Obstetric Violence against Women in the Portuguese Context: A Qualitative In-Depth Approach

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Abstract

Evidence suggests that women worldwide experience mistreatment during institutional childbirth. This qualitative study aimed to explore obstetric violence in Portugal, specifically, its related factors and perceived impact. The inductive thematic analysis of 19 semi-structured interviews with women living in Portugal (22-41 years old), who identified themselves as victims, revealed six central themes: (1) obstetric violence, (2) the impact of obstetric violence, (3) victims' awareness, (4) coping strategies, and (5) explanatory factors. This study adds relevant evidence on what (experiences), why (explanatory factors), and how (processes and coping strategies) obstetric violence might occur, as well as its psychological, interpersonal, and physical impacts.

Keywords: *Obstetric Violence; Coping; Impact; Qualitative Study*

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Introduction

Worldwide, women are threatened when they experience disrespectful, abusive, or negligent treatment during childbirth, including psychological or physical abuse, discrimination, abandonment, and privacy violations (Bohren et al., 2019; Castro & Rates, 2021; Miltenburg et al., 2018; Silveira et al., 2019). Thus, it is important to explore women's perceptions related to pregnancy and childbirth, as they might inform health care policies and clinical practices. The current study aimed to explore women's voices regarding their experiences of obstetric violence. Obstetric violence involves dehumanized care provision, which can involve health professionals' negative conduct affecting the woman's body and reproductive system (e.g., Annborn & Finbogadóttir, 2022; Trajano & Barreto, 2021). Similar to other forms of violence, obstetric violence has a range of severity levels, including subtle forms (e.g., the prohibition of a birth partner, restriction of the woman's mobility) and more severe practices (e.g., abdominal pressure [Kristeler Manoeuvre] and threats) (Bohren et al., 2019; Pontes et al., 2021).

Obstetric violence is a worldwide public health concern due of its non-negligible prevalence across countries, affecting women of all backgrounds, ages, cultures, and socioeconomic status (Abuya et al., 2015; Carer et al., 2021; Kruk et al., 2014; Limmer et al., 2023; Martínez -Galiano et al. 2020). Global structural factors perpetuating social and gender inequalities, as well as patriarchal structures that reinforce gender stereotypes may facilitate obstetric violence (Bohren et al., 2019; Sadler et al., 2016). Specifically, these social structures and inequalities might allow practices involving the objectification of the women's body, the restriction of their autonomy, and the minimization of their suffering (e.g., "the woman must be a good mother", "must prioritize the baby's well-being over her own" and, "must collaborate during labor") (Bohren et al., 2019; Smith-Oka, Rubin & Dixon, 2021). Furthermore, there are specific

cultural and social factors that might influence the experience of obstetric violence, such as social norms regarding motherhood and labor/birth (e.g., physiological or medicalized birth), and health policies of obstetric health (Bohren et al., 2019; Savage & Castro, 2017). For these reasons, countries with underfunded healthcare systems, limited financial and human resources, and few support systems for the most vulnerable population may be more prone to obstetric violence (Savage & Castro, 2017; Smith-Oka et al., 2021). In fact, there is significant evidence focused on obstetric violence in women from low-income countries such as Nigeria, Ghana, Guinea, and Myanmar (Bohren et al., 2019). These studies highlighted a significant number of women who reported experiences of physical and verbal abuse, stigma, discrimination, non-consensual interventions, and inequalities in treatment during labor, suggesting a greater risk among younger women with less education (Bohren et al., 2019).

Nevertheless, there is a recent concern related to obstetric violence in middle- and high-income countries, where even though there are more resources in the healthcare system, the prevalence of obstetric violence seems to be non-negligible. In addition to the structural factors previously highlighted, the excessive medicalization of childbirth and rigid high hierarchy in the relationships between health professionals and women might contribute to experiences of obstetric violence (Mena-Tudela et al., 2020b; WHO, 2018). Studies suggest that there is a set of unnecessary medical interventions (such as scheduled cesarean or early inductions or episiotomies), that might undermine women's autonomy in the decision-making processes, with a negative impact on childbirth (Costa et al., 2022; Mena-Tudela et al., 2020b; WHO, 2018). Conversely to the evidence gathered from the low-income countries, some studies developed in middle and high-income countries suggest that women's higher levels of education and their attendance in antenatal classes might increase their awareness about

their rights and ability to identify abusive health care practices (Gonzalez-De la Torre et al., 2023; Martínez-Galiano et al., 2021; Mena-Tudela et al., 2020a).

Therefore, this study focuses on women's perspectives and experiences on obstetric violence in Portugal. Evidence from our country suggests that women report experiencing excessive unnecessary or not-consented medical interventions, lack of information, feelings of objectification, verbal abuse, threats, blaming, and exclusion of birth partners during childbirth (Barata, 2022a; Barata, 2022b). A large-scale study developed during the COVID-19 pandemic among 1845 women, using a self-report questionnaire based on standards of care defined by the World Health Organization (2016), suggested that approximately 23% of women reported emotional, physical, and verbal abuse during childbirth, as well as non-evidence-based practices and unequal access to outstanding maternal health care services across different regions (Costa et al., 2022). However, national research exploring women's perspectives about the impact of obstetric violence on their psychological functioning, as well as the factors that can mitigate or intensify the potential negative impact of this experience remains limited.

Some international evidence suggests that disrespectful and abusive practices are associated with a greater likelihood of developing psychological stress (McGarry et al., 2017) or depression (Silveira et al., 2019) in the postpartum period. Moreover, other negative impacts, such as physical injuries to the baby and mother, feelings of mistrust and resentment, weakening of family ties, and impact on the mother-baby relationship have been reported (Elmir et al., 2010; Garcia, 2020; Martinez-Galiano et al., 2020; Silveira et al., 2019; Taghizaden et al., 2021). Long-term impact includes negative memories of childbirth, nightmares, panic, and fear of childbirth (Annborn & Finnogadóttir, 2022; Dias & Pacheco, 2020; Taghizaden et al., 2021; Vedam et al., 2019).

In sum, the literature suggests that, on one hand, there are some factors affecting obstetric violence across the world (e.g. gender inequalities) and, on the other hand, there are other specific cultural and social factors that might explain this type of violence (e.g. conditions and policies in the healthcare systems). As such, more cross-cultural research is required to gain a more in-depth understanding of the social specificities that may influence women's expectations, perceptions, and experiences of pregnancy and childbirth (Dias & Pacheco, 2020; Mena-Tudela et al., 2020a; Savage & Castro, 2017; Silveira et al., 2019; Taghizadeh et al., 2021). Therefore, this study aimed to explore women's perceptions related to pregnancy and childbirth in the Portuguese context. Specifically, we aimed to explore (1) women's perceptions of mistreatment experiences during their pregnancy and childbirth (what type of mistreatment experiences they faced, and why do they occur?) (2) the processes and dynamics of abusive experiences in the obstetric context (how do women cope with these experiences?) (3) perceived impact of these experiences on women's psychosocial functioning.

