth [70,87,101,103]; violence in childbirth [66,67,94]; violence against women [87] or violation of maternal rights in childbirth [81]; institutional [71,76,85,95,97,111], structural [63,68,76,94,97] and symbolic [68] violence in childbirth. The variety of terms used to designate OV reinforced the lack of consensus and difficulty in naming it, aggravated by the fact that many of these terms, when used as synonyms, end up presenting different definitions, criticisms, and gaps [40]. According to the studies analyzed, for a better understanding, we present the main substitute terms, their context of application, and their different implications (Table 3).

Table 3. Surrogate terms.

Term	Definition	Use/Context	Ethical, Legal, and Social Implications
Disrespect and abuse	Interactions or conditions in healthcare facilities that are recognized as humiliating or undignified by women. This category includes: physical abuse; non-consensual care; non-confidential care; undignified care; discrimination based on specific attributes; neglect of care; and detention in healthcare facilities [112].	Used by international organizations, such as the WHO, as a comprehensive term for different categories of violence during childbirth that violate women’s rights.	Recognizes a wide range of abuse and disrespect, but without necessarily providing a legal framework; promotes public policies.
Mistreatment in Childbirth	Intentional or unintentional actions by staff, as well as structural conditions in health services, with the potential to reduce the ability to provide the best possible care. These include: physical abuse; sexual abuse; verbal abuse; stigma and discrimination; failure to comply with professional standards; poor relationships between health professionals and women; and conditions and restrictions in the health system [35].	Applied in WHO publications, as it is considered less provocative among healthcare professionals [40,113,114].	Reporting unethical practices; configuration of ethical and institutional violations. Subject to criticism for considering the character of intentionality in obstetric care [115,116].

Table 3. *Cont.*

Term	Definition	Use/Context	Ethical, Legal, and Social Implications
Traumatic Birth	Any event during labor and delivery that, among other causes, may be determined by inappropriate human and technical conduct, with undesirable results for the mother and newborn, even in the absence of clinical complications.	A clinical and psychological term used in the field of mental health. It emphasizes the emotional and psychological aspects of the childbirth experience.	Emphasizes the lasting effects on women’s mental health, with a focus on emotional recovery.
Dehumanization of Birth	Violent practices normalized by healthcare professionals, who implement labor in an interventionist context through obsolete protocols, excessive medicalization, and denial of reproductive rights.	Present in critical analysis of biomedical and technocratic models of care.	Criticism of the loss of women’s prominence; implies the need to transform obstetric care models.
Institutional Violence	Abusive practices that stem from the structure and culture of health institutions, with authoritarianism towards women and routines centered on professional convenience.	Addressed in the field of public health and human rights.	It holds the healthcare system accountable, not just the professional; it points to organizational failures.
Structural Violence	Invisible and systemic violence produced by the economic and political organizations, expressed in the unequal distribution of power and discrimination and injustice in childbirth care, based on socioeconomic, racial, and gender inequalities.	Sociological and public health discussions, especially in vulnerable populations.	Emphasizes how intersectional oppressions affect intrapartum care; calls for equitable health policies.
Symbolic Violence	A subtle and naturalized form of domination, in which women accept violence as normal. Manifested in the symbolic power differential between social groups, preventing women from playing a leading role in labor, through the imposition of medical procedures without consent, coercion, and demoralization.	Critical analysis of medical culture and the acceptance of submission as part of the care process.	It hinders the reporting and recognition of violence; it perpetuates violent practices as “normal.”

Many of these concepts overlap, but they have distinct nuances that are important for critical reflection on childbirth care. While some concepts prioritize the individual and subjective experience of women (such as “traumatic childbirth” or ‘dehumanization’), others shift the focus to systemic and sociopolitical dimensions (such as “institutional violence” and “structural violence”). This terminological plurality does not represent fragmentation, but rather an expansion of the understanding necessary to address the multiple layers of OV.

In the literature, all the substitute terms identified were used more or less interchangeably with the concept of interest, depending on the country of study, the context in which women were placed, the stakeholders involved, and the research methods used. Although each of these terms has an underlying definition that emphasizes different aspects of OV, commonalities were apparent, highlighting abusive intervention in the physiology of TP, gender inequalities, professional hierarchy, violence against women, and threats to their rights.

Expressions of violence or dehumanization in childbirth were commonly operationalized in research, political actions, and social activism in Latin American countries. The conceptual review also revealed a global trend in the scientific community toward the use of terminology related to disrespect, abuse, or mistreatment, especially in research conducted in Africa, North America, Asia, and Europe.

3.6. Attributes of the Concept

The attributes are an integral part of the concept, corresponding to its characteristics and allowing its context to be identified [51]. As attributes of OV in labor, the literature has

identified: physical violence; verbal violence; psychological and emotional violence; sexual violence; institutional violence and structural violence.

Physical violence refers to the use or threat of physical force inflicted on women, which may or may not result in actual physical harm. In the analysis, it was characterized by aggression and abuse of the use of physical force by health professionals, including slapping, pinching, pushing and beating [64,65,68,71,72,74–81,83–86,91–94,96,101,102,104,106,108,111]; uncomfortable physical interactions, through the application of excessive force, to subject the woman to physical examinations and invasive procedures [66–70,73,76–79,82,85,87,91,93–95,97,100,101,103,105,107,109,110]; physical restraint through immobilization in bed [65,68,78,83–85,91]; the use of force, forcing the legs open to perform vaginal touches or at the moment of fetal expulsion [65,75,78,84–86,97,107,111]; not allowing free movement and adopting vertical positions during labor [65–67,72,73,85–88,91,96,99,103,104,107,110,111]; devaluation of physical pain [65,68–72,78,79,82,83,85–89,91–97,101,103–107,110,111]; and restriction or denial of food or liquid intake [65,67,83,85,86,91,96,97,104,107].

