

Nursing Strategies for the Prevention of Obstetric Violence in Normal Childbirth: Integrative Review

Estratégias de Enfermagem na Prevenção da Violência Obstétrica no Parto Normal: Revisão Integrativa
Estrategias de Enfermería para la Prevención de la Violencia Obstétrica en el Parto Normal: Revisión Integrativa

RESUMO

Objetivo: mapear evidências científicas, sobre as estratégias de enfermagem utilizadas para prevenção da violência obstétrica (VO) no parto normal. **Material e Método:** trata-se de uma revisão integrativa da literatura, conduzida entre junho e outubro de 2025, nas bases BDENF, LILACS, PubMed/MEDLINE e SciELO. Foram incluídos estudos primários publicados em português, inglês e espanhol, a partir do ano 2000. **Resultados:** foram incluídos na amostra final 16 estudos. A partir da análise crítica emergiram as seguintes categorias: a) cuidado centrado na mulher e no acompanhante; b) boas práticas clínicas e ambiência do parto; c) governança e qualificação profissional. **Considerações finais:** a análise evidenciou que as ações de enfermagem são fundamentais para uma assistência ética, humanizada e centrada na mulher, embora ainda existam desafios relacionados à equidade, formação profissional e políticas públicas que garantam dignidade e direitos no ciclo gravídico-puerperal. **DESCRIPTORIOS:** Cuidados de enfermagem; Parto normal; Violência obstétrica.

ABSTRACT

Objective: to map scientific evidence on nursing strategies used to prevent obstetric violence (OV) in normal childbirth. **Material and Method:** this is an integrative literature review conducted between June and October 2025 in the BDENF, LILACS, PubMed/MEDLINE, and SciELO databases. Primary studies published in Portuguese, English, and Spanish since 2000 were included. **Results:** Sixteen studies were included in the final sample. The following categories emerged from the critical analysis: a) care centered on the woman and her companion; b) good clinical practices and birth environment; c) governance and professional qualification. **Final considerations:** the analysis showed that nursing actions are fundamental for ethical, humanized, and woman-centered care, although there are still challenges related to equity, professional training, and public policies that guarantee dignity and rights in the pregnancy-puerperal cycle. **DESCRIPTORS:** Nursing care; Normal childbirth; Obstetric violence.

RESUMEN

Objetivo: recopilar evidencia científica sobre las estrategias de enfermería utilizadas para prevenir la violencia obstétrica (VO) en el parto normal. **Material y método:** se trata de una revisión integradora de la literatura, realizada entre junio y octubre de 2025, en las bases BDENF, LILACS, PubMed/MEDLINE y SciELO. Se incluyeron estudios primarios publicados en portugués, inglés y español a partir del año 2000. **Resultados:** se incluyeron 16 estudios en la muestra final. A partir del análisis crítico surgieron las siguientes categorías: a) atención centrada en la mujer y en el acompañante; b) buenas prácticas clínicas y ambiente del parto; c) gobernanza y cualificación profesional. **Consideraciones finales:** el análisis puso de manifiesto que las acciones de enfermería son fundamentales para una asistencia ética, humanizada y centrada en la mujer, aunque siguen existiendo retos relacionados con la equidad, la formación profesional y las políticas públicas que garanticen la dignidad y los derechos en el ciclo gestacional y puerperal. **DESCRIPTORIOS:** Cuidados de enfermería; Parto normal; Violencia obstétrica.

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INTRODUCTION

Obstetric violence (OV) comprises disrespectful, abusive, or negligent practices against women during pregnancy, childbirth, and the postpartum period, constituting a violation of human rights and compromising women's physical and emotional health^(1,2). The World Health Organization (WHO) defines OV as any action



or omission that causes physical or psychological suffering, without informed consent or in disregard of women's autonomy⁽³⁾.

Several terms are used to describe it—such as "institutional violence," "childbirth maltreatment," and "medicalization abuse"—all related to gender inequality and the violation of reproductive rights^(4,5).