Method

Participants

This study was conducted with 19 women living in Portugal (22-41 years old; *M* = 33.2; *SD* = 1.1), who identified themselves as victims of obstetric violence. The inclusion criteria considered were: (1) age equal to or greater than 18 years; (2) women residing in Portugal who gave birth in hospitals; (3) birth occurred before the COVID-19 pandemic (March 2020 to March 2022). The period of the COVID-19 pandemic was defined as an exclusion criterion because this time interval presents specificities likely to bias the results of the study (e.g., during the period of the COVID-19 pandemic, health care provision and standards underwent significant changes).

Insert Table 1 about here

Instruments

Sociodemographic Questionnaire

Sociodemographic data (e.g., age, nationality, marital status, and number of children), as well as obstetric and delivery information (e.g., gestational age of the baby at the time of delivery, type of delivery, and delivery plan) were collected through a self-report questionnaire.

Semi-Structured Interview Guide

All authors of this project are Psychologists. Their expertise informed the development of the questions, as well as considered the gaps in the previous literature (i.e., the need to explore the women's perspectives on the impact of obstetric violence on their psychological functioning, as well as the factors that can mitigate or intensify the potential negative impact of this experience). The semi-structured guide included open-ended questions to explore women's perceptions about the following dimensions: (1) their experience of pregnancy and childbirth regarding prenatal care, humanization of care, procedures, and postpartum (e.g., "*How would you describe prenatal care considering both positive and negative aspects*?"); (2) the fulfillment of their rights, specifically with regards to choices and options, autonomy and self-determination in decision-making, privacy and confidentiality (e.g. "*In what way do you consider that you had an active participation in decision-making on the procedures implemented by health professionals*?") (3) Identification of abusive obstetric clinical practices (e.g., "*Thinking about your experience, do you identify any practice that you consider abusive, that is, that undermined your rights within the scope of hospital obstetric care*?"); (4) the perception of the impact of childbirth experience (e.g., "*How did your experience in the context of childbirth impact your life in the short and long term*?").

Data Collection and Analytical Procedure

This research project was approved by the Ethics Committee of the Lusófona University (Ref. 43/2021). The sampling process was intentional, benefiting from the support of the following partners to disseminate the study and recruit our participants: one association that support women's rights in pregnancy and childbirth, one organization advocating for victims of obstetric violence, and an activist lawyer who is widely recognized for advocating for birth rights in Portugal. These partners disseminated the study in their mailing lists and social media (e.g., Instagram, Facebook), and women who met the inclusion criteria and agreed to be contacted by the research team were then contacted by the first author. The research objectives and participation conditions (e.g. procedures, audio-recorded interviews, voluntary participation, confidentiality, and anonymity) were provided to the participants, and informed consent was obtained. Face-to-face interviews were conducted in Portuguese, by the first author, between January and May 2022. These interviews lasted an average of 60 minutes and were audio recorded. The participants' privacy and confidentiality were ensured. All participants were debriefed after the interviews and signposted to relevant services or support if required (i.e., team members' contacts and referral to specialized support if needed). The sample size was determined using theoretical saturation criteria, which means that more interviews would not provide new data.

The interviews were transcribed verbatim in Portuguese by the first author and subsequent data processing and respective analyses were performed using the QRS Nvivo10 software. Audio files and transcribed interviews were anonymized and stored electronically with restricted access and password protected. Data were analyzed by the first author using thematic analysis according to the steps defined by Braun and Clarke (2006): (1) familiarization with the data through the transcription of the interviews and

their initial exploration; (2) creation of initial codes through the identification of significant patterns in the data; (3) searching for themes and subsequent coding into categories; and (4) review of themes to ensure internal consistency and external heterogeneity. Finally, the themes and subthemes were defined and hierarchized. An inductive and inclusive approach to the data was adopted. To ensure data analysis validity and reliability, the categorization and coding process was systematically discussed among the research team. Feedback from some participants on the results was obtained to check for data accuracy and validity. Trustworthiness was also ensured by providing examples of participants' expressions to illustrate the themes identified. Only in this stage of the research process, the original Portuguese narratives shared by the participants were translated by the first author to English and revised by the other authors.

Results

Characteristics of Participants

Most of the women who agreed to participate in this study were Portuguese (*n*=16; 84.2%). All women reported living with their children and their parents; most were married at the time of the interview (*n*=12; 63.2%) and had two children (*n*=10; 52.6%). Concerning academic qualifications, most participants had completed a bachelor's degree (*n*=12, 63.2%) and were employed (*n*=14, 73.7%). Regarding monthly family income, our participants earned between 800€ and 4500€, and most of them earned between 1500€ and 2500€ (*n*=14; 40%).

Among the obstetric and delivery characteristics, the maternal age at the time of delivery ranged from 17 years and 36 years (*M*=28.47; *SD*=1.63). Regarding the gestational age at delivery, most occurred at 39 weeks of gestation (42.1%). Most of the reported deliveries were vaginal (78.9%), involving analgesia before or at the time of

delivery (89.5%), and having a birth partner during the labor (78.9%). Most participants mentioned having attended antenatal classes (84.2%), but did not have a birth plan (73.7%) in place. Finally, 13 participants reported that, in the immediate postpartum period, they had skin-to-skin contact with the baby (68.4%) (see Table 1).

Women's Experiences and Meanings

Five main themes emerged in this study: (1) *Obstetric Violence*, which involves a range of abusive or negligent practices of health care professionals; (2) the *Impact of Obstetric Violence*, which involves psychological, physical, and interpersonal effects from the experience; (3) *Victims' awareness*, which pertains to the reactions of victims towards mistreatment, encompassing the point at which women came to realize the violent nature of their experience; (4) *Coping Strategies*, which refers to the strategies identified by women to deal with the experience; and (5) *Explanatory Factors of Obstetric Violence*, which includes structural factors that are perceived as causing or heightening mistreatment.