Verbal violence was reflected in the aggressive and authoritarian verbal behavior of health professionals, preventing effective communication. It was described as shouting and inappropriate, offensive and judgmental language [63–66,68,70,72–75,77–81,83–86,88–97,99,101–108,110,111]; ironic, derogatory, discriminatory and infantilizing comments [64,68,70,71,73,75,78,88,91,93,96,97,103,107,111]; insensitivity to the woman's concerns, by denying or omitting information [63,65,68–70,72,73,76,77,80–83,85–87,89,90,92,93,95–107,109–111]; and the use of technical vocabulary, so that the woman did not understand the information transmitted [85,93,95,96,104,107].

Psychological or emotional violence was portrayed as any aggression against women, without direct physical contact with health professionals. In the review of articles, it manifested itself basically in the form of reprimands and intimidation, abandonment of care or detention in health units after childbirth [63–66,68,70,72–76,78,79,83,84,90–94,96,101–104,108,110,111]; authoritarian, humiliating, hostile and punitive treatment [63,68,70,71,74,78–81,103,110,111]; coercion into accepting interventions and/or complying with professional orders [69,81,83,91,95–97,101,107]; blaming and holding people responsible for not accepting medical procedures or even for the outcome of childbirth [79,84,101,103,107,110,111]; and disregard for women's requests or devaluing their needs [63,64,69–72,75,78,84–87,92–99,101–107,111].

In the field of sexual violence, OV included any behavior (physical, psychological or verbal) perceived by the woman as sexual in nature and a controlling, coercive, harmful or unwanted attitude. There were several characterizing attributes, namely: harassment and rape [74]; disrespect for maternal privacy with inappropriate body exposure [64,65,68,72–74,78–86,88–93,95,96,98,100,102–111]; and repeated vaginal touching by multiple professionals and students [67,87,89,91,97,100,103,107,110,111].

The typology of institutional violence in labor described standardized and non-recommended interventions, carried out without prior consent [63–69,72–74,76–95,97–111]; impediment or denial of the presence of a companion [63,66,73,74,77–79,81,82,85,87,89,93,94,97,101,105,107,110]; failure to encourage skin-to-skin contact and early breastfeeding [66,82,83,94,95,99,111]; negligence and disregard for care [63–65,71–77,79–81,83–87,89–94,96,97,99–102,104–108,111]; forced detention in health units, with undue demands for payment for childbirth care [64,65,74,79,80,83,84,86,88,91,96,102,104,106,108,111]; and extortion and financial bribes to guarantee care [68,69,71,74,85].

Structural violence was represented by attributes related to discrimination based on specific characteristics of women [63–65,67,68,70,72–81,83–86,89–93,95,96,98–104,106–111]; violation of the right to confidentiality in care [63–65,68,71–74,77–86,89,91,93,95,96,98,100,102,104–111]; precarious professional practice [63,64,68,70,72,73,75–80,82,85–92,95–

101,103,105–108,110,111]; and systemic failures in health units [63,68–75,77,79,81,83–86,88–92,94–103,105–108,110,111].

3.7. Antecedents of the Concept

The antecedents provide the context and are necessary for its occurrence [51]. In this study, they corresponded to the precursors of OV and were grouped into pre-existing conditions (related to the woman's characteristics, health history, pregnancy period and context of involvement) and determinants of labor (including obstetric events and intrinsic aspects of health systems and their professionals).

Characteristics such as maternal age [64,66,70,72,75,76,78,79,95,100,103,111]; ethnic minorities [66,80,93]; religion [83,93]; refugee or foreigner status [89]; marital status [64,66,68,69,72,75,83,95,103,111]; education [67–70,72,74,78–90,96,99,100,103,104,106,109]; occupation [70,86,99,109]; economic status [63,65,68,69,74,76,80,84,90,91,95,107,109,110]; and living area [70,72,77,78,81,90,91,100,106], were identified as predictors of OV in labor.

Health problems and traumatic experiences included women with chronic illnesses [78], infectious diseases [80,101], psychiatric disorders [74,101], rape or sexual abuse [74] and drug use [95]. Lack of knowledge about sexual and reproductive rights, as well as legal aspects of care, especially in underdeveloped or developing countries [63,67,70,72,76,77,81,83,85,90,92,93,96,99,105,106,109,110], failure to plan for pregnancy [88], non-existent or insufficient prenatal surveillance [86,96,102,104,106], inaccessibility to childbirth education [101] and the presence of pregnancy complications [98], emerged as other previous factors associated with OV.

Regarding the context of insertion, the presence of a patriarchal system that favors men, allowing them to maintain political power, moral authority and social control, combined with a conservative culture, contributed to exposure to gender inequality, preventing or limiting women's decision-making capacity in childbirth [64,68,76,77,97,100,101,107]. Some studies have highlighted, especially in minority groups, that gender discrimination, supported by stereotypes that ally femininity with irrationality and weakness, leads to misogynistic behavior against women [68,75,77,79,83,84,91,95,111]. Moral prejudices, based on pre-established social relations, have thus been reflected in unequal power relations with health professionals [64,68,73,76,90,95,97,106].

The lack of a legal system that recognizes violence in labor also seemed to contribute as a pre-existing antecedent to the perpetuation of bad practices by health professionals, as well as to their underreporting by women [77,84].

Multiple antecedents inherent to the history of childbirth were identified, which preceded OV: primiparity [69,74,98,100] or multiparity [64,66,72,83,89,98,107]; forced admission to health units [73]; absence of a companion [64,72,73,84,89,96,104,108]; obstetric risk factors [69]; language barriers [104]; duration of Labor [72,88,96,100,106]; absence and/or insufficient maternal preparation for childbirth [75,101]; type of delivery [76–79,98,100,106,107]; episiotomy [100,101,107]; delivery at night [73,88,90,104]; category and sex of professional [67,71,80,83,91,107,111]; sector of care and type of health facilities [65,70,71,76,79,84,91,96,98,102,104,106,108]; complications during and/or after delivery [71,74,79,88,102,106,107,111]; longer length of stay in health institutions [88,111]; transfer of the newborn to a neonatal intensive care unit [98,107]; and previous history of home birth [96]. Also in the literature, the bio-medical model emerged as an important antecedent, being referred to in most of the studies analyzed (47%), as a highly medicalized, technocratic and reductionist model that objectifies the female body, not respecting the recommendations for a respected and satisfactory birth [63–67,69,70,73,75,76,78,82,84,86–88,90,94,95,97,100,101,103,107].

