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Disrespectful, abusive, or neglectful situations toward puerperae in a brazilian maternity ward

Situações desrespeitosas, abusivas ou negligentes com puérperas em uma maternidade brasileira

Situaciones irrespetuosas, abusivas o negligentes hacia las puérperas en una maternidad brasileña

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ABSTRACT

Objective: To explore situations of disrespect, abuse, or neglect toward puerperae during their stay at a maternity ward in the Brazilian countryside. **Methods:** Exploratory, descriptive, qualitative study with 27 puerperae aged 18–35 years, with low-risk pregnancies and signs of psychological distress. Data collection included postpartum sociodemographic information and semi-structured interviews. Symbolic interactionism guided the theoretical framework, and narrative analysis guided the methodological approach. **Results:** Twenty-four puerperae underwent cesarean section, and three had vaginal delivery. The narratives revealed two main findings: (I) The maternity ward environment witnessed disrespectful, abusive, or neglectful situations, verbal or physical in nature. Verbal abuse involved rudeness, insults, and lack of attentive care from healthcare professionals. Physical abuse included actions causing bodily harm. (II) Fragility, impatience, and insufficient time dedicated to mother-infant care by professionals. Narratives from women in shared rooms highlighted these patterns. **Conclusion:** Puerperae are vulnerable to disrespect, abuse, and neglect during hospitalization in maternity wards in rural Brazil. The findings confirm the persistence of dehumanized, aggressive, and unsafe obstetric care, emphasizing the need for strategies to improve professional attitudes, ensure respectful treatment, and promote patient safety.

Keywords: Malpractice, Violence, Parturition, Maternal health.

RESUMO

Objetivo: Explorar situações de desrespeito, abuso ou negligência vivenciadas por puérperas durante a permanência em uma maternidade do interior do Brasil. **Métodos:** Estudo exploratório, descritivo e qualitativo com 27 puérperas, de 18 a 35 anos, com gestação de baixo risco e sinais de sofrimento psíquico. A coleta de dados incluiu informações sociodemográficas no pós-parto e entrevistas semiestruturadas. O referencial teórico foi o interacionismo simbólico, e a análise narrativa constituiu o referencial metodológico. **Resultados:** Vinte e quatro puérperas foram submetidas à cesariana e três ao parto vaginal. As narrativas revelaram dois achados principais: (I) O ambiente da maternidade foi cenário de situações de desrespeito, abuso ou negligência, de natureza verbal ou física. O abuso verbal incluiu grosserias, insultos e ausência de cuidado atencioso por parte dos profissionais de saúde. O abuso físico compreendeu atos que causaram

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danos corporais. (II) Fragilidade, impaciência e pouco tempo dedicado ao cuidado do binômio mãe-bebê. As narrativas de mulheres em enfermarias compartilhadas evidenciaram esses padrões. **Conclusão:** As puérperas estão vulneráveis a situações de desrespeito, abuso e negligência em maternidades do interior do Brasil. Os achados confirmam a persistência de práticas obstétricas desumanizadas, agressivas e inseguras, demandando ações para um cuidado respeitoso e seguro.

Palavras-chave: Negligência médica, Violência, Parto, Saúde materna.

RESUMEN

Objetivo: Explorar situaciones de irrespeto, abuso o negligencia vividas por puérperas durante su estadía en una maternidad del interior de Brasil. **Métodos:** Estudio exploratorio, descriptivo y cualitativo con 27 puérperas, de 18 a 35 años, con embarazo de bajo riesgo y signos de sufrimiento psíquico. La recolección de datos incluyó información sociodemográfica posparto y entrevistas semiestructuradas. El marco teórico fue el interaccionismo simbólico y el análisis narrativo constituyó el marco metodológico. **Resultados:** Veinticuatro puérperas fueron sometidas a cesárea y tres tuvieron parto vaginal. Las narrativas revelaron dos hallazgos principales: (I) El entorno de la maternidad fue escenario de situaciones de irrespeto, abuso o negligencia, de carácter verbal o físico. El abuso verbal incluyó groserías, insultos y falta de atención por parte de los profesionales de salud. El abuso físico comprendió actos que causaron daños corporales. (II) Fragilidad, impaciencia y escaso tiempo dedicado al cuidado del binomio madre-bebé. Las narrativas de mujeres en salas compartidas evidenciaron estos patrones. **Conclusión:** Las puérperas son vulnerables a situaciones de irrespeto, abuso y negligencia en maternidades del interior de Brasil. Los hallazgos confirman la persistencia de prácticas obstétricas deshumanizadas, agresivas e inseguras, requiriendo acciones para un cuidado respetuoso y seguro.