Insert Table 2 about here

Obstetric Violence

All the women identified at least one experience of obstetric violence in the context of pregnancy and childbirth. Specifically, these experiences included poor rapport between women and health care providers, the perceived failure to meet professional standards of care, physical abuse, verbal abuse, secondary victimization, birth partners mistreatment, and prejudice. *Poor rapport between women and health care providers* refers to ineffective communication, with partial explanations or incomplete information provided by health professionals, as well as a lack of support and dehumanized care or a loss of autonomy during labor, involving the objectification

of their bodies, such as the systematic and intrusive touches by several professionals without consent or explanation:

> And without saying anything, she introduced the 'microlax' [laxative] into my anus, without any explanation, I even jumped. She then said, *Go to the bathroom.* (P10, 41 years old)

> I no longer even know how many (health care providers) have touched me. What's more, if you ask me if they were doctors, if they were nurses or assistants, and if it was the man from the kitchen, I do not know. They come in, and they do not identify themselves... They do not speak with people and come in and touch. And then they do not say anything, and they turn their backs. (P4, 36 years old)

Furthermore, obstetric violence was described by the participants as the *failure to meet professional standards of health care*. Several women reported lack of informed consent and negative professionals' attitudes during physical examinations as deviations from professional standards:

> And it was always speedy: *come on, it must be signed because if not, there is no hospitalization*. Okay, I signed it. (P1, 29 years old)

> It was in our plan that we didn't want that to happen. She went into [the bedroom], placed her fingers in, and performed a membrane sweep. The pain was excruciating. She did not even ask (me) anything. (P19, 30 years old)

The participants vividly described their feelings of abandonment, which means that these women felt left behind or dismissed about their concerns and feelings:

> The whole time I was dilating and then in labor I was absolutely alone. I was so alone that I felt abandoned. They forgot that I was there. (P7, 37 years old)

Medical negligence was strongly noted as the failure of professionals to meet the required standards of care, even in the presence of physical symptoms:

> It was only when the shift changed that I told a new nurse who came to introduce herself: *I'm not feeling well. I have already told your colleagues. I'm not feeling well and there's something that's not right*. Only then did she check the temperature, and I had a fever. (P9, 35 years old)

Physical and verbal abuse was also mentioned by our participants. Regarding *physical abuse*, women pointed out the use of physical force and the perception of body violation as the most prominent practices:

> And that's what I felt that I was there with two enemies in front of me. It does not matter what I screamed or how much I screamed, that did absolutely nothing. What I felt in the moment and then over the days, I felt even more was that I was raped. I was saying: no, no, no, and people kept doing things to my body (P13, 26 years old).

According to our participants, *verbal abuse* included threats by professionals, allegations, and offensive language. Some participants expressed concerns not solely about the offensive and unkind manner professionals interact, but also regarding the professionals' perceptions of them:

> I was asking: 'but is everything alright?' -*Yeah, stay quiet for now*. Like, you are there because you have a baby, you are nobody. (P18, 34 years old)

Secondary victimization was identified by the participants, including minimizing the negative impact of obstetric violence by the informal support network (family and friends), along with the blaming of the victim within the judicial process:

> Later, during the court proceedings, we presented our side of the story, and the doctor claimed she used a suction cup because I did not cooperate. Did not

> cooperate!? I was physically unable to, and I should not be blamed for that. (P4, 36 years old)

Another dimension mentioned by some participants was *birth partners mistreatment,* which involves verbal abuse (e.g., harsh and rude language, judgmental comments, threats) and exclusion from the labor and birth process (e.g., refusal to provide information and/or explanations):

> My husband was pushed out, was pushed away by two people. I do not know if they were nurses or assistants, and he was pushed out without any explanation to the door outside the delivery ward. Even today, he says, I was thinking that you were going to die. I did not understand why suddenly someone came in and expelled me from there. (P4, 36 years old)

Finally, although less frequent, experiences of *prejudice* were reported by some participants, namely a set of negative beliefs about these women, including those related to the participants' nationality:

> Between these moments of pain, one of the nurses said: *But are not you Brazilian? Do your people say that they are happy? Where is your joy now?* And that was the point that made me upheaval there. (P1, 29 years old)

Impact of Obstetric Violence

The perceived impact of obstetric experience by our participants involved psychological, interpersonal, and physical impacts. The *psychological impact* during and after the violence experience includes immediate reactions, such as crying, despair and tremors. Some participants reported panic, and the negative feelings related to childbirth:

306 Always in that mouth chatter of *it's your fault if something happens, you're not*
307 *cooperating; you don't help*. Okay, and of course panic set in there, did not it?
308 (P17, 33 years)

309 Others emphasized a sense of relief with the birth of the child, which means that
310 instead of experiences of happiness or being delighted by the child, these women felt
311 that their difficult childbirth experience is no longer happening:

312 When people said they felt happiness and joy when they held their babies in
313 their arms…I did not feel any of that. I felt relieved that he had already been
314 out. (P2, 25 years old)

315 Participants highlighted their feelings of fear and thought that they might be in a
316 particularly vulnerable situation if they shared their feelings and needs:

317 So, I really kept quiet. I chose to be a little quieter because I was really afraid of
318 what could happen if I started complaining a lot more. (P1, 29 years old)

319 This feeling of fear tends to last over time and generalize to various situations, such
320 as the perceived lack of security and trust in healthcare services and professionals:

321 Nowadays, I go to a doctor, and I no longer feel the confidence I used to have
322 in doctors. I would go to the office and feel calm and comfortable, and I would
323 go calm. Not now, not with me or my daughter; going alone… terrifying, very
324 afraid of what they might do to her without her parents' consent. (P19, 30 years
325 old)

326 Linked to this experience of fear and the feeling of vulnerability, participants
327 reported feeling helpless guilty, but also a sense of frustration:

328 It was at this moment that I couldn't even say: wait a minute! I could not, words
329 could not come out, and nothing came out. I accepted what was happening. (P3,
330 22 years old)

> Many women must have the same thought that I had of thinking that it was our fault, that we were insufficient, that we should have spoken up. (P1, 29 years old)

> Even today, these issues... seven years have passed, and they still disgust me a lot. (P4, 36 years old)

The psychological impact of this experience included depressive symptoms and post-traumatic stress such as nightmares, recurrent traumatic memories (flashbacks), and avoidance of thoughts or places related to the experience:

> I had nightmares about it for, I don't know, one year or more. I remembered screaming in the middle of the night. (P15, 38 years old)

Likewise, the interviewees described recurrent feelings of sadness, isolation, and changes in their thought process, as well as some described a formal diagnosis of postpartum depression:

> I didn't think of throwing myself out of the window, I didn't think of throwing the boy out of the window, but I would see myself falling out of the bedroom window with the child in my arms. Sense of abyss, sense of helplessness, sense of sadness, that's how I was. (P8, 34 years old)

> I had postpartum depression when 'X' [her baby] was four months old. He was an intense baby; he needed attention as I did. Maybe I also needed attention and affection in that postpartum period (P16, 33 years old).