At the level of health systems, the power regulated by technical-scientific knowledge and the moral hegemony attributed to doctors has been indicated as one of the main determinants of OV in institutional childbirth, with the secondary maternal role being representative in the acceptance of imposed interventions [63,64,68,76,85,87,95,97,100,107].

According to the socio-economic and geopolitical context, the analysis listed other antecedents related to health systems, respectively: inefficient management and leadership policies, with an inability to respond to maternal care [63,74,79,83–86,88–90,97,98] and a lack of professional supervision and accountability [63,64,70,73,86,88,94,96,100,105]; overload of differentiated hospital units [71,81,96,102,105]; logistical failures in inter-hospital transfers [63] or denial of hospital transportation for childbirth [89]; bureaucracies in organizational regulations [63,77,100,110]; inequalities in accessibility to obstetric care (failure to respect free access to intrapartum care in the public sector [66] or informal co-funding of certain services according to a specific health professional [69]); and disparities in care between the public and private sectors [76,100,108].

The inadequacy of the physical infrastructure of health units [68,71–73,77,79,84–86,90–92,105,107,108,110] and the lack of human and material resources [63,68,71–73,75,79,83–86,88–92,97,98,100,105,107,108,110,111] also represented a number of key factors for the occurrence of OV within the care system where childbirth takes place.

In the analysis, the following antecedents linked health professionals to figurative OV actions: inadequate ethical and professional conduct [68,75,80,85,86,89,96,97,99]; insufficient clinical competence [75,108,111]; poor quality of interpersonal care relationship [63,70,73,76,78,85,87,89–92,98,101,110]; lack of training in interpersonal and communication skills [70,76–79,82,85,86,88,90,96–98,103,105]; lack of acceptance or limited knowledge about respectful maternal care guidelines [63,67,77,79,85–88,90,91,97,99,101,105,107,108]; precarious working conditions, contributing to stress, occupational burnout and dissatisfaction [68,71,81,88,91,96,99,100,102,106]; and unsafe provision of care, with the presence of a high number of trainees and failures in their teaching/supervision [66,73,88,105].

3.8. Consequents of the Concept

Consequences refer to the results or manifestations of the concept of interest, and are interconnected with their antecedents and should follow them [51]. In this conceptual analysis, most of the consequences identified were based on the findings of qualitative research and were listed as physical, emotional, psychological, socio-cultural and health behavior repercussions.

The physical manifestations pointed to the result on the woman's body, resulting from the experience of violence in labor, highlighting the presence of injuries, due to the application of excessive force in the execution of medical techniques or aggression by health professionals [68,71,75,94,97,99]; discomfort and intense pain caused by routine procedures and without scientific evidence [65,69–71,73,75,77–79,82–89,94,95,97–100,103,105,110,111]; and bodily pain due to failure to promote pain relief, due to incorrect execution or inappropriate timing of analgesic and anesthetic techniques, as well as failure to ensure adequate administration of drugs [68–71,77–79,82,85,89,91,93,95,97–101,103,105,107,110].

The risk of complications in the woman's hemodynamic state, associated with obstetric emergencies and professional negligence were also physical consequences of OV [67,68,70,73,79,89,94,95,97,105]. Postpartum physical problems related to pelvic floor dysfunction [82] and, inevitably, difficulties in the emotional and sexual relationship between the couple [82,94] were also identified.

Some of the emotional consequences were feelings of disappointment, incomprehension, sadness, anxiety, anguish and additional stress [63,68,71,73–75,78,82,84,87,89,90,97–99,101,103–105,109,110], due to not being allowed to have a companion, deprivation of

information, disrespect for individual choices, discrimination and stigmatization, complications for maternal-fetal well-being, lack of professional empathy and the conditions of the care units. The derogatory comments and bodily exposure, in front of various health professionals and students, generated humiliation, offense, shame, frustration and a sense of violation of intimacy and privacy [63,68,71,72,74,75,82,84,90,92,97,100,101,105,110].

The poor quality of care, boosted by the hostility of health professionals, triggered fear, anger, distrust, loneliness and abandonment, as well as feelings of devaluation, contempt, dehumanization and objectification [63,65,67,68,70,71,73,75,82,84,87,90,91,93–97,99,101,103–105,107]. Women perceived a loss of autonomy and self-control, accompanied by a feeling of powerlessness and disempowerment, which made labor a more difficult process [63,68,69,76,77,82,84,87,92,95,97,98,100,101,103,105,107].

Regret and self-blame for resorting to health facilities for childbirth also emerged as emotional consequences, with a negative impact on self-confidence [75,99] and non-acceptance of the childbirth experience [101]. Panic and aversion to a new pregnancy were other feelings recognized [71,82,90,94,101,105].

The emotions described also characterized their perception of labor as a traumatic and unsatisfactory event [63,66,68,70,73,75,82,84,87,88,90,92,94,95,97,98,101,103,105,109,110], with difficulties in breastfeeding and bonding [82,94,97,98].

It has been found that the psychological consequences, as well as being disturbing, can remain in the woman's life from short to long term, and with varying degrees of pregnancy. Situations of baby blues [101], psychological trauma [94], severe depression [82,101], postpartum psychosis [90] and PTSD [101] were identified.

The social effects of OV have taken place in a patriarchal culture, which affects various sectors of society, including medicine, and in which women in particular are not aware of the existence of this type of violence, tending to make it invisible. In this scenario, maternal acceptance, naturalization, devaluation and under-reporting of situations of violence during labor were evident, and are commonly identified consequences [64,65,68,69,71–76,78,80,81,83–85,87–91,93,95,96,99–106,110,111]. In just one of the studies included in this review, some women and their partners, out of distrust and anger at the attitudes of health professionals, triggered social conflicts through blaming and direct aggression, and did not passively accept the violence committed [94].