Globally, the situation is alarming: a recent meta-analysis estimated the prevalence of VO in about 59% of births, with variations between 48% and 70%⁽¹⁾. In Brazil, the Nascer no Brasil (Birth in Brazil) survey found that 44% of women reported experiences of disrespect, lack of privacy, or physical and psychological violence^(6,7). Other studies indicate that up to 87% of women in labor experienced some type of violence during childbirth⁽⁸⁾. These practices violate principles of dignity, autonomy, and physical integrity, in addition to affecting breastfeeding and adherence to postpartum care⁽⁹⁻¹¹⁾.

Childbirth is a unique event in a woman's life, requiring humanized care centered on her needs⁽¹²⁾. In this context, nursing plays an essential role in promoting comprehensive care, emotional support, and encouragement of female empowerment, valuing safe and humanized practices⁽¹³⁻¹⁶⁾. Health education is identified as a fundamental strategy for the prevention of OB, as it strengthens autonomy, expands access to information, and improves the quality of care⁽¹⁷⁾. This study is justified by the need to systematize knowledge about nursing strategies in the prevention of obstetric violence, contributing to the fulfillment of humanization policies and the Sustainable Development Goals (SDGs 3 and 5), which provide for health, well-being, and gender equality⁽¹⁸⁾.

MATERIAL AND METHOD

Type of study

This is an integrative literature review (ILR) proposed in the literature and recommendations of the *Preferred Reporting Items for Systematic Reviews and Meta-Analyses* (PRISMA)^(19,20).

The study followed six steps: formulation of the research question; establishment of inclusion and exclusion criteria; definition of the information to be extracted from the studies; evaluation of the included studies; interpretation of the results; and synthesis of knowledge⁽²¹⁾.

Eligibility criteria

The formulation of the guiding question considered the acronym PVO, where P (Population): women in normal labor/nursing professionals; V (Variable of interest): prevention of VO and O (Outcome): nursing strategies/interventions.

The review sought to answer the following guiding question: what nursing strategies are described in the

literature for the prevention of VO in normal childbirth?

Sources of information

Searches were conducted in the following databases: Nursing Database (BDENF), Latin American and Caribbean Health Sciences Literature (LILACS), *National Library of Medicine* (PubMed/MEDLINE), and *Scientific Electronic Library Online* (SciELO) by all researchers.

Search strategies

The keywords and terms were chosen using the Health Sciences Descriptors (DeCs) / *Medical Subject Headings* (MeSH): "Nursing care"; "Normal birth"; "Obstetric Violence"; "Nursing care"; "Normal birth" "Obstetric Violence"; "Atención de enfermería"; "Normal birth"; "Obstetric violence". The search strategy combined the Boolean descriptors AND and OR according to each database (Table 1).