Regarding *interpersonal impact*, such as on intimate relationships, participants reported difficulties in bonding with their partner, especially experiencing changes in individual functioning (e.g., irritability, sadness, isolation) and difficulties in maintaining intimate and sexual relationships:

> Every time my boyfriend tried to touch me, I always remembered the birth and the way I had been treated, because that was a bit of a violation of my body. That's how I felt. (P9, 35 years old)

In addition, the participants described the impact on their interaction with the baby, citing emotional ambivalence in those moments and expressing difficulties and perceived limited confidence regarding their ability to parenting, particularly regarding breastfeeding:

> About six months after giving birth, I did not feel well. I could not go out with my baby and was happy. It was difficult to interact. (P12, 38 years old)

Finally, the *physical impact* (for the woman and the child) described by the participants included immediate harm, such as the postpartum consequences stemming from an episiotomy, together with the irreversible damages resulting from childbirth:

> And it also changed in the postpartum period, I had a very long cut, very stepped on and I couldn't pee and poop. (P13, 26 years old)

> This 'beautiful birth' left my daughter with sequelae for the rest of her life. I have also experienced irreversible damage. I have undergone hip replacement surgery, which is something that gets into the elderly. At 36 years of age, I had hip replacement. (P4, 36 years old)

Victims' Awareness

Victims' awareness was mentioned by almost all participants, specifically the mistreatment recognition, the challenging 'normality,' and the recognition of the birth partners mistreatment. *The mistreatment recognition* is associated with the moment women realize their childbirth experience was abusive. This awareness did not consistently occur immediately. Some women reported recognizing the abusive aspects

of their childbirth experience while still in the hospital, others needed an extended period to fully integrate this realization:

> I had much information about childbirth, so I realized, while still in the hospital, that the situation was awful for me. (P12, 38 years)

> I think I only had a full understanding of it almost two years after childbirth. (P15, 38 years)

Some participants reported *challenging the perceived normality* of the experience, recognizing the sense that something had gone wrong without yet identifying the nature of the violence:

> And I was trying to convince myself that the experience hadn't been that bad. But the truth is, I would just cry every time I talked about the birth. (P13, 26 years old)

Finally, the victims *recognized the mistreatment of their birth partners* and realized that this experience had also affected them. Specifically, they mentioned depressive symptoms and self-blame associated with the perceived helplessness they felt in falling protecting both the woman and the baby during the process of labor and birth:

> It was challenging because my husband was very traumatized by the childbirth experience. He thought he was going to lose us, and that he had not done anything. The feeling of guilt after birth was 100 %. (P1, 29 years old)

Coping Strategies

Findings from this study revealed that the coping strategies used by the participants to deal with the mistreatment experience could be described as primary strategies (i.e., more immediate) or more long-term strategies, such as sharing the experience, seeking formal and informal support, meaning-making, , and making a formal complaint. In this context, the *primary strategies* included passive responses,

characterized by acceptance of their reality and experience as mentioned by a participant:

> I noticed in the hospital a predisposition to accept everything. Okay, I would like to do it that way, but I can't, it doesn't matter, I'll change my idea if necessary. (P13, 26 years old)

Others highlighted a more assertive behavior in which the woman managed to impose their views:

> And I said: *Doctor, I appreciate your opinion, but I don't want an episiotomy*. It's my will. This time, I do not want to. If it goes wrong, I will take over. (P11, 27 years old)

Sharing the experience with others was mentioned by most participants as a strategy of self-validation in this context, getting support from other women and breaking the belief of being a 'unique case':

> I'll share what I think is important. If I can ever help even one person with one of my shares, I think it's worth it. (P14, 39 years old)

Our participants revealed that they *search for formal support*, particularly professional help from mental health staff, such as psychologists or psychiatrists, as a resource to minimize the impact of the victimization experience and to support them managing the emotional burden:

> At the time I didn't know what I know today, and it was a very traumatic childbirth. I did a lot of psychotherapy after that. (P17, 33 years old)

These participants described *informal sources of support*, such as friends or family, as an important resource:

> My sister is the girl's godmother, and from the beginning, when I needed her, she supported me a lot. However, nowadays I try not to pass on these concerns to her. I rely a lot on my husband, and he relies on me. (P4, 36 years old)

Moreover, *meaning-making* coping was adopted by some women to overcome the abusive experience:

> And that was the beginning of the healing process and accepting what happened and at the same time accepting that I can't change what happened, but I can face what I can do now. And if every woman who passes by me (in my role as a nurse) manages to stop them from doing what they did to me, it will be one woman less. Okay, that gave me focus again (...) I decided to pursue a specialty in maternal health precisely because I started to think that I could try to do something different. (P6, 31 years old)

Finally, some participants referred to *filing complaints* as a strategy to cope with their experiences, seek justice, and aim to raise awareness about this type of violence. They hoped to contribute to a more effective identification of such cases, thereby reducing the risk to other women:

> If I can make a complaint? I will. I have nothing to lose. I do not gain anything from this, but other mothers can gain, because at least it attracts attention. (P9, 35 years old)

Explanatory Factors of Obstetric Violence

This theme refers to participants' perceptions on the factors associated with obstetric violence. Specifically, this theme involves the *social endorsement,* acceptance and normalization of obstetric violence within social and institutional contexts. According to the participants, social legitimization might perpetuate obstetric violence

451 practices, which in turn undermine women capacity to recognize the abusive nature of
452 such behaviors:

453 And they don't feel that it's a childbirth, it's more like: let's get this over with
454 because it’s the normal procedure in the hospital. They do not feel the need to
455 explain, because it’s just part of their daily routine. (P16, 33 years old)

456 Additionally, participants also considered that a set of *healthcare system constraints*
457 may facilitate these practices, especially the lack of human resources:

458 They said the obstetrician would arrive in the morning. I think during the night,
459 there was no obstetrician, or if there was, they were only on call for
460 emergencies, which was not the case, right? And in the morning, I remember it
461 was already broad daylight. I said, *but no one is coming to see me? I am in a lot*
462 *of pain.* (P7, 37 years old)

463 **Discussion**

464 This study aimed to explore women’s perceptions and experiences related to
465 pregnancy and childbirth in the Portuguese context. All women reported at least one
466 experience of obstetric violence during childbirth, such as poor rapport between women
467 and health care providers, failure to meet professional standards of care, physical and
468 verbal abuse, secondary victimization, and prejudice. Data from this research is in line
469 with previous studies completed in Portugal (Barata, 2022a, 2022b; Costa et al., 2022),
470 in which abusive experiences, threats, and blame were reported, but the current research
471 adds to the previous insights by adding evidence about the experiences of stigma and
472 prejudice, secondary victimization, and poor rapport between women and health care
473 providers.

474 Our participants mentioned the loss of autonomy as the primary constraint in
475 their relationship with health professionals, including their exclusion from the decision-

making process regarding childbirth, lack of support, and non-personalized care. These dehumanization practices of care and objectification of women's bodies are consistent with international findings and may be framed in the literature on gender differences and inequalities (e.g., Aguiar & d'Oliveira, 2011; Annborn & Finnbogadóttir, 2022; Villarmea & Kelly, 2020). Gender inequalities have been identified as structural conditions that perpetuate power imbalances, limiting women's autonomy, and contributing to their objectification in the obstetric context (Bohren et al., 2019; Sadler et al., 2016; Smith-Oka et al., 2021). In certain circumstances, the delivery process in the hospital context and, particularly, the medicalization of childbirth, can increase women's feelings of losing their individuality and autonomy given that healthcare providers might follow routine procedures without considering individual needs and more person-centered approach to pregnancy and childbirth (Carer et al., 2021; Diniz et al., 2015; Kruger & Schoombee, 2009; Mena-Tudela et al., 2020b).