Palabras clave: Mala praxis, Violencia, Parto, Salud materna.

INTRODUCTION

Disrespect, abuse, or neglect toward women during the pregnancy–puerperium cycle is common in healthcare services, particularly in maternity wards (ADINEW YM, et al., 2023; ANNBORN A e FINNBOGADÓTTIR HR, 2022; CONCEIÇÃO HN, et al., 2023; HAJIZADEH K e MIRGHAFOURVAND M, 2021; LEAVY E, et al., 2023; PERERA C, et al., 2022; PIJL MSGVD, et al., 2020; SANTIAGO RV, et al., 2018; WHO, 2014). These situations may be verbal—such as humiliations, hostile communication, or reprimands—or physical, including coercive acts and non-consensual procedures causing injury (WHO, 2014; JUNGARI S, et al., 2021).

In Latin America, the term obstetric violence is used to describe such practices, though its definition lacks global consensus (AMORIM MM, et al., 2020). Harmful, non-consensual interventions, like routine episiotomy and the Kristeller maneuver, violate women's rights and erode trust in health institutions (DINIZ CSG e CABRAL CDS, 2022; WHO, 2014). These evidence-free interventions are linked to adverse maternal and child outcomes (LEAL MC, et al., 2019).

A systematic review found that abuse and disrespect occur in 43% of childbirths in Latin America (TOBASÍA-HEGE C, et al., 2019). In Brazil, the Nascer no Brasil study, with 24,000 puerperae, reported a 44% prevalence of physical or psychological violence, high rates of unnecessary cesarean sections, and women's preference for surgical delivery due to fear of pain (LEITE TH, et al., 2023; LEAL MC, et al., 2019).

Such experiences negatively impact childbirth, generating psychosocial repercussions and increasing the risk of postpartum depression (PPD) and postpartum post-traumatic stress disorder (PPTSD) (CONCEIÇÃO HN, et al., 2023; OLADAPO OT, et al., 2018). Women exposed to obstetric neglect have a 19.69-fold greater risk of developing PPD (SOUZA KJ, et al., 2017). Additionally, verbal abuse and PPD are significantly associated with PPTSD (GANKANDA WI, et al., 2021).

This study investigates how puerperae experienced disrespect, abuse, or neglect during their stay in a maternity ward. Objective explore situations of disrespect, abuse, or neglect toward women during their stay at a maternity ward in the countryside of Brazil.

METHODS

This exploratory, descriptive qualitative study is guided by Symbolic Interactionism (SI), which examines how individuals interact with others and themselves, emphasizing the meanings and interpretations they attribute to relationships and events (BLUMER H., 1986; CARVALHO VD, et al., 2010; CHARON JM, 2009; VICENTE JB, et al., 2023). SI explores how people interpret experiences and the reasons behind their behaviors. It was chosen because, when puerperae face disrespect, abuse, or neglect during their maternity ward stay, they assign meanings to these events, influencing subsequent behaviors. The study also adopts narrative analysis, which encourages participants to share stories, expressing feelings, thoughts, and emotions within temporal and cultural contexts (CAMPBELL KA & HART C., 2019; CASMINI C & SUPARDI S, 2020; REYNOLDS J & BERESFORD R, 2020). The content-categorical approach enables detailed examination of each narrated sentence and the associated emotional, cognitive, and behavioral expressions (LIEBLICH A, et al., 1998).

Study design and participants

This study was conducted in a small municipality in Brazil's countryside. Data were collected at a reference center for pregnancy-puerperium care, which provides prenatal and postpartum services. As the municipality lacks a maternity ward, deliveries occurred in a neighboring town, after which women returned for postpartum consultations—about 15 per month. Both facilities are public, linked to Brazil's Unified Health System (SUS). Participants were identified through the researcher's connection with the center's staff. Inclusion: women aged 18–35, low-risk pregnancy, up to six months postpartum, with psychological distress. Exclusion: psychiatric diagnoses, neurodevelopmental disorders, premature birth, fetal loss, or miscarriage.