OV during labor can also have a negative influence on women's attitudes towards their health and that of their baby in the next pregnancy and future birth. The behavior of seeking healthcare for pregnancy monitoring and choices regarding childbirth in health facilities may thus be compromised. The results showed women's intention to underuse and reluctance to go to health facilities for specialized care [63–65,71,73,74,79,80,84–86,89,90,94,104,105,107,108,111], with the option of home birth [71,75,80,84,86,89,107,108,111], which despite being more insecure, provides a more welcoming environment in their view. The decision to give birth at home, with no trained professionals and a higher risk of maternal and fetal complications, could also have implications for an increase in the rate of maternal and perinatal morbidity and mortality [63,64,73,74,79,84–86,89,90,94,107,108,111].

3.9. Related Terms

According to Rodgers' conceptual analysis methodology, it is essential to distinguish carefully between substitute terms and related terms, which are concepts that have some relation to the concept of interest, may contribute to its constitution, but do not seem to share the same set of attributes [51].

Several related concepts were identified during the process of reviewing the studies. Two of them were unquestionably the concepts of gender-based violence [64,66,68,76,77,87,

94,95,97,100,101,107,109,111] and fundamental human rights [64–68,70,71,74–82,85,86,89–97,99,101–105,107–109].

It is practically impossible to approach the concept of OV without relating it to a serious form of violation of women's sexual and reproductive rights. The UN's warning against the erroneous notion of using the term gender-based violence as a synonym for violence against women has helped us to understand that, in the context of this analysis, it is a related term. The concept of gender-based violence is broader and aims to highlight the gender dimension in the subordination of women in society and their vulnerability to violence, but it can also be directed against anyone who does not respect the roles that society imposes on them, whether men or women, which is why men can also be victims of gender-based violence, especially sexual violence [117].

The concepts of respectful maternal care [65,69,71–75,77–81,85,88–93,95,96,98,102–110], humanization of childbirth [66,76,87,103,106,111] and woman-centered care [79,82,84,94,95] were also related concepts, although their definitions are irreducibly antagonistic to the concept of interest. They clearly do not share common attributes with the expression OV, but they do form part of a network that allows them to be framed and differentiated [51].

In the analysis, the concepts of institutional childbirth [65,71,74,75,81,86,91,93,99–101,104–106,108–111] and intrapartum care [63,65,69–71,73–76,78–80,82,84–86,89,91,92,96,98,109] also appeared as related terms.

3.10. Model Case

A model case was designed to demonstrate the defining attributes, antecedents and consequents identified in the corpus of analysis. It should preferably be written in the context in which the concept of interest was analyzed [43,51], so this case represents a situation of OV in labor. It is a fictitious model case, written in isolation by one of the researchers (AF) and reviewed by two higher education teachers involved in the research (MZ and MSS).

Ms. M, aged 19, went to the hospital due to regular and painful uterine contractions. The obstetrician told her to remove her clothes and that he would carry out a vaginal examination to assess dilation. No information about the procedure was given, only that she would be admitted to hospital. She was admitted to the delivery room by a nurse midwife who did not show up, but simply provided various types of care, including catheterizing the peripheral vein to administer saline, taking blood for analysis and cardiotocography. She tried to tell her that she had a birth plan, but it was useless given the lack of attention from the midwife, who was talking at the same time to other nurses and trainees who entered the room. The pain of the contractions became more intense, and she rang the doorbell. Another health professional, who did not identify herself, came in and told her to spread her legs. She did not explain or ask permission for a vaginal examination. The procedure was uncomfortable and painful, leaving Mrs. M in tears. She heard the following comment: "My little girl is still in early labor and has a lot of crying to do. We are going to put oxytocin in the IV to make these contractions more effective, because the baby has to be born." Ms. M asked if it was really necessary, as she wanted a natural birth. In a harsh and rude tone of voice, the doctor replied that she was following the protocol. She asked if she could perform epidural analgesia. It was refused, without any clinical justification. Without giving up on the obstetrician's attention, she said she wanted to get up and move around the room, which she was not allowed to do either, on the grounds that the department was overloaded with too many parturients and there were not enough professionals to supervise her. Ms. M emphasized that if her mother could join her, it would help her to control herself. According to the institution, if possible, the mother would only come in to watch the birth. The hours continued to pass, and the contractions became more painful

and unbearable. Every time Ms. M asked for help, a doctor, nurse and trainees would come and repeatedly perform vaginal examinations in short periods of time. They still did not ask for consent or provide information about the progression of the dilation, or about the procedures carried out, such as the artificial rupture of the bag of waters. They did not take care to close the bedroom door, leaving Mrs. M embarrassed and intimidated. The labor did not progress and Ms. M, once again without being informed beforehand or signing any consent form, underwent a cesarean section. She only realized when she was already in the operating room when the anesthesiologist came in. The baby was born, and she heard him crying. The nurse immediately took the baby, wrapped him in a cloth and put him on the resuscitation table so that the pediatrician could do a physical examination. Ms. M could not see her son's face, no one explained to her if everything was all right, and there was no possibility of skin-to-skin contact, one of her greatest wishes. After the cesarean section, she was transferred to the recovery room and a nurse placed the baby next to her. She said she needed help because she was in pain and could not position herself to fit the baby to her breast. The nurse said that she had work to do and was not available to help with breastfeeding, so it would be more appropriate to give the baby milk by bottle. Although she was reluctant, she eventually agreed, thinking of her son's well-being. Two hours after giving birth, Ms. M's mother was able to visit her. Demoralized, sad and frustrated, she confessed to her mother that her experience had been impersonal and unsatisfactory, and that she never wanted to get pregnant again. However, she also realized that the health professionals had done everything to ensure that the baby was born safely.

In this model case, the antecedents of OV were institutional hierarchy and maternal submission to the biomedical model, the poor quality of the relationship between professionals and women (characterized by a lack of empathy, active listening and support), as well as systemic constraints such as work overload in the health unit and inadequate institutional regulations (barriers to the presence of the significant person). Attributes were represented by verbal abuse (rude language and coercion), painful and unnecessary procedures that do not respect scientific evidence, body objectification, disregard for needs and preferences (natural childbirth, freedom of movement, skin-to-skin contact and early breastfeeding), violation of privacy, lack of information and consent and denial of a companion. The manifestation of negative emotions resulting from the lack of empowerment during labor, leading to the desire not to get pregnant again, emerged as a consequence of OV. The mother's view of the role of the professionals in terms of the final outcome of the birth showed acceptance of the violence suffered.