Ineffective communication with healthcare providers is a cross-cutting dimension, including the lack of information and explanations about procedures as a failure to meet professional standards of care. Lack of prior information or refusal to explain the procedure contributes to an inability for women to make informed decisions (Bezerra et al., 2020; Bohren et al., 2015; Cassiano et al., 2016; Dias & Pacheco, 2020; Elmir et al., 2010), which seems to be particularly critical in the Portuguese context as Barata's studies have also acknowledged (Barata, 2022a, 2022b). Physical and verbal abuse were also reported in this study, including excessive force and physical restraint, as well as threats, judgmental approach, and insults, sometimes directed towards the birth partner, along with their exclusion from the process. While verbal, emotional and physical abuse of women is relatively well documented in national and international literature (e.g., Bohren et al., 2019; Costa et al., 2022; Limmer et al., 2023, Reuther,

2021), these behaviors directed at women's birth partners emerged in this study as something novel. Previous findings in the Portuguese context also highlighted the exclusion of the birth partner from the birth experience (Barata, 2022a, 2022b), but not the verbal abuse directed toward these birth partners. Thus, considering the significant role of women's birth partners at this sensitive moment, these results reveal that threatening behaviors might weaken the supportive role of these elements.

Social endorsements and healthcare system constraints were reported by our participants as legitimizing obstetric violence, which highlights previous evidence suggesting that normalizing obstetric violence might be due to a lack of awareness among both professionals and women, who do not perceive these practices as abusive (Freedman et al., 2014; Savage & Castro, 2017; Sen et al., 2018). In this study, participants found it challenging to question professionals' behaviors, as they were perceived as established clinicians following clinical policies and procedures. They also noted that abusive practices, such as the restriction of autonomy, were socially accepted. Societal expectations regarding women's behavior in obstetric settings and gender stereotypes increase the normalization of abusive practices (Ayala et al., 2021; Bohren et al., 2016; Hennig, 2016; Leite et al., 2022; Sen et al., 2018), its invisibility and endurance (Freedman et al., 2014; Sen et al., 2018).

This is also true for women as some of them easily found themselves to be victims, while others mentioned taking months or even years to having been able to recognize the abusive nature of their experiences, which highlights the lack of consensus regarding the abusive nature of certain practices (Freedman et al., 2017; Lansky et al., 2019; Sen et al., 2018). This finding is particularly relevant as women sometimes felt unsafe to question, seek support, or convey their concerns and share their experiences of pain with health professionals, because of the fear of potential retaliation

and escalation of abusive acts (Aguiar & D'Oliveira, 2011; Bezerra et al., 2020; Elmir, 2010; Kruger & Schoombee, 2009).

By contrast, some women revealed that sharing their experiences and seeking formal support were the most frequent coping strategies. Sharing this abusive experience breaks the 'single case' believe and facilitates the unrestrained expression of emotions, allowing for greater understanding, integration, and validation of the experience (Elmir, 2010, Bezerra et al., 2020; Diamond-Smith et al., 2016; Kruger & Schoombee, 2009). One of the most innovative results of this study is the acknowledgement of the positive role of mental health staff, as well as support from significant others, such as family, friends, and partners, during childbirth and postpartum. This evidence is noteworthy to support women who have experienced obstetric violence, since not only mobilizing mental health professionals is very important for preventing or reducing psychological difficulties, but also informal support can help them overcome such difficulties, by providing them with feelings of comfort, assistance, and security (Bezerra et al., 2020; Diamond-Smith et al., 2016).

This support seems to be critical as our findings stress that obstetric violence is particularly detrimental to women's psychological functioning, but it also entails interpersonal and physical impacts (e.g., such as severe vaginal hematoma resulting from episiotomy and labral rupture). While the impact on women's psychological functioning is acknowledged in the literature (e.g., Ayers et al., 2016; Annborn & Finnogadóttir, 2022; Martinez-Vázquez et al., 2021; Martinez-Vázquez et al., 2022; Silveira et al., 2019; Paiz et al., 2022), and documented in this study, an innovative result from the current work is the perceived interpersonal impact of obstetric violence. As such, intimate relationships and mother-baby quality relationships were weakened by this abusive experience, as women reported increased detachment from their intimate

partners and significant challenges in restarting sexual relationships because of the violence they endured. Specifically, some women perceived the violence during childbirth as a form of 'violation,' which in turn negatively impacted their sexual relations, leading to heightened avoidance and discomfort (Elmir et al., 2010; Taghizadeh et al., 2021). The mother-baby relationship also seems to be impaired, including difficulties in breastfeeding, challenges in establishing a bond, or displaying hypervigilant behaviors toward the baby (Elmir, 2010; Taghizadeh et al., 2021).

Overall, these findings are innovative as they suggest that obstetric violence is more than an individual (woman-centered experience) or cultural (patriarchal social structure) matter. This study adds an intermediate ecological level to better understand obstetric violence, which refers to women's close interpersonal relationships (formal and informal). First, these relationships can also be affected by abusive experiences (e.g. when the birth partner is also the target of abusive behaviors). Second, interpersonal relationships, such as supportive relations, are important protective factors to mobilize. Third, the impact of obstetric violence might also involve dyadic relations with both the baby and partner.

Limitations and Implications for Research and Practice

Despite the innovative findings described above, several limitations should be considered. First, the characteristics of the sample are acknowledged and discussed. Based on national statistics for Portugal (PORDATA, 2022), it is important to be careful when discussing the current findings. It is worth highlighting the higher level of education of our participants compared to the average in the Portuguese population. Nevertheless, they earn a similar average monthly income (2063€) to the national average monthly income (i.e., 39177€ per year/14 months= around 2700€). The sample in this study had a lower average age of mothers at the birth of their children (28.4

years) compared to the Portuguese national average (31.6 years). Regarding marital status, it is worth noting that less than half of Portuguese women (41%) are in a married relationship, in contrast to the sample, where all women are married or live in a civil partnership. As such, our sample is dissimilar in these demographics when compared with the national population, and it also lacks diversity, given that it is composed mostly of Caucasian women. Ethnicity and socioeconomic status are important markers of the incidence of obstetric violence and the severity of abuse (Dwekat et al., 2020; Sen et al., 2018), which should be further explored in future studies, including more diverse community-based samples. Nevertheless, the intentional selection of the current sample– that is, women who recognize themselves as victims of obstetric violence– may justify these differences, as the characteristics of our participants might have made them more prone to identifying obstetric violence experiences, providing a deeper and more comprehensive understanding of this topic. Second, we did not explore any differences or similarities among the narratives of the women considering their background characteristics, which would be further explored in future studies. Finally, in this study we only included the women's voices, which require further studies that include the perspective of health professionals to gain a more comprehensive understanding of obstetric violence.