Data collection

Semi-structured in-depth individual interviews and postpartum sociodemographic data were chosen in line with the SI theoretical framework and the methodological framework of narrative analysis. Data collection occurred from February 25 to April 4, 2022, and concluded with saturation of meaning (HENNINK MM, et al., 2016), which in this study was reached after 27 interviews. The first author (L.D.M.) had previous experience conducting research in this municipality, which facilitated access to the reference center. The 27 interviews happened in a private room at the service and were conducted by the same researcher (L.D.M.) who used the following guiding question: "Did you experience any situations of disrespect, abuse, or neglect during your stay at the maternity ward?". All the interviews were recorded and lasted an average of 40 minutes.

Ethical considerations

Approval for the study was obtained from the Research Ethics Committee of the Ribeirão Preto Nursing School (Certificate of Ethics Appreciation Presentation - CAAE) under the code 52894921.2.0000.5393 and approval code: 5.238.536. Before data collection, the first researcher (L.D.M.) explained the study, cleared any doubts, and read and collected the signatures for the Free and Informed Consent Term (TCLE).

Data analysis

The data as analyzed using the content-category analysis (LIEBLICH A, et al., 1998). The results were analyzed as follows: a) the audio transcriptions were done craftily and *ad verbatim* using basic software (Windows Media Player and Microsoft Word). There was no use of transcription/qualitative analysis programs (L.D.M.); b) primary reading of texts from audio transcripts (L.D.M.); c) documentation of the eminent features (L.D.M.); d) discovery of other relevant characteristics (L.D.M. and T.O.G.); e) insertion of iconic passages in two categories (L.D.M. and T.O.G.) For this study's methodological description, we used the COnsolidated criteria for REporting Qualitative research (COREQ).

RESULTS

Sociodemographic data of 27 women aged between 18 and 35 years old. Fourteen of them self-reported as white and 13 as non-white (black or mixed); 14 were legally single but had a partner; 13 had completed high school and 13 were engaged in domestic activities. Regarding the use of licit and/or illicit drugs, one mentioned alcohol consumption and one mentioned using tobacco. As for medication, two mentioned using hormonal contraceptives, three were using sertraline, and one had a prescription for it, but did not take the medication.

Regarding their obstetric history, 24 had a cesarean section, while three had a vaginal delivery. In terms of psychological distress, 23 showed signs of puerperal fatigue, and 16 had signs of puerperal depression. It should be noted that participants could present more than one sign of psychological distress when the data was obtained (**Table 1**).

Table 1 - Sociodemographic data of the puerperae according to Mapelli LD, et al., 2025.