3.11. Determining Hypotheses and Implications of Concept Analysis

The final stage of Rodgers' evolutionary method consists of formulating hypotheses and identifying reasons for the continued development of the concept under analysis [49,51]. Based on our research, we established the following hypotheses: (1) identifying and preventing OV in labor can help recognize violent practices and protect women; (2) the impact of a violent birth experience can increase the risk of complications in women's lives and interpersonal relationships; (3) reducing unnecessary interventions, since knowledge about abusive care can decrease invasive procedures, that are not based on scientific evidence; and (4) the importance of human rights and legislation, proposing that OV can drive legal and ethical changes for dignified treatment.

Further research could transform birth care, particularly through the request for specific interventions to address OV by health professionals, policymakers, and educators.

Implications for healthcare professionals include raising awareness of the concept of OV through the creation of spaces for reflection and debate on misinterpretations of the concept, potential underlying causes of its occurrence, and the development of effective

solutions; reviewing medical protocols, with the implementation of guidelines based on the humanization of childbirth; training to act in accordance with the code of ethics in situations of risk for disrespectful behavior; integrated training in respectful maternal care, for a more woman-centered approach and respect for her autonomy and informed consent; adoption of a more empathetic, respectful, and communicative attitude toward women, ensuring emotional support, trust, and the right to shared information and autonomy in labor; promotion of comfort and privacy measures, through investments and organizational changes in childbirth environments, to reduce incidents of non-confidential care; and adoption of strategies to eradicate OV through registration and reporting, contributing to a culture of accountability.

A greater understanding of the concept by policymakers could also have important repercussions, with the promotion of campaigns aimed at raising public awareness about women's rights in childbirth; encouraging health policies that promote safe childbirth care, through the allocation of resources to ensure the training of professionals and consequent supervision in the application of humanized practices; formulating legislation that criminalizes OV and contributes to the visibility of the problem; disseminating information to civil society, institutions, women, and health professionals about the regulations and legal repercussions of violence in the obstetric context; creating means for reporting and punishing the different actors involved (health institutions, managers, and health professionals); definition of systems for monitoring and evaluating the performance of obstetric practices, identifying corrective measures and establishing shared responsibilities between health professionals and hospital service managers; implementation of support and guidance spaces for victims of OV; implementation of preventive actions to reduce cases of OV, as well as its complications, with a view to reducing public health costs.

In the field of health education, greater knowledge about the definition of OV, based on current research, will be crucial for raising awareness among future health professionals, with changes to their curricula, namely with the discussion of the concept of OV, to better prepare them to identify inappropriate behaviors and reflect on their actions; encouraging students to change their paradigm, moving from a view of care focused solely on the technical component to an approach that values the role of women in childbirth; developing debate on gender-based violence and respectful maternal care; training future health professionals to change their attitudes and behaviors towards women, addressing stereotypes and prejudices, developing empathy and active listening skills and emphasizing the importance of shared decisions during childbirth; applying interactive methodologies for simulated training and acquiring skills in ethical decision-making; and encouraging the reporting of unethical behavior and irregularities. Health educators must also commit to their own development, keeping up to date with the best recommendations.

3.12. Synthesized Conceptual Definition of Obstetric Violence

After analyzing the literature, a definition of the concept was proposed, focusing on its applicability to intrapartum obstetric care, with the intention that it could serve as a reference for health professionals. The following conceptual definition of OV was developed: "Any violent and inadequate action in maternal care during labor and delivery, based on gender inequality and influenced by sociocultural, political and structural factors. It is manifested by the abusive physical exposure of women to aggression or unnecessary interventions; offensive and discriminatory comments; denial of assistance and/or procedures performed without consent; coercion, dehumanization and neglect; and lack of empathy and emotional support. It also involves the objectification of the female body and disrespect for women's preferences. These practices compromise women's dignity,

privacy and physical and mental integrity, with serious repercussions on maternal and child health.”

Figure 2 represents the main aspects of the concept of OV in labor, based on Rodgers’ evolutionary method, allowing for a synthesized conceptual definition.

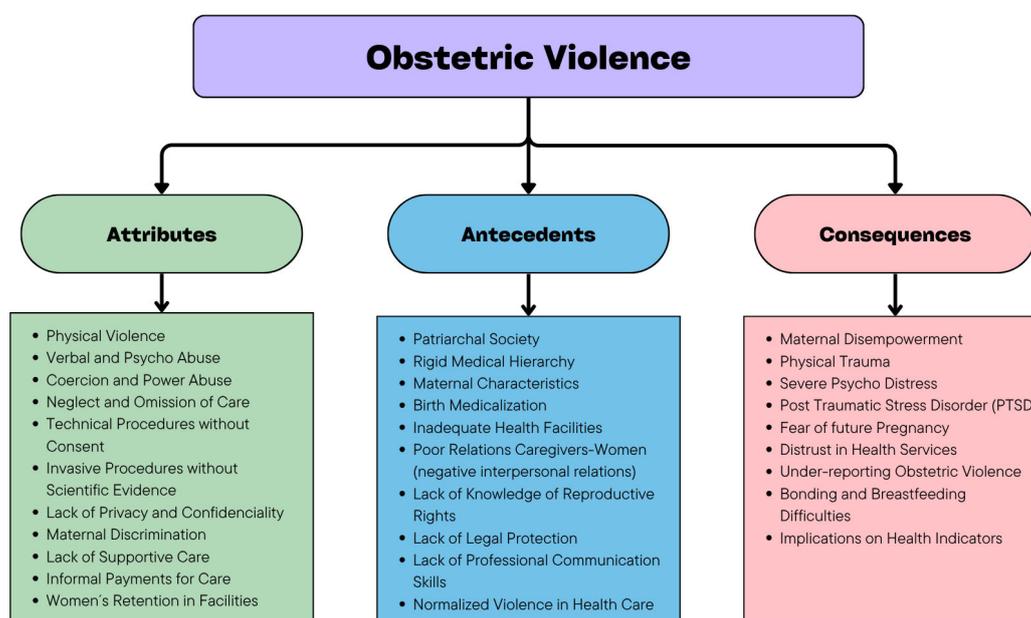


Figure 2. Conceptual model of obstetric violence in labor.

4. Discussion

The literature reviewed revealed recurring patterns of OV in healthcare institutions in different global contexts. The studies conducted in Africa (Ethiopia, Ghana, Mozambique, Nigeria, Tanzania, Tunisia and Kenya), Latin America (Brazil and Peru), North America (USA), Asia (India and Nepal), Europe (Spain, France, Hungary, Poland and Switzerland) and the Middle East (Iran, Jordan, Palestine and Turkey) showed the prevalence of the phenomenon, indicating that it is not restricted to specific regions, but that it is a systemic problem. Most quantitative research has shown that OV affects a wide range of women, with an overall incidence between 65 and 100% [65,67,69,77–79,81,83–86,88,91,93,96,99,100,102,104,107–109,111].

The review of the studies showed that the problem emerges from the context of institutional care in childbirth, with the main antecedents of the concept being maternal characteristics and institutional and cultural barriers.

Area of residence and educational status stood out as predisposing conditions, especially among women living in rural areas [70,77,90,91,100,106] and with a lower level of education [67,68,70,78–90,96,99,100,103,104,106,109], even though the number of cases of OV reported was lower. The justification given was that many of these women in rural areas are unaware of their rights, do not know what to expect from care and have lower expectations of childbirth care [70,72,76–78,81,90,91,96,100,106]. On the other hand, women with a higher level of education seek more access to information and feel more empowered [67,81] and able to report violations of their rights [76,81,83]. A study in northern India, in which the majority of women had a secondary education, also showed disrespect in childbirth regardless of sociodemographic characteristics [71].

Age, marital status, occupation and economic condition were other factors identified in the vulnerability to OV, especially affecting younger women [64,70,75,76,78,79,95,100,103,111], single women [64,68,72,75,83,95,103,111], those without formal employment status [70,86,99,109] and those with unfavorable economic conditions [65,68,74,76,80,84,90,91,95,107,109,110].

Therefore, older age, maternity within marriage and a higher level of education were protective factors against violence in childbirth, since health professionals tend to adopt less disrespectful and abusive behavior towards women who have previous childbirth experience and/or have greater knowledge about dignified care in childbirth. In completely different obstetric settings, the results indicated that Polish women with higher education showed greater concern about consensual care in childbirth, compared to women with less education [78], as did women with differentiated training and childbirth experience in a tertiary hospital in India, requesting information about the progression of labor [92]. Also in an Ethiopian university hospital, high school education was associated with a greater likelihood of maternal reporting of OV [83]. In a study of public and private maternity hospitals in France, experiencing childbirth as a negative event was not associated with the woman's age or socio-professional category [98].

The hierarchy and authoritarian hospital culture, in some environments also characterized as stigmatizing and discriminatory, was another of the main antecedents that operationalized OV at birth, normalizing dehumanized treatment and further aggravating inequality in access to a respectful birth [64,68,69,71,76,78,79,83,87–90,93–95,97,100,101,103,104,107,111].

Research in Kenya indicated that childbirth care embedded in a culture of patriarchy led to maternal inability to distinguish between acceptable standards of care and human rights violations [64]. Other studies have revealed the serious influence of gender construction on social stigmatization and the abusive intersectional approach towards single mothers in labor [68,111]. Alarming, research data from European, African and Middle Eastern countries has also shown that health systems and care models have corrupt policies of informal payments for certain obstetric interventions, thus representing a lack of respect for universal rights in childbirth [69,71,85].

The different levels of assistance in obstetric care were also described as fundamental conceptual backgrounds. In sub-Saharan Africa, South Asia and certain parts of Latin America, there are huge challenges in accessing quality care, leading to skilled birth being a limited event, particularly for women in rural areas. In primary care, uncomplicated women are cared for in health centers by trained nurse midwives. In urban centers, access to tertiary hospitals for high-risk births and specialized neonatal care is restricted and faces a lack of adequate infrastructure, as well as a shortage of doctors and equipment. Regarding these geographical contexts, the results were in agreement on the occurrence of OV both in differentiated hospitals and in health centers, shaped by pre-existing conditions and aggravated by the overload of health systems and their professionals, who in situations of greater demotivation, stress and exhaustion tend to act in an authoritarian and violent manner [63,70–75,81,83–86,88–94,96,100,102,104–108,111].

In North American and European countries, although the adequacy of their health systems is mentioned, it was found that the dominance of the biomedical model marked by one-sided communication and a lack of empathy determined experiences of OV [78,82,95,97,101,103]. Contrary to what the literature says about the conditions of health institutions in developed countries, studies in obstetric clinics in Sweden and maternity services in France have indicated the lack of structural conditions with overcrowded services, insufficient staffing, lack of funding allocated to childbirth care and misuse of resources, as generators of professional violence against women in labor [97,98].

Reflecting on the above, we can say that the definition and understanding of the concept of OV can vary greatly depending on the cultural and social context in which it is analyzed. In some societies, traditional practices, cultural beliefs, and social norms influence how childbirth is perceived and conducted. For example, in developing countries, women often face poor health conditions, lack of access to quality services, and limited resources. In this context, OV may be perceived as a difficult but inevitable part of the

health system, where violent attitudes or procedures are considered standard or there is submission to medical decisions. In developed countries, where access to information and women's rights is more widespread, perceptions tend to be different. Many women are more aware of their rights and can identify OV practices, such as procedures without consent, negligence, or disrespectful treatment. Therefore, interventions that may be considered disrespectful in Western countries may be perceived as part of traditional practices or care in underdeveloped countries, which complicates the application of a universal definition. Bohren et al. [35] reiterate that understanding OV must take into account cultural specificities, resource limitations, differences in the training of health professionals, and possible cultural resistance to changes proposed by Western models of obstetric care.