Despite these limitations, this study adds relevant data on what (experiences), why (explanatory factors), and how (processes and coping strategies) obstetric violence might occur in Portugal, which enables us to identify a set of recommendations for practice and policy making at different levels. First, considering that the social endorsement, normalization, and devaluation of these experiences seem to legitimize obstetric violence and heighten its negative impact, it is essential to raise social awareness about this specific type of violence. Not only can health providers may

endorse beliefs that justify abusive practices, but also women do not always recognize themselves as victims. Second, healthcare systems must provide effective mechanisms to safeguard women's and children's rights and implement policies, guidelines, regulations, and care protocols that ensure person-centered, safe and respectful birth and post-birth care. One of the key findings of this study was that interpersonal relationships surrounding women serve as a significant protective factor for those who have experienced obstetric violence. Moreover, it is essential to provide appropriate responses to the psychological and physical needs of these women (e.g., psychological support from mental health staff to address their emotional difficulties). Finally, ensuring continuous training for healthcare providers is critical to ensure humanized and trauma-informed care during pregnancy and childbirth. Further efforts deemed necessary to prevent secondary victimization in women who report obstetric violence, given that it negatively affects their psychological functioning.

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References

Abuya T., Warren C.E., Miller N., Njuki R., Ndwiga C., Maranga A., Mbehero F., Njeru A. & Bellows B. (2015). Exploring the prevalence of disrespect and abuse during childbirth in Kenya. *PLoS One*, *10*(4). https://doi.org/10.1371/journal.pone.0123606

Aguiar, J. M. D., & d'Oliveira, A. F. P. L. (2011). Violência institucional em maternidades públicas sob a ótica das usuárias. *Interface-Comunicação, Saúde, Educação, 15*, 79-92. https://doi.org/10.1590/S1414-32832010005000035

Annborn, A., & Finnbogadóttir, H. R. (2022). Obstetric violence a qualitative interview study. *Midwifery, 105*, 103212. https://doi.org/10.1016/j.midw.2021.103212

Ayala, P. M. (2021). Violencia obstétrica reproduciendo el dolor. *Via Inveniendi Et Iudicandi, 16*(2), 1-29. https://doi.org/10.15332/19090528.6783

Ayers, S., Bond, R., Bertullies, S., & Wijma, K. (2016). The aetiology of post-traumatic stress following childbirth: a meta-analysis and theoretical framework. *Psychological Medicine*, *46*(6), 1121-1134. https://doi.org/10.1017/S0033291715002706

Barata, C. (2022a). Body Broken in Half: tackling an Afro-Brazilian migrant's experience of obstetric violence and racism in Portugal through art making. *REVISTA [CON]TEXTOS*, *10*. https://revistes.ub.edu/index.php/contextos/article/view/38608/37565

Barata, C. (2022b). Mix of Races, Bad Uterus: Obstetric Violence in the Experiences of Afro-Brazilian Migrants in Portugal. *Societies*, *12*(3) 78. https://doi.org/10.3390/soc12030078

Bezerra, E. O., Bastos, I. B., Bezerra, A. K. B., Monteiro, P. D. V., & Pereira, M. L. D. (2020). Aspectos de la violencia obstétrica institucionalizada. *Enfermagem Foco, 11*(6), 157-164. https://doi.org/10.21675/2357-707X.2020.v11.n6.3821

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. https://dx.doi.org/10.1191/1478088706qp063oa

Bohren, M. A., Vogel, J. P., Hunter, E. C., Lutsiv, O., Makh, S. K., Souza, J. P., ... & Gülmezoglu, A. M. (2015). The mistreatment of women during childbirth in health facilities globally: a mixed-methods systematic review. *PLoS Medicine, 12*(6), e1001847. https://doi.org/10.1371/journal.pmed.1001847

Bohren, M. A., Vogel, J. P., Tunçalp, Ö., Fawole, B., Titiloye, M. A., Olutayo, A. O., ... & Hindin, M. J. (2016). "By slapping their laps, the patient will know that you truly care for her": a qualitative study on social norms and acceptability of the mistreatment of women during childbirth in Abuja, Nigeria. *SSM-population Health*, *2*, 640-655. https://doi.org/10.1016/j.ssmph.2016.07.003

Bohren, M. A., Mehrtash, H., Fawole, B., Maung, T. M., Balde, M. D., Maya, E., ... & Tunçalp, Ö. (2019). How women are treated during facility-based childbirth in four countries: a cross-sectional study with labour observations and community-based surveys. *The Lancet*, *394*(10210), 1750-1763. https://doi.org/10.1016/S0140-6736(19)31992-0

Carer, A. M. S., Costa, M. S. B., Monteiro, V. C. M., Belarmino, A. C., Cavalcante, K. O., & Ferreira Junior, A. R. (2021). Experiencias de puérperas sobre violencia obstétrica en la perspectiva fenomenológica. *Revista Cubana de Enfermería, 37*(1). http://scielo.sld.cu/scielo.php?script=sci_arttext&pid=S0864-03192021000100006&lng=es&tlng=en.

673 Costa, R., Barata, C., Dias, H., Rodrigues, C., Santos, T., Mariani, I., Covi, B., et al.
674 (2022). Regional differences in the quality of maternal and neonatal care during
675 the COVID -19 pandemic in Portugal: Results from the IMAgiNE EURO study.
676 *International Journal of Gynecology & Obstetrics*, *159*(1).
677 https://doi.org/10.1002/ijgo.14507
678 Cassiano, A. N., Santos, M. G., Santos, F. A. P. S., Holanda, C. S. M., Oliveira
679 Maranhão, T. M., Enders, B. C., & Carvalho, J. B. L. (2016). Expressões da
680 violência institucionalizada ao parto: uma revisão integrativa. *Enfermería*
681 *Global, 15*(4), 452-489. https://doi.org/10.6018/eglobal.15.4.236891
682 Diamond-Smith, N., Sudhinaraset, M., Melo, J., & Murthy, N. (2016). The relationship
683 between women's experiences of mistreatment at facilities during childbirth,
684 types of support received and person providing the support in Lucknow,
685 India. *Midwifery, 40,* 114-123. https://doi.org/10.1016/j.midw.2016.06.014
686 Dias, S. L., & Pacheco, A. O. (2020). Marcas do parto: As consequências psicológicas
687 da violência obstétrica. *Revista Arquivos Científicos (IMMES), 3*(1), 04-
688 13. https://doi.org/10.5935/2595-4407/rac.immes.v3n1p4-13
689 Diniz, S. G., Salgado, H. D. O., Andrezzo, H. D. A., Carvalho, P. D., Carvalho, P. C.
690 A., Aguiar, C. D. A., & Niy, D. Y. (2015). Violência obstétrica como questão
691 para a saúde pública no Brasil: origens, definições, tipologia, impactos sobre a
692 saúde materna, e propostas para sua prevenção. *Journal of Human Growth and*
693 *Development, 25*(3), 377-376. https://dx.doi.org/10.7322/jhgd.106080
694 Dwekat, I. M. M., Tengku Ismail, T. A., Ibrahim, M. I., & Ghrayeb, F. (2020).
695 Exploring factors contributing to mistreatment of women during childbirth in
696 West Bank, Palestine. *Women and Birth*.
697 https://doi.org/10.1016/j.wombi.2020.07.004