P	Age	SSC	Educational Level	M	PPM	TSB	TPMS	Job
P1	24	Brown	Incomplete high school	Yes	P_1 CP_1 M_0	9	Baby blues. Fatigue	Housewife
P2	35	White	Undergraduate	Yes	P_1 CP_1 M_0	150	Depression Anxiety Fatigue, BED	Librarian
P3	18	White	High school	Yes	P_1 CP_1 M_0	90	Depression, Anxiety, Fatigue	Housewife
P4	25	Black	Incomplete high school	No	P_3 CP_3 M_0	18	Baby blues, Fatigue	Housewife
P5	34	White	High school	Yes	P_3 VP_1 CP_2 M_0 Current: C	75	Depression, Fatigue	Housewife
P6	23	Light brown	Incomplete high school	Yes	P_2 CP_2 M_0	45	Depression, Anxiety, Fatigue	Housewife
P7	22	Black	High school	No	P_1 CP_1 M_0	40	Depression, Anxiety, Fatigue	Housewife
P8	25	White	High school	Yes	P_1 VP_1 M_0	7	Baby blues	Housewife
P9	18	Black	High school	No	P_1 CP_1 M_0	120	Depression Anxiety, Fatigue	Junior Guard
P10	28	White	High school	Yes	P_1 CP_1 M_0	9	Baby blues, Fatigue	Housewife
P11	23	White	Undergraduate	Yes	P_1 CP_1 M_0	8	Baby blues, Fatigue	Psychologist
P12	27	Black	High school	Yes	P_3 CP_3 M_0	60	Depression, Anxiety	Housewife
P13	30	Brown	Incomplete middle school	Yes	P_1 CP_1 M_0	30	Depression, Anxiety, Fatigue	Housewife
P14	22	Light brown	Incomplete high school	Yes	P_2 VP_1 CP_1 M_0 Current: C	90	Depression, Anxiety	Housewife/ Farmer
P15	32	Brown	Undergraduate	Yes	P_2 CP_2 M_0	12	Baby blues, Fatigue	Nurse
P16	28	White	Incomplete high school	Yes	P_2 CP_2 M_0	12	Depression, Anxiety, Fatigue	Housewife
P17	34	White	High school	Yes	P_4 CP_4 M_0	90	Depression, Fatigue, BED	Entrepreneur
P18	23	Black	High school	No	P_2 CP_2 M_0	60	Depression, Anxiety, Fatigue	Housewife
P19	27	Brown	Incomplete undergraduate	Yes	P_1 CP_1 M_0	180	Depression, Anxiety, Fatigue, BED, NSSI	Self-employed
P20	29	White	Incomplete high school	Yes	P_3 CP_3 M_0	120	Depression Fatigue	Housewife
P21	18	Brown	Middle school	Yes	P_1 VP_1 M_0	8	Baby blues, Fatigue	Housewife
P22	34	White	Undergraduate	Yes	P_3 CP_3 M_0	90	Depression, Anxiety, Fatigue, OCD	Educator
P23	35	Brown	High school	Yes	P_3 VP_3 M_0	60	Anxiety, Fatigue	Entrepreneur
P24	20	White	High school	Yes	P_1 CP_1 M_0	10	Baby blues, Fatigue	Housewife
P25	32	White	Undergraduate	Yes	P_1 CP_1 M_0	50	Depression, Fatigue, OCD	Social worker
P26	33	White	Undergraduate	No	P_2 CP_2 M_0	90	Anxiety, Fatigue	Clerk
P27	28	White	High school	Yes	P_3 VP_1 CP_2 M_0 Current: C	150	Fatigue	Farmer/ Hair stylist

Legend: Puerperal woman (P); Self-reported Skin Color (SSC); Educational Level (EL); Mate (M); Pregnancy, Parturition, Miscarriage (PPM); Cesarean (C); Vaginal (V); Time since birth (in days) (TSB); and Traces of Postpartum Mental Suffering (TPMS).
Source: Mapelli LD, et al., 2025.

The narratives analyzed produced two findings:

1. The walls of the maternity ward have become witness to disrespectful, abusive, or neglectful situations of a verbal or physical nature.
2. Gaps in the care received by the binomial.

Finding 1

The walls of the maternity ward have become witness to disrespectful situations of a verbal nature when they noticed rudeness and/or insignificant care directed at women by healthcare professionals. Hostile communication and verbal reprimands directed at women were uttered by different classes of healthcare professionals involved in obstetric care and occurred, both during perinatal and in neonatal care.

> "*It was terrible, it was horrible! She* [obstetrician] *was too rude! She shouted at the nurses for them to leave! At the time of the cesarean section, she* [obstetrician] *said something so rude: 'Oh God, another baby! There should be a button to turn it off!*'" (P11).

> "*At the time of the cesarean section, she* [obstetrician] *did not treat me poorly. But upon arrival at the maternity ward, she told me that I should not have gone there 40 weeks along and that the OBGYN of the reference center should have waited until I completed 41 weeks, and she just sent women there* [maternity]. *I felt like she took it out on me* […]*"* (P12).

> "*The nurses want us to recover and shower quickly after the cesarean section. No one* [healthcare professionals] *asks you, 'How are you feeling today?' or 'Did you get some sleep?" They barely speak to you* [healthcare professionals] *or say good morning* (crying)' […]" (P19).

> "*During the cesarean section, they* [healthcare professionals] *mocking me. 'Where is your wedding ring? Another single mother!' They asked me, 'Did you eat before you came here?' and I nodded yes. They said, 'You're so stupid! Turn your head around because you'll throw up!'* (crying). *I heard one of them* [healthcare professionals] *say: 'I don't care about aesthetics* [cesarean stitches], *I care about getting out of here!*'" (P27).

Disrespectful situations include the blaming or delegation of responsibility to the woman for complications during labor.

> *"The anesthetist* [at the maternity ward] *asked me: 'Since when have you been feeling contractions?' and I replied, 'Around one in the afternoon'. He then asked, 'And you've only seeked the doctor now?'* […]" (P26).

> *"Arriving at the maternity ward, the doctor* [obstetrician] *was angry because there was meconium* […]" (P2).