While in Western structures the concept of OV is supported by women's rights, its application may still be limited by cultural, institutional, and perception issues. In low- and middle-income countries, these limitations are exacerbated. Often, the priority in these regions is to ensure basic access to healthcare, with the focus usually on survival and reducing maternal mortality, which can limit attention to issues of respect and dignity during childbirth. We believe that imposing Western models can reinforce an ethnocentric view, disregarding the local specificities and realities of these populations. Given the undeniable differences in the interpretation and implications of the concept in different cultural circumstances, as well as the limitations of its application, it is essential that approaches to OV are sensitive to sociocultural diversity, seeking a balance between respect for local traditions and the defense of women's rights.

Returning to the results of our conceptual analysis, according to Rodgers' model, the characteristics of the concept included multiple forms of violence.

The most common expressions of verbal and psychological violence occurred through shouting, insults and/or blaming the woman for her own suffering [68,70,73,75,76,78,79,85,88–90,92,94,95,97,100,101,103,105,110]. Physical violence was recurrent, with some studies highlighting the episiotomy procedure without consent, the use of painful techniques without anesthesia and forced restraint during childbirth [72,76,78]. This type of violence was significant in 59% of the studies in the sample ($n = 29$), of which 55% ($n = 27$) affected African, Indian and Middle Eastern women. The data indicated that physical abuse is the more frequent feature of the concept in underdeveloped countries, suggesting that physical force is seen by health professionals as a form of power and intimidation over women, so that they become submissive to care in childbirth. However, it is curious to note that physical violence has also been reported in countries such as Sweden and Switzerland [97,101], which reinforces the need for researchers to pay more attention to these contexts, as parturients have also indicated that they were coerced into accepting unnecessary procedures and were threatened if they did not follow the instructions of health professionals [69,101].

Another of the attributes that was clearly critical and associated with investigations in Latin America, the USA and Europe was the performance of routine and invasive procedures on the mother's body, most of the time without explanation and informed consent [66,67,69,76–78,82,87,95,97,98,103], demonstrating the imposition of the biomedical model in childbirth care and the exclusion of women from the decision-making process. We observed a trend in Latin America towards excessive medicalization in labor and its association with vacuum cupping, which is becoming very visible in the USA and Europe.

Undignified care and negligence stood out in the analysis of conceptual attributes, as they appear transversally, in practically all the studies, although with great evidence in Africa and Asia, where they are practiced against women who are discriminated based on of their characteristics. Once again, the overload of systems and the lack of

training for professionals in respectful maternal care were suggestive of the problem. In Africa, the forced detention of women in health institutions after childbirth, with demands for payment, was also highlighted as a defining characteristic of the concept [64,65,74,79,80,83,84,86,91,96,102,104,106,108,111].

The consequences of OV were extensive, affecting not only the physical well-being, but also the mental and social health of women. Examples in the physical sphere include perineal trauma and avoidable obstetric complications, compromising postpartum recovery [68,94,97–99,103,104]. In psychological terms, it was the basis of clinical symptoms of anxiety, postpartum depression and PTSD, weakening the dyad relationship [75,82,90,94,97,101,103,105,110]. Socially, many women felt that they were part of a “production system” in which their bodies were depersonalized and their choices disregarded, causing them to lose confidence in health services and to not consider medical care for future births [63–65,71,73–75,79,80,82,84–86,88–90,93,94,97,99,101,103,105,107,108,111].

The continuum of exposure to OV has also suggested social implications for its continued naturalization and underreporting, in favor of maternal safety and positive birth outcomes [65,68,69,71–76,78,80,81,83–85,87–93,95,96,99–106,110,111]. Authors have pointed out that the reference to OV was more frequent in late evaluations, when the women were no longer in the institutions under the care of professionals [74,80,88,104], justified by the fear of retaliation.

This study highlighted some essential points: (1) the non-consensual role of sociodemographic and institutional factors in the real prevalence of OV in labor; (2) the influence of social, cultural, economic and structural antecedents on the experience of OV, as well as the attribution of different conceptual characteristics, reinforcing the complexity of an internationally recognized definition; (3) the physical and emotional dimension of the woman affected as a consequence of OV and, interconnected with serious repercussions on social health standards; (4) the fact that OV has become something normalized, justified by gender issues regarding the female role in society and its domination by professionals and institutions, and; (5) the unintentionality of health professionals in the practices that lead to OV, but their role as representatives of this violence, as well as its perpetuation in a structural system closely linked to female social injustice.

The assessment of the concept’s empirical referents, that is, observable phenomena and concrete experiences of OV, varied in the studies analyzed, through questionnaires with integrated scales and/or qualitative assessment of maternal testimonies.

Among the quantitative studies, different measuring instruments were used, from scales to checklists, based on a variety of conceptual frameworks. In 21 studies, questionnaires were used which integrated instruments based on Bowser and Hill’s categories of disrespect and abuse [64,65,70–81,83,84,86,88,91–93,96,102,104,106–109,111]. Only two studies assessed the prevalence and types of mistreatments in institutional childbirth, according to the Bohren et al.’s classification [78,100]. Investigations in Latin America used the legal definition of OV as a framework for the research questions [66,76], while in another study [67], the data collection instrument was based on the WHO Guidelines on Care Practices in Normal Childbirth [118]. Other scales have been used in studies in Europe and East Asia, such as the “Mother’s Autonomy in Decision Making” in assessing women’s experience of autonomy in decision-making during maternity care [69]; the “Questionnaire for Assessing the Childbirth Experience” to measure the domains of maternal emotional state, relationship with the healthcare team, first moments with the newborn and later feelings, one month or more after childbirth [98]; and the “Childbirth Verbal Abuse and Neglect Scale”, to identify situations of verbal abuse and negligent care in hospital childbirth [70].

As shown in a previous review of methodological approaches to mistreatment during childbirth [114], this review also found that examining the frequency of the concept’s at-

tributes is an effective strategy for monitoring the effects of programs to improve respectful maternal care [64,65,71,74,78,81,83,96,102,104,108]. However, methodological limitations have been pointed out, especially in relation to the analysis of the deeper causes of OV or the lack of precision of the results due to the maternal and contextual circumstances mentioned above, such as the fear of reporting possible retaliation, the culture of acceptance of OV and the bias of memory or social response.