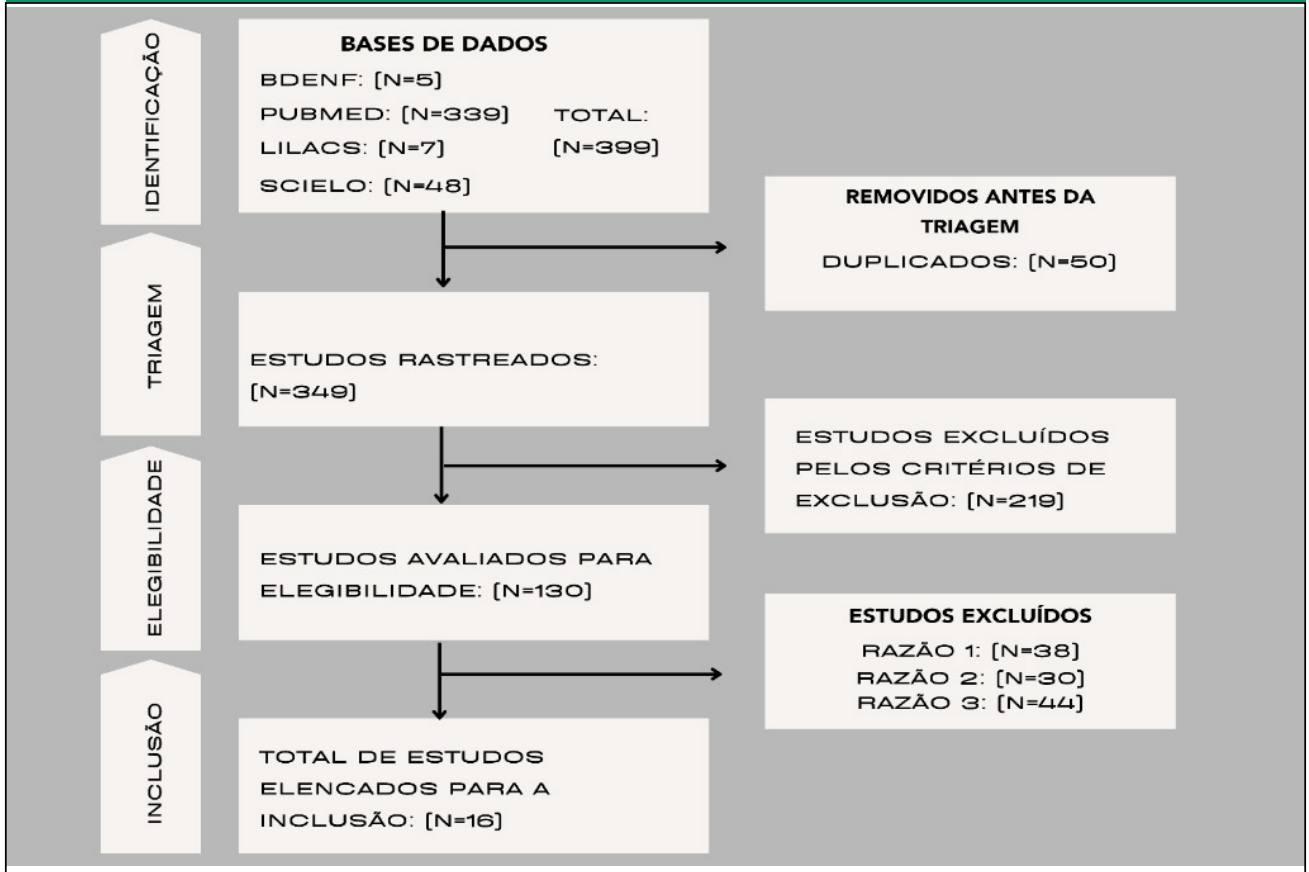
Databases	Search strategy	Articles found
Nursing Database (BDENF)	("Cuidados de enfermagem" OR "Nursing care" OR "Atención de enfermería") AND ("Parto normal" OR "Normal Birth" OR "Parto normal") AND ("Violência obstétrica" OR "Obstetric Violence" OR "Violencia obstétrica")	5
Latin American and Caribbean Health Sciences Literature (LILACS)	("Cuidados de enfermagem" OR "Nursing care" OR "Atención de enfermería") AND ("Parto normal" OR "Normal Birth" OR "Parto normal") AND ("Violência obstétrica" OR "Obstetric Violence" OR "Violencia obstétrica")	7
National Library of Medicine (PubMed / MEDLINE)	"Cuidados de enfermagem" OR "Nursing care" OR "Atención de enfermería" AND "Parto normal" OR "Normal Birth" OR "Parto normal" AND "Violência obstétrica" OR "Obstetric Violence" OR "Violencia obstétrica"	339
Scientific Electronic Library Online (SciELO)	("cuidados de enfermagem" OR "nursing care" OR "atención de enfermería") AND ("parto normal" OR "normal birth" OR "natural childbirth") AND ("violência obstétrica" OR "obstetric violence" OR "violencia obstétrica")	48

Source: prepared by the authors.

The *Preferred Reporting Items for Systematic Reviews and Meta-Analyses flow diagram* (Page et al., 2021)

was used to document the number of articles at each screening stage (Figure 1).

Figure 1 - Documentation of the number of articles at each stage of screening



Source: adapted from Page *et al.* ²²

Study selection and data collection process

Data collection was carried out between June and October 2025. We included original full-text articles available (*free*) in their entirety, primary studies, with an initial milestone associated with the Prenatal and Birth Humanization Program (PHPN) in 2000⁽²²⁾, in Portuguese, English, and Spanish, and related to the proposed study topic. The exclusion criteria used were: articles of the following nature (opinion articles, documentary articles, or articles based on secondary data) that did not address the theme in any way, articles that were not free, and duplicate articles.

The articles were evaluated according to their title and abstract, blinded

by two (02) independent researchers, who checked for the presence of the established inclusion criteria, and subsequently used *Rayyan Software*⁽²³⁾.

The data extraction procedure followed the recommendations in chapter 7 of the *Joanna Briggs Institute (JBI) Centre of Excellence reviewers' manual*⁽²⁴⁾ and the information was tabulated in a spreadsheet prepared by the authors in *Microsoft Office Excel*[®]. In this way, the research findings were refined and presented descriptively and in tables.

Critical analysis of studies and synthesis

The included articles were coded for the purpose of synthesizing the results and were identified by the letter 'A' followed by a cardinal number

(e.g., A1, A8, A16). They were then evaluated according to evidence-based practice (EBP) and levels of scientific evidence.

RESULTS

A total of 399 articles were identified. After reading the titles, 130 articles were selected for abstract reading, and after reading the abstracts, 45 articles were selected for full-text reading.

Sixteen articles were selected that met the inclusion criteria for the study objective. The publications included in this review are distributed across the BDEFN (3), LILACS (2), *SciELO* (5), and *NIH – Medline / Pubmed* (6) databases.

In Table 2, the articles were arranged by analysis code, author, year, and journal of publication.

Table 2 - Distribution of articles on nursing strategies for the prevention of obstetric violence in normal childbirth according to coding and journal

Code	Journal
A1 ⁽²⁵⁾	Revista Enfermagem Atual In Derme
A2 ⁽²⁶⁾	Physis: Revista de Saúde Coletiva
A3 ⁽²⁷⁾	Enfermagem em Foco
A4 ⁽²⁸⁾	Nursing
A5 ⁽³⁾	Revista Cuidarte
A6 ⁽²⁹⁾	Escola Anna Nery
A7 ⁽³⁰⁾	Escola Anna Nery
A8 ⁽³¹⁾	Acta Paulista Enfermagem
A9 ⁽³²⁾	Texto & Contexto Enfermagem
A10 ⁽³³⁾	Nursing
A11 ⁽³⁴⁾	Interface (Botucatu)
A12 ⁽³⁵⁾	Enfermería Actual
A13 ⁽³⁶⁾	HU Revista
A14 ⁽³⁷⁾	Revista Ciência & Saúde Coletiva
A15 ⁽³⁸⁾	Enfermería Global
A16 ⁽³⁹⁾	Escola Anna Nery

Source: prepared by the authors.

The highest number of publications was in 2020 (n=4/25%). Studies conducted in Brazil predominated, followed by one (n=1/6.25%) study con-

ducted in partnership between Brazil and Canada. The predominant language was Portuguese, followed by English. The largest number of publications included were Pubmed (n=339/37.7%),

followed by Scielo (n=48/31.25%).

The articles were then arranged according to coding and classified accord-

Quadro 3 - Distribuição de artigos sobre estratégias de enfermagem na prevenção da violência obstétrica no parto normal, segundo codificação, amostra, tipo de estudo, nível de evidências e principais achados

No.	Population and sample	Type of study	Level of evidence	Main findings
A1 ⁽²⁵⁾	Obstetric Nursing Residents (n = 23)	Qualitative exploratory descriptive stud	Level IV	Strategies: health education for women and families, with information on VO, the stages of TP, MNFs for pain relief, and practices not recommended; constant updating and continuing education in health, with debates, discussion groups, and case studies to broaden the residents' perspective and promote change in practices; and humanization of care and respect for women's autonomy.
A2 ⁽²⁶⁾	The population of Piauí, especially women (n = 14,000)	Descriptive study of the experience report type.	Level V	Strategies: mobilization of civil society in the construction of desirable dynamics and realities; dissemination of the theme to the public; promotion of actions to raise awareness and inform the population about this type of delivery and its benefits; ensuring good obstetric practices and ensuring the presence of the woman's companion of choice at the time of delivery, non-invasive technologies, and NMPs for pain relief.
A3 ⁽²⁷⁾	Women who had a normal delivery (n = 101)	Qualitative study, exploratory and descriptive	Level IV	Strategies: discussions and reflections in services that provide care to women during pregnancy and the postpartum period, as well as for the professionals who work in these services.
A4 ⁽²⁸⁾	Nurses (n = 10)	Exploratory and descriptive research with a qualitative approach	Level IV	Strategies: professional training and constant communication about humane, ethical, and legal care; replacing mechanical and hostile techniques with a model more centered on women as individuals; transforming hospitals and maternity wards into truly welcoming places; creating a solid bond between health professionals and women in labor; health education and continuing education for good care practices.

A5 ⁽³¹⁾	Postpartum women (n = 10)	Cross-sectional study, qualitative approach	Level IV	Strategies: effective communication by the team, especially by professionals who work directly with these women; health professionals should advise women about their rights, including the right to have a companion of their choice throughout the delivery process; preserve the image of the parturient, ask for her permission, and consider her needs and complaints without minimizing or underestimating them.
A6 ⁽²⁹⁾	General public (n = 414)	Multicenter survey via the Opinio platform.	Level IV	Strategies: inform women, families, society, and professionals about rights to obstetric care; offer humanized care; change the culture of silence, encouraging reporting, oversight, and correction of professional practice.
A7 ⁽³⁰⁾	Nurses and nursing undergraduates students (n = 18)	Methodological reflection on qualitative research	Level V	Strategies: make VO an appealing topic for academia and political supporters, policymakers, managers, and professionals; transform VO into a topic of complaints and reports to bring it into the academic world, allowing individuals to occupy all social spaces; challenge society to mobilize and share leadership roles in this humanization movement with women.
A8 ⁽³¹⁾	Obstetric Nurses (n = 20)	Descriptive study with a qualitative approach.	Level IV	Strategies: monitoring of the obstetric nurse in labor and delivery with effectiveness and humanization and promoting acceptance; providing consistent information to promote the reduction of instrumental deliveries, since this culture is deeply rooted in society; reflecting on the importance of combating VO in the training of obstetric nurses.
A9 ⁽³²⁾	Health managers (n = 16)	Descriptive, exploratory study with a qualitative approach.	Level IV	Strategies: Ensure a welcoming environment and qualified listening for pregnant women; Comply with the Companion Law (Law No. 11,108/2005); Humanize care, including in cases of abortion; Promote training and capacity building for health professionals; Implement the guidelines of the Stork Network; Encourage interdisciplinary action and strengthen management focused on quality and humanization of care.
A10 ⁽³³⁾	Health professionals (-)	Systematic review bibliographic study	Level I	Strategies: Overcome the fear and isolation of pregnant women; promote health education; encourage the exchange of information and feelings between nurses and parturients; act with empathy in care; train and sensitize professionals to humanization; ensure welcoming as a care practice; respect women's physiology and favor the interests of parturients in care.
A11 ⁽³⁴⁾	Obstetric Nursing Residents (n = 15)	Descriptive and exploratory study with a qualitative approach	Level IV	Strategies: Offer support and protection to women with the minimum necessary interventions; ensure dignified, quality, and respectful care; provide clear and understandable information about procedures, risks, and alternatives; promote health education; support social movements in the fight against abuse and unnecessary interventions; hold public hearings and take action with the Public Prosecutor's Office to curb abuse and seek to change the model of childbirth care, making it more humane.
A12 ⁽³⁵⁾	Postpartum women (n = 20)	Qualitative descriptive study	Level IV	Strategies: Invest in the updating and training of health professionals; ensure humane care, with respect, dignity, and quality; offer health education in the PN addressing the topic of VO; promote individual and group educational activities for pregnant women; strengthen nursing care practices based on humanization and comprehensive care; encourage women's protagonism during childbirth; stimulate research and reflection on the topic among health professionals and students.
A13 ⁽³⁶⁾	Obstetric Nurses (n = 16)	Descriptive, exploratory, and qualitative study	Level IV	Strategies: Recognize the role of obstetric nurses in humanizing care; adopt a woman-centered model of labor and delivery; encourage the training and capacity building of other professionals; incorporate practices based on scientific evidence; meet the demands and expectations of pregnant women with respect and empathy; understand the subjective dimensions of each woman; promote discussions and research on the impact and prevention of VO.
A14 ⁽³⁷⁾	Women (n = 555)	Multicenter, multimethod cross-sectional study with quantitative and qualitative components,	Level III	Strategies: Disseminate information about childbirth and VBAC; promote women's empowerment; encourage social mobilization; disseminate evidence-based best practices; reduce unnecessary interventions and cesarean sections; improve women's childbirth experience.
A15 ⁽³⁸⁾	Postpartum women (n = 35)	Descriptive study with a qualitative approach	Level IV	Strategies: Ensure dignified and respectful care; recognize and combat domestic violence; hold perpetrators accountable; strengthen women's rights; promote a humanized childbirth model.
A16 ⁽³⁹⁾	Pregnant women and women who have recently given birth (n = 56)	Descriptive and exploratory study	Nível IV	Estratégias: Garantir acesso igualitário e seguro aos serviços de saúde; assegurar internação e atendimento humanizado; investir e pactuar ações entre os níveis da rede de cuidados; promover a corresponsabilização pelo cuidado à gestante; oferecer transporte seguro quando não houver vaga; respeitar os direitos das mulheres; realizar avaliação contínua da assistência obstétrica; implementar e fortalecer políticas de humanização no parto e nascimento.