Disrespectful situations of a physical nature are externalized through acts that cause physical injuries to the women during their stay at the maternity ward.

> "*I had no idea that five months after she* [baby] *was born, I would have this purple mark on my belly. This purple mark is due to the cesarean section! During the cesarean section, the doctor forced my belly excessively to get her* [baby] *out. By forcing my belly like that, I got a lot of bruises! During the first month* [after giving birth], *my belly was very painful! I look at this purple stripe on my belly and feel like crying!*" (crying) (P2).

> "*The nurse went to clean my mouth* [after I vomited]. *I was wearing braces, she* [the nurse] *cleaned it carelessly and ended up cutting my mouth!* (crying). *In the room, the nurses pulled the tape that covered the stitches* [cesarean section], *and I screamed in pain!* (crying). *I couldn't wait to get out of that maternity ward!*" (crying) (P27).

In popular imagery, loneliness is rarely associated with the maternity ward. However, the participants' narratives show that loneliness has been present during their maternity stay and the fact that they were not allowed a companion further emphasizes this feeling.

> "*I just didn't feel completely alone there because I had my mother* [companion] *with me. I think many mothers feel loneliness in that maternity ward*" (P17).

> "*They* [maternity] *didn't allow my mother to accompany me* […]" (P27).

> "*A nurse told my partner: 'you, here? – it's not going to work; a woman should be accompanying her, to help with breastfeeding and changing nappies'. My partner lowered his head and did not answer. The nurses there* [maternity] *are so rude!*" (P19).

Faced with the negative experiences endured during their stay at the maternity ward, the participants had the perception that they could have had better quality care if they had used private services.

From this perspective, SUS is seen as an unqualified service instead of considering the individual unpreparedness of healthcare professionals.

> "*I know that one day, if I get pregnant again, I want to try for a vaginal delivery, and I'm willing to pay for it! If I see that vaginal childbirth is not going to happen, I will pay for the cesarean section!*" (P2).

> *"SUS did this last delivery, and it was traumatic! For the other two births, I had health insurance. The* [maternity] *doctors were all angry because I should have been in the maternity ward earlier. I said I had tried to go earlier, but it wasn't my fault, and that the ambulance was delayed on the road. I had a cesarean section done by a doctor who didn't even mention his name! The nurses* [maternity] *hardly ever visit the women. This last cesarean was the first one I did through SUS and it was not a pleasant experience*" (P22).

Finding 2

The participants' narratives about the care received in the shared rooms pointed out fragility, lack of patience, minimal dialogue, and little to no time spent caring for the binomial by maternity healthcare professionals.

> "*There is no help at the maternity ward. I stayed in that room* [shared room] *and the nurses weren't explaining to me how I should take care of him* [baby]. *In order not to leave him* [baby] *starving, I bought 'X'* [infant formula]" (P10).

> "*The pediatrician* [maternity] *entered the room* [shared room] *and said: 'he* [newborn] *has 'almond-shaped eyes', haven't you noticed?' and left the room. The second time, he* [pediatrician] *came into the room to discharge me, and he asked me: 'Do you remember that I told you about the 'almond-shaped eyes?' and he continued, 'I think he has Down Syndrome'. But no one from the maternity* [healthcare professionals] *came to talk to me about him, about breastfeeding. I left* [maternity] (crying), *like I had never cried before. They weren't tears of happiness; they were tears of despair!*" (P17).

These deficiencies in care experienced by participants in the shared rooms had a negative impact on breastfeeding. The precariousness of information and support for made them feel insecure and face difficulties, leading to negative and traumatic experiences, in addition to a lack of motivation toward breastfeeding.

> "*The hard thing about it* [maternity] *is that the nurses don't help you with breastfeeding. They* [nurses] *say: 'Just put the baby on your chest. You must latch him on your breast!' I left the maternity ward with super cracked nipples!*" (P5).

> "*After the baby was born, as it had been about seven years since I breastfed, I ended up forgetting how to do it. The baby took the wrong breast and my breast was raw! I*

> *don't know if it's because I already had two children, but they* [healthcare professionals] *only told me that I was supposed to breastfeed her* [baby]*, but they didn't explain how. The nurses* [maternity] *hardly visited the women. It was traumatic!" (P22).*
>
> "*In the maternity ward, it works like this: was the baby born? Yes. Now find a way to breastfeed! The maternity nurses messed up my mental health! They told me that I would not be able to breastfeed and that if I wanted to stop trying, I should start using a bottle. I insisted on breastfeeding, and they told me* [healthcare professionals] *that I was going to have to put up with his* [baby's] (crying) […]" (P24).