698 Elmir, R., Schmied, V., Wilkes, L., & Jackson, D. (2010). Women's perceptions and
699 experiences of a traumatic birth: A meta-ethnography. *Journal of Advanced*
700 *Nursing*, *66*(10), 2142–2153. https://doi.org/10.1111/j.1365-2648.2010.05391.x
701 González-de la Torre H, González-Artero P.N., Muñoz de León-Ortega D., Lancha-de
702 la Cruz M.R., Verdú-Soriano J. (2023). Cultural Adaptation, Validation and
703 Evaluation of the Psychometric Properties of an Obstetric Violence Scale in the
704 Spanish Context. *Nursing Reports*, *13*(4).
705 https://doi.org/10.3390/nursrep13040115
706 Fitzke, R. E., Marsh, D. R., & Prince, M. A. (2021). A longitudinal investigation of the
707 meaning-making model in midlife adults who have experienced trauma. *Journal*
708 *of Clinical Psychology*, 1–16. https://doi.org/10.1002/jclp.23272
709 Freedman, L. P., Ramsey, K., Abuya, T., Bellows, N., Ndwiga, C., Warren, C. E., … &
710 Mbaruku, G. (2014). Defining disrespect and abuse of women in childbirth: a
711 research, policy, and rights agenda. *Bulletin of the Word Health Organization,*
712 *92*, 915-917. https://doi.org/10.2471/BLT.14.137869
713 Garcia, L. M. (2020). A concept analysis of obstetric violence in the United States of
714 America. *Nursing Forum, 55*(4), 654-663. https://doi.org/10.1111/nuf.12482
715 Hennig, S. (2016). "Shut Up… and Push!"- Obstetrical Violence, Dignified Health Care
716 and the Intersection with Human Rights. *Journal of Integrated Studies*, *8*(1).
717 https://jis.athabascau.ca/index.php/jis/article/view/216
718 Kruger, L. M., & Schoombee, C. (2009). The other side of caring: abuse in a South
719 African maternity ward. *Journal of Reproductive and Infant Psychology*, *28*(1),
720 84-101. https://doi.org/10.1080/02646830903294979
721 Kruk, M., Kujawski, S., Mbaruku, G., Ramsey, K., Moyo, W., & Freedman, L. (2018).
722 Disrespectful and abusive treatment during facility delivery in Tanzania: a

facility and community survey, *Health Policy and Planning*, 33(1). https://doi.org/10.1093/heapol/czu079

Lansky, S., Souza, K. V. D., Peixoto, E. R. D. M., Oliveira, B. J., Diniz, C. S. G., Vieira, N. F., ... & Friche, A. A. D. L. (2019). Obstetric violence: influences of the Senses of Birth exhibition in pregnant women childbirth experience. *Ciencia & Saude Coletiva, 24*, 2811-2824. https://doi.org/10.1590/1413-81232018248.30102017

Leite, T. H., Marques, E. S., Esteves-Pereira, A. P., Nucci, M. F., Portella, Y., & Leal, M. D. C. (2022). Desrespeito e abusos, maus-tratos e violência obstétrica: um desafio para a epidemiologia e a saúde pública no Brasil. *Ciência & Saúde Coletiva, 27*, 483-491. https://doi.org/10.1590/1413-81232022272.38592020

Limmer, C., Stoll, K., Vedam, S., Leinweber, J., & Gross, M. (2023). Measuring disrespect and abuse during childbirth in a high-resource country: Development and validation of a German self-report tool. *Midwifery*, *126*. https://doi.org/10.1016/j.midw.2023.103809

Martínez-Galiano, J. M., Martinez-Vazquez, S., Rodríguez-Almagro, J., & Hernández-Martinez, A. (2021). The magnitude of the problem of obstetric violence and its associated factors: A cross-sectional study. *Women and Birth, 34*(5), e526-536. https://doi.org/10.1016/j.wombi.2020.10.002

Martinez-Vázquez S, Rodríguez-Almagro J., Hernández-Martínez A., Martínez-Galiano J.M. (2021). Factors Associated with Postpartum Post-Traumatic Stress Disorder (PTSD) Following Obstetric Violence: A Cross-Sectional Study. *Journal of Personalized Medicine*,*11*(5), 338. https://doi.org/10.3390/jpm11050338

Martinez-Vázquez, S., Hernández-Martínez, A., Rodríguez-Almagro, J., Delgado-Rodríguez, M., & Martínez-Galiano, J. M. (2022). Relationship between

perceived obstetric violence and the risk of postpartum depression: an observational study. *Midwifery*, *108*, 103297. https://doi.org/10.1016/j.midw.2022.103297

Mena-Tudela D, Iglesias-Casás S., González-Chordá V. M., Cervera-Gasch Á., Andreu-Pejó L., Valero-Chilleron M. J. (2020a). Obstetric Violence in Spain (Part I): Women's Perception and Interterritorial Differences. *International Journal of Environmental Research and Public Health, 17*(21). https://doi.org/10.3390

Mena-Tudela D., Iglesias-Casás S., González-Chordá V. M., Cervera-Gasch Á., Andreu-Pejó L., Valero-Chilleron M. J. (2020b). Obstetric Violence in Spain (Part II): Interventionism and Medicalization during Birth. *International Journal of Environmental Research and Public Health*, *18*(1), 199. https://doi.org/10.3390/ijerph18010199

McGarry, J., Hinsliff-Smith, K., Watts, K., McCloskey, P., & Evans, C. (2017). Experiences and impact of mistreatment and obstetric violence on women during childbearing: a systematic review protocol. *JBI Evidence Synthesis, 15*(3), 620-627. https://doi.org/10.11124/JBISRIR-2016-002950

Miltenburg, A.S., van Pelt, S., Meguid, T., & Sundby, J. (2018). Disrespect and abuse in maternity care: individual consequences of structural violence. *Reproductive Health Matters,* 26(53), 88-106. https://doi.org/10.1080/09688080.2018.1502023