Legend: NFM – non-pharmacological methods; MP – Public Prosecutor's Office; PN – prenatal care; TP – labor; VO – obstetric violence.

Source: prepared by the authors.

Regarding the level of evidence of the studies, level IV predominated (n=12/75%), followed by level V (n=2/12.5%), level III (n=1/6.25%), and level I (n=1/6.25%).

The quality of the studies was assessed according to the hierarchy of levels of evidence. This classification comprises seven levels: level 1 – systematic reviews or meta-analyses of randomized clinical trials (RCTs) or guidelines based on these reviews; level 2 – at least one well-designed RCT; level 3 – well-conducted but non-randomized clinical trials; level 4 – good quality cohort or case-control studies; level 5 – systematic reviews of descriptive or qualitative studies; level 6 – a single descriptive or qualitative study; level 7 – expert opinion and/or committee reports⁽²¹⁾.

DISCUSSION

The narrative analysis gave rise to three thematic categories, namely: Category A - Care centered on the woman and her companion; category B - Good clinical practices and birth environment; and category C - Governance and professional qualification.

Category A: Care centered on the woman and her companion

Studies A2, A4, A8, A9, A13, and A15 highlight care centered on women and their companions as an essential strategy for preventing obstetric violence (OV), supported by national and international guidelines for the humanization of childbirth^(18,26,28,36,38,40). This category articulates three axes: health education and birth plan (BP), therapeutic communication and informed consent, and the presence of a companion and continuous support. Health education and the BP, according to A1, A6, and A10, favor female empowerment, promoting autonomy and reducing power asymmetries between professionals and parturients

^(25,29,33). Recognized by the WHO, the BP strengthens women's protagonism, allowing them to express preferences and reduce unnecessary procedures^(25,26,27,34).

Therapeutic communication, highlighted in A10 and A4, is a central element in building bonds, trust, and shared decision-making. Informed consent emerges as an ethical and relational act, guaranteeing women the right to decide about their bodies and protecting them against forms of VO, such as non-consensual invasive procedures^(32,36-38). The literature (A6, A7, A8) associates effective communication with reduced anxiety and active participation by the pregnant woman during labor^(28,29,30).