The majority of the qualitative studies used in-depth semi-structured interviews [68,82,87,90,94,97,101,103,110], one study used unstructured interviews exclusively [63] and in one online study the answer to an open question was the option [95]. Two publications also presented results that combined the interview technique with focus group discussions [75,105] and two others with focus groups [73,89]. The empirical references for drawing up scripts and preparing focus groups were guided by the WHO evaluation tools applied in multi-country studies [75], the Respectful Maternal Care Charter [89], literature reviews and preliminary research [63,68,73,87,90,94,95,101,103,105,110] and in the knowledge and experience of researchers [63,68,73,82,94,97].

Evaluating qualitative studies has allowed us to gain a deeper understanding of OV, since knowing women's perceptions of the experience of childbirth is a reliable tool for researchers to get closer to this reality, identifying the weaknesses inherent in the care offered by health services [114]. Thematic analysis has also made important contributions to understanding social and cultural vulnerability in the face of exposure to discrimination in maternal care [63,68,75,89,90,95,103,105], as well as health outcomes [82,94]. However, self-reporting is subjective and may not concisely represent the extent of OV, limiting the ability to make broader generalizations about the results. Some studies have pointed out the systematic error of information, due to the participants' memory failures [68,95,103] or social desirability [75,82]. One study also highlighted the possible bias on the part of the researcher, related to the way they analyze and interpret the data [70].

The combination of methodologies was used in two of the studies reviewed [85,99], which initially sought to measure the frequency of OV, in the form of mistreatment [85] or disrespect and abuse [99], through the application of surveys, and subsequently to explore these manifestations qualitatively, through semi-structured interviews and/or focus groups. Although referred to as the most effective methodologies for assessing violence inflicted on women in institutional childbirth [114], combining the incidence of the phenomenon with the self-perception of the experience, not one study considered the impact on maternal health.

It has become clear that the use of assessment tools is fundamental to identifying, monitoring and analyzing the occurrence of OV during labor, and that they vary depending on their focus, method and scope. The study of OV must also encompass different methodologies, implying the need to adapt methodological procedures to the reality of each context. Continued research is essential to develop rigorous assessment tools.

5. Conclusions

The literature review that followed Rodgers' evolutionary method for the analysis of OV during labor reinforced the fact that this concept is complex (involving physical, psychological and social dimensions, and can occur both explicitly and implicitly) and dynamic (being subject to transformations as international debates on reproductive rights and the humanization of childbirth progress). This approach revealed that OV is a multi-causal event, comprising varied antecedents and expressions, as well as multiple interconnected consequences.

The results of this research revealed empirical indicators that allowed for an operational definition of the concept, providing further clarification and allowing us to argue that

OV incorporated into care during labor results from a combination of social and cultural prejudices, unequal power and systemic flaws in institutional structures, which shape the actions of health professionals when interacting with women.

Concepts determine our perception of reality, allowing us to identify unrecognized events and experiences, so clarifying and naming the concept of OV reflects an important function in society and its ability to respond. However, the analysis showed that this complicated issue still lacks a universally accepted definition and is used in different ways in different countries, legislations and cultural contexts.

We therefore believe that this study provides a clearer and more defined framework for understanding the conditions surrounding the concept, making substantial contributions to its operationalization, reducing ambiguities, facilitating scientific debate and supporting future research. By elucidating and specifying the attributes of OV, it allows a more comprehensive view of the concept, both by obstetricians, midwives, nurses, psychologists, sociologists, activists and political agents, making them aware that it continues to represent a threat to women's reproductive well-being.

Methodologies for investigating OV provide a solid basis for carrying out more effective interventions, promoting change in obstetric practices and ensuring that women have their rights respected during childbirth. The use of different tools makes it possible to map the prevalence of OV, identify critical areas and provide evidence to support public policies aimed at a more ethical and humanized form of professional care.

Given the high incidence and far-reaching effects, the relational aspects of intrapartum care should be considered when developing interventions to prevent OV. Improving the quality of intrapartum care and mitigating this harmful reality should be a priority worldwide. However, although several intervention projects have already been implemented in various countries, it has become clear that there is a long way to go.

6. Strengths and Limitations of the Study

As this was a concept analysis focusing exclusively on maternal perceptions, this was a strong point of this study, revealing how women perceive the violent behavior they suffer during healthcare, in a context as specific as labor. However, we could not help but recognize that this research would be more complete if it involved the views of health professionals, family members, social agents and health unit administrators.

This study, which involved a comprehensive review of extensive literature, presented challenges in terms of data extraction and categorization, but provided a broad perspective on the concept. It brought together research from four major continents, which was clearly another strength of the analysis. However, the sample encompassed very heterogeneous studies, identifying realities of labor care, which mostly involved geographical regions with particularities, such as the African continent, which placed restrictions on the generalization of the results.

Another limitation was the search for studies in English, Spanish and Portuguese, and relevant publications in other languages may have been missed. The review also failed to include sources of gray literature, which is why we recommend the development of future studies that incorporate publications from international agencies or non-governmental organizations on their OV analyses. We would also like to highlight the rigor of the review, reinforced by a protocol, exhaustive searches of scientific databases, double screening of titles, abstracts and full-text articles, and the evaluation of studies according to specific criteria to ensure the exclusive inclusion of high-quality articles.

Supplementary Materials: The following supporting information can be downloaded at: <https://www.mdpi.com/article/10.3390/sci7030097/s1>, Table S1: Quality appraisal of the included

studies; Table S2: Characteristics of the studies selected by the scoping review; Table S3: Articles reviewed and main characteristics identified by Rodger's Evolutionary Method.

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Abbreviations

The following abbreviations are used in this manuscript:

JBI	Joanna Briggs Institute
MMAT	Mixed Methods Appraisal Tool
OV	Obstetric Violence
PRISMA-ScR	Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews
PTSD	Post-Traumatic Stress Disorder
WHO	World Health Organization

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