Breastfeeding in the maternity ward culminates in attitudes taken by the women themselves, which are not always appropriate, such as cross-breastfeeding.

> "*They didn't say anything, they didn't give any milk, they didn't explain how to breastfeed* [healthcare professionals]. *The girl's baby was her first and she couldn't breastfeed. I could see that the child was hungry! I picked him up and breastfed him myself. Girl, this child breastfed so much that he slept throughout the entire night!*" (P20).

DISCUSSION

Situations of verbal or physical disrespect, abuse, or neglect by maternity healthcare professionals were reported as traumatic (ADINEW YM, et al., 2023). Women experienced shouting, swearing, humiliation, slapping, pushing, and insensitivity (SANTIAGO RV, et al., 2018; AŞCI Ö e BAL MD, 2023). Harmful practices included fasting, repeated vaginal exams, unnecessary oxytocin, Kristeller maneuver, mobility restriction, denial of analgesia, and ignoring birth plans (SANTIAGO RV, et al., 2018; SILVA-FERNANDEZ CS, et al., 2023; AŞCI Ö e BAL MD, 2023; AVCI N e KAYDIRAK MM, 2023). Excluding companions—contrary to law (BRASIL, 2005)—fostered loneliness (JACKSON L, et al., 2022; RODRIGUEZ J, et al., 2023). A review found 0.9–65.5% rude treatment and 6.2–40.9% coercive communication (SILVA-FERNANDEZ CS, et al., 2023).

Deficient communication and the limited time spent by professionals with patients in postpartum care also reflect difficulties in breastfeeding, as indicated by studies from various countries (DHAREL D, et al., 2020; FEENSTRA MM, et al., 2018; YILAK G, et al., 2020). These findings suggest that the decision to supplement breastfeeding with formula or to exclusively use these formulas is influenced by the limited commitment of healthcare professionals, along with a lack of encouragement and stimulation for breastfeeding (LEITE TH, et al., 2023).

In a cross-sectional study involving 695 puerperae in Rio de Janeiro, Brazil, it was found that 204 practiced cross-breastfeeding (SEEHAUSEN MPV, et al., 2017). The study cites the frequency of cross-breastfeeding from the Brazilian National Survey on Child Nutrition, a population-based study with 5,831 biological mothers, reported that 21.1% of them engaged in this practice (SEEHAUSEN MPV, et al., 2017). This is the reason healthcare professionals should be aware of the recommendations provided to nursing mothers regarding breastfeeding and infant feeding, as cross-feeding is more frequent among those who did not receive and/or did not understand the recommendations (SEEHAUSEN MPV, et al., 2017).

Situations of disrespect, abuse, or neglect affect maternal health and (consequently, the newborn's) continue to be a reality throughout the world (PAHO, 2024). These behaviors go against the efforts of the World Health Organization (WHO) in abolishing practices considered futile during labor, and the United Nations (UN) in prioritizing women's health in the Sustainable Development Goals (PAHO, 2024). Different studies conducted in various contexts agree that the stay at the maternity ward has caused psychological distress among women and that healthcare professionals working in these settings have been the main diffusers (PIJL MSGVD, et al., 2020; SILVA-FERNANDEZ CS, et al., 2023; AVCI N e KAYDIRAK MM, 2023).

This study's limitation is being conducted in a single health service. Its strength lies in supporting previous findings on disrespect, abuse, and neglect in maternity wards. It reinforces the need for effective prevention, including raising awareness, training professionals, and promoting evidence-based obstetric practices (AVCI N e KAYDIRAK MM, 2023; MENEZES FR, et al., 2020).

CONCLUSION

Women in the puerperium are susceptible to disrespectful, abusive, or neglectful situations during their stay at a maternity ward in the countryside of Brazil. This article proves the presence and continuity of dehumanized, aggressive, and unsafe obstetric care. Through the narratives of the participants, it was possible to identify the need to raise awareness, and the need for better training of healthcare professionals, encouraging obstetric practice based on scientific evidence to qualify childbirth and care for the binomial.

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