The presence of a companion of one's choice, guaranteed by Law No. 11,108/2005, is recognized in A9 and A14 as a protective strategy⁽³²⁾. In addition to providing emotional support, the companion acts as an advocate for the rights of the woman in labor. The continuous support of obstetric nurses, doulas, and companions reduces unnecessary cesarean sections and increases maternal satisfaction^(29,30). The integration of information, ethical communication, and continuous support transforms women into active participants in childbirth^(25,29,34,35). These findings reinforce the importance of institutional protocols and the incorporation of these practices as a standard of nursing care aimed at preventing OB and promoting safe and humanized care^(25,26).

Category B: good clinical practices and birth environment

The adoption of good clinical practices associated with a humanized environment is recognized in studies A1, A8, A10, A11, and A13 as one of the main nursing strategies for preventing obstetric violence (OV)^(25,31,33). These practices, supported by evidence and WHO recommendations, value the

physiology of childbirth and the role of women^(18,26,33). Among the interventions, non-pharmacological methods (NPMs) for pain relief stand out—such as warm baths, walking, ball exercises, breathing, and massage—which reduce stress and increase the control of the parturient^(26,29,33). Freedom of position during labor, as noted in A6 and A8, is equally essential for reducing unnecessary interventions and promoting safer and more comfortable deliveries.

Respect for physical, psychological, and cultural privacy is another essential marker of quality. Appropriate environments, such as PPP rooms, and measures such as welcoming, active listening, and clear communication strengthen the bond between the team and the pregnant woman, reducing the perception of abandonment or disrespect. Immediate skin-to-skin contact between mother and newborn (NB) is identified as a high-impact practice, promoting emotional bonding, physiological stability, and stimulation of breastfeeding, and is considered a concrete indicator of humanized care^(29,34,38).

These practices reinforce the transition from the biomedical-interventionist model to a woman-centered model, requiring professional training and organizational changes that ensure adequate infrastructure and evidence-based protocols. The reviewed literature demonstrates positive effects in reducing unnecessary interventions and increasing maternal satisfaction, although inequalities in access persist—especially among black and peripheral women, highlighting the need for policies and research focused on social justice and equity in health.

Category C: governance and professional qualification

The Governance and Professional Qualification category brings together structural and educational strategies

focused on the quality and safety of obstetric care, preventing practices classified as obstetric violence (OV)⁽³²⁾. A6, A10, and A13 highlight the importance of implementing evidence-based clinical protocols, audits, reporting systems, and continuing education for teams^(28,33,36). Care protocols aligned with WHO recommendations and humanization policies act as instruments of institutional governance, guiding conduct centered on women and reproductive rights^(27,35,36,38).

Periodic audits are essential tools for monitoring and feedback, allowing for the evaluation of indicators such as episiotomy rates, the presence of companions, and consent records. Institutions that adopt regular audits demonstrate greater adherence to good practices and a reduction in adverse events^(29,2929). At the same time, secure reporting systems enable women to report situations of disrespect without fear of retaliation, strengthening institutional accountability and

a culture of transparency^(29,32). These practices promote ethical environments and reinforce trust between users and health professionals.

Continuing education in health appears to be a transformative axis of institutional culture^(25,27,32,33,35). Continuing education programs on human rights, therapeutic communication, anti-racism, and culturally safe care contribute to the training of professionals who are aware of and able to prevent OBV^(22,30,32,33,35). Governance and qualification strategies show that the prevention of obstetric violence requires not only the individual action of nurses, but also a solid organizational structure, with clear protocols, monitoring, and continuous professional development. There is still a lack of studies evaluating the sustainability and cost-effectiveness of these interventions, reinforcing the need for multicenter research and implementation adapted to different sociocultural realities.

FINAL CONSIDERATIONS

The studies highlighted important contributions by nursing to improving care, with a focus on health promotion, women's autonomy, and professional qualification. The analysis was structured into three categories: care centered on women and their companions, good clinical practices and the birth environment, and governance and professional qualification, which reinforce the role of nursing in building ethical and transformative care.

The integration of these dimensions demonstrates that the prevention of obstetric violence requires humanized practices, based on evidence and supported by continuous training and institutional governance. Despite advances, challenges related to the equity and sustainability of actions persist, highlighting the need to strengthen public policies and training strategies that ensure respectful births centered on women's dignity.

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