Paiz, J., Castro, S., Giugliani, E., Ahne, S., Dall'Aqua, C., & Giugliani, C. (2022). Association between obstetric violence and symptoms suggestive of postpartum depression. *BMC Pregnancy Childbirth, 22*(1),664. https://doi.org/10.21203/rs.3.rs-1034466/v1

Pontes, B. F., Quitete, J. B., Oliveira, D. M., Goulart, M. C. L., Regazzi, I. C. R., &

773 Knupp, V. M. A. O. (2021). Repercussões físicas e psicológicas na vida de
774 mulheres que sofreram violência obstétrica. *Revista Científica de Enfermagem-*
775 *RECIEN, 11*(35). https://doi.org/10.24276/rrecien2021.11.35.443-450
776 PORDATA [website]. Estatísticas. https://www.pordata.pt/pt. Data updated on
777 04/09/2024. Accessed December 9, 2024.
778 Reuther, M. (2021). *Prevalence of Obstetric Violence in Europe: Exploring*
779 *Associations with Trust, and Care-Seeking Intention* [Unpublished bachelor
780 thesis]. University of Twente].
781 Sadler, M., Santos, M. J., Ruiz-Berdún, D., Rojas, G. L., Skoko, E., Gillen, P., &
782 Clausen, J. A. (2016). Moving beyond disrespect and abuse: addressing the
783 structural dimensions of obstetric violence. *Reproductive Health*
784 *Matters*, *24*(47), 47–55. https://doi.org/10.1016/j.rhm.2016.04.002
785 Savage, V., & Castro, A. (2017). Measuring mistreatment of women during childbirth:
786 A review of terminology and methodological approaches. *Reproductive Health*,
787 *14*(1), 1-27. https://doi.org/10.1186/s12978-017-0403-5
788 Sen, G., Reddy, B., & Iyer, A. (2018). Beyond measurement: the drivers of disrespect
789 and abuse in obstetric care. *Reproductive Health Matters*, *26*(53), 6-18.
790 https://doi.org/10.1080/09688080.2018.1508173
791 Silveira, M. F., Mesenburg, M. A., Bertoldi, A. D., De Mola, C. L., Bassani, D. G.,
792 Domingues, M. R., Stein, A., & Coll, C. V. N. (2019). The association between
793 disrespect and abuse of women during childbirth and postpartum depression:
794 Findings from the 2015 Pelotas birth cohort study. *Journal of Affective*
795 *Disorders*, *256*, 441–447. https://doi.org/10.1016/j.jad.2019.06.016
796 Smith-Oka V., Rubin S.E., Dixon L.Z. (2022). Obstetric Violence in Their Own Words:
797 How Women in Mexico and South Africa Expect, Experience, and Respond to

Violence. *Violence Against Women*, *28*(11). https://doi.org/10.1177/10778012211037375

Taghizadeh, Z., Ebadi, A., & Jaafarpour, M. (2021). Childbirth violence-based negative health consequences: a qualitative study in Iranian women. *BMC Pregnancy and Childbirth, 21*(1), 1-10. https://doi.org/10.1186/s12884-021-03986-0

Trajano, A. R., & Barreto, E. A. (2021). Violência obstétrica na visão de profissionais de saúde: a questão de gênero como definidora da assistência ao parto. *Interface-Comunicação, Saúde, Educação, 25*. https://doi.org/10.1590/interface.200689

Villarmea, S., & Kelly, B. (2020). Barriers to establishing shared decision-making in childbirth: Unveiling epistemic stereotypes about women in labour. *Journal of Evaluation in Clinical Practice*, *26*(2), 515-519. https://doi.org/10.1111/jep.13375

Vedam, S., Stoll, K., Taiwo, T. K., Rubashkin, N., Cheyney, M., Strauss, N., ... & Declercq, E. (2019). The Giving Voice to Mothers study: inequity and mistreatment during pregnancy and childbirth in the United States. *Reproductive Health, 16*(1), 1-18. https://doi.org/10.1186/s12978-019-0729-2

World Health Organization. (2016). *Standards for improving quality of maternal and newborn care in health facilities.* World Health Organization. https://www.who.int/publications/i/item/9789241511216

World Health Organization. (2018). *WHO recommendations on intrapartum care for a positive childbirth experience*. World Health Organization. https://www.who.int/publications/i/item/9789241550215

822 **Table 1**

823 *Sociodemographic and Childbirth Care Characteristics*

Variable	N (%)
Number of children	
1 child	8 (42.1)
2 children	10 (52.6)
3 children	1 (5.3)
Education Level	
Elementary school	1 (5.3)
High School	3 (15.8)
Higher education (bachelor's degree, master and PHD)	15 (78.9)
Marital Status	
Married	12 (63.2)
Life Partners	7 (36.8)
Nationality	
Portuguese	16 (84.2)
Others	3 (15.9)
Working Status	
Employed	14 (73.7)
Employed and Student	4 (21.1)
Unemployed	1 (5.3)
Delivery type	
Vaginal delivery	15 (78.9)
Cesarean section	4 (21.1)
Procedure	
Episiotomy	12 (63.2)
Induction of labor	11 (57.9)
Analgesia	17 (89.5)
Childbirth care	
Had a birth partner	15 (78.9)
Skin-to-skin	13 (68.4)
Birth Plan	
Yes, partially followed	1 (5.3)
Yes, but not followed	4 (21.1)
No birth plan	14 (73.7)

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827 **Table 2**

828 *Themes and Subthemes*

Themes	Sub-themes
Obstetric Violence (*N*=19; *f*=813)	Poor rapport between women and provider (*N*=19; *f*=468)
	Failure to meet professional standards of care (*N*=19; *f*=188)
	Physical abuse (*N*=17; *f*=62)
	Verbal abuse (*N*=17; *f*=60)
	Secondary victimization (*N*=10; *f*=22)
	Birth partners mistreatment (*N*=8; *f*=27)
	Prejudice (*N*=6; *f*=14)
Impact of Obstetric Violence (*N*=19; *f*=271)	Psychological impact (*N*=19; *f*=222)
	Interpersonal impact (*N*=12; *f*=24)
	Physical impact (*N*=10; *f*=24)
Victims' Awareness (*N*=17; *f*=70)	Mistreatment recognition (*N*=13; *f*=22)
	Challenging 'normality' (*N*=8; *f*=18)
	Recognition of birth partners mistreatment (*N*=7; *f*=20)
Coping Strategies (*N*=16; *f*=126)	Primary strategies (*N*=11; *f*=46)
	Sharing the experience (*N*=11; *f*=46)
	Search for formal support (*N*=9; *f*=22)
	Meaning making (*N*=9; *f*=17)
	Search for informal support (*N*=7; *f*=15)
	File a complaint (*N*=6; *f*=28)
Explanatory Factors of Obstetric Violence (*N*=16; *f*=44)	Social endorsement (*N*=11; *f*=24)
	Healthcare system constraints (*N*=10; *f*=20)

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