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EFFECT OF AN EDUCATIONAL WORKSHOP ON THE PREVENTION OF OBSTETRIC VIOLENCE ON THE KNOWLEDGE OF COMMUNITY HEALTH AGENTS

Efeito de oficina educativa sobre a prevenção da violência obstétrica no conhecimento de agentes comunitários de saúde

Efecto de un taller educativo sobre prevención de la violencia obstétrica en el conocimiento de los agentes comunitarios de salud

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RESUMO

Objetivo: analisar os efeitos de uma oficina educativa sobre prevenção da violência obstétrica no conhecimento de agentes comunitários de saúde. **Método:** estudo quase-experimental realizado em Acarape, Ceará, Brasil, em dezembro de 2024. Participaram agentes vinculados às Unidades Básicas de Saúde do município. A coleta de dados ocorreu em três momentos: pré-teste, intervenção educativa e pós-teste. A intervenção incluiu aula teórico-prática sobre definição, exemplos e prevenção da violência obstétrica, riscos associados, papel do agente e parto humanizado. **Resultados:** observou-se aumento do conhecimento após a intervenção, especialmente na identificação de práticas de violência obstétrica, como negligência e violência verbal. Também houve melhora na percepção sobre o parto humanizado e maior segurança para lidar com casos.

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Conclusão: a oficina educativa demonstrou ser eficaz na capacitação dos agentes para identificar e abordar a violência obstétrica, fortalecendo seu papel na promoção de um atendimento mais humanizado nas comunidades.

DESCRIPTORES: Violência obstétrica; Educação em saúde; Capacitação; Agentes comunitários de saúde.

ABSTRACT

Objective: to analyze the effects of an educational workshop on obstetric violence prevention in the knowledge of community health agents. **Method:** a quasi-experimental study was conducted in Acarape, Ceará, Brazil, in December 2024. Participants were agents from local Primary Health Care Units. Data collection occurred in three stages: pre-test, educational intervention, and post-test. The intervention included a theoretical-practical class covering obstetric violence, prevention, associated risks, the agent's role, and humanized childbirth. **Results:** an increase in knowledge was observed, particularly in identifying practices such as neglect and verbal abuse. There was also improved perception of humanized childbirth and greater confidence in addressing obstetric violence. **Conclusion:** the workshop proved effective in training community health agents, enhancing their ability to identify and address obstetric violence and contributing to more humanized care in their communities.

DESCRIPTORS: Obstetric violence; Health education; Training; Community health agents.

RESUMEN

Objetivo: analizar los efectos de un taller educativo sobre la prevención de la violencia obstétrica en el conocimiento de los agentes comunitarios de salud. **Método:** estudio cuasi-experimental realizado en Acarape, Ceará, Brasil, en diciembre de 2024. Participaron agentes vinculados a Unidades Básicas de Salud del municipio. La recolección de datos se realizó en tres etapas: pretest, intervención educativa y postest. La intervención incluyó una clase teórico-práctica sobre la definición, ejemplos y prevención de la violencia obstétrica, riesgos asociados, papel del agente y parto humanizado. **Resultados:** se observó un aumento del conocimiento, especialmente en la identificación de prácticas como negligencia y violencia verbal. También mejoró la percepción del parto humanizado y la seguridad al abordar casos de violencia. **Conclusión:** el taller educativo fue eficaz para capacitar a los agentes comunitarios, fortaleciendo su actuación en la promoción de una atención más humanizada en sus comunidades.

DESCRIPTORES: Violencia obstétrica; Educación para la salud; Capacitación; Agentes comunitarios de salud.

INTRODUCTION

Obstetric violence (OV) is a worrying reality that affects women around the world. It is defined as any act of violence (physical, verbal, or psychological), negligence, or inappropriate use of technologies and procedures that have not been consented to by the woman giving birth.¹ This type of violence against women, which can occur during pregnancy, childbirth, and the postpartum period, is practiced by health professionals in psychological or physical ways that violate women's human and reproductive rights.

In addition, studies also point to the use of trichotomy, food deprivation, deliberate administration of oxytocin, routine early amniotomy, adoption of the supine position, encouragement of voluntary pushing (Valsalva maneuver) and Kristeller, procedures such as episiotomy, forceps, and even cesarean sections, which are consistent with the practice of OV.²

Obstetric violence has become a matter of concern over the years, and in Brazil it has gained more notoriety due to the

increase in the number of reports. This practice is recurrent in both public and private hospitals, disproportionately affecting black women with low levels of education and income, highlighting a gender and class problem.³

In view of this, some factors contribute to the increase in OV rates, such as the lack of clear policies and guidelines, the lack of training and awareness among health professionals, social and cultural inequalities, outdated models of care, barriers to access to health services, and the lack of information, which is one of the factors that most contributes to OV. Misinformation and its relationship with obstetric violence are topics of great relevance, highlighting the importance of awareness and access to information to prevent and combat this problem in maternal health care.⁴

Thus, Community Health Agents (CHAs) can contribute to combating OV, as they play a fundamental role in promoting health and disseminating information. The CHA is a key figure for the FHS, as they convey important health-related information to the population and enable

the population's demands to reach the FHS.⁵ In this context of VO, CHA can assist in promoting maternal health and early identification of risk situations, including cases of VO. Therefore, it is necessary to train these professionals on the subject so that they can be educators and disseminators of information to prevent and mitigate this form of violence. In this sense, considering CHAs as facilitators between scientific knowledge and popular knowledge, it is essential to ensure the qualification of these professionals in order to increasingly improve their practice.

In this context, this study is relevant in that it seeks to train CHAs on the prevention of obstetric violence, promoting educational activities that seek to expand their knowledge so that they can help convey information on the subject, know how to identify cases of OV, and thus be able to help combat it in an effective and humane manner.

Given the above, the objective was to analyze the effects of an educational workshop on the prevention of obstetric violence on the knowledge of community health workers, in order to make them multipliers.

METHOD

This is a quasi-experimental study conducted at Basic Health Units (BHUs) in the municipality of Acarape, in the state of Ceará, from January to December 2024.

The study population consisted of CHAs from the Family Health Strategy (FHS) of the municipality of Acarape, Ceará. The criteria adopted for inclusion in the study were: age above 18 years and being assigned to work at the health unit. The exclusion criteria were: professionals who were on leave (maternity, health), vacation, or were absent on the day of the intervention.

Initially, a preliminary survey was conducted of the number of CHAs belonging to the selected health units, totaling 32 professionals working in the BHU of Acarape: BHU São Benedito - 10 CHAs (subdivided into São Benedito I - 6 CHAs and São Benedito II - 4 CHAs); BHU Canta Galo - 6 CHAs; BHU Centro - 5 CHAs; BHU São Francisco - 5 CHAs; BHU Riachão - 3 CHAs; BHU Poço Escuro - 3 CHAs. Thus, the study population was used, without the need for sample calculation. The CHAs were approached in the field and invited to participate in the study, after explaining the objective and benefits of the research. However, there was

a sample loss, resulting in the participation of 20 of the 32 professionals initially planned for the workshop. This reduction occurred due to refusals, absences, or other uncontrollable factors. Although no sample calculation was applied, the final sample represents most of the accessible population, allowing for data analysis with due consideration of this limitation.

Data collection took place in three stages: Stage 1: Application of a pre-test to assess the knowledge of CHAs before the educational intervention. Stage 2: Application of the educational intervention through a theoretical-practical workshop (40 minutes). Stage 3: Application of the post-test to assess the knowledge of CHAs after the educational intervention.

The first stage consisted of applying a questionnaire containing sociodemographic data created by the researchers and the pre-test with multiple-choice questions to assess the CHAs' knowledge of the subject before the educational intervention.

After applying these instruments, the educational intervention was carried out through a theoretical-practical class lasting an average of 60 minutes, addressing the following topics: conceptualizing obstetric violence, examples of violence, promoting knowledge about violence prevention, future risks of obstetric violence, humanized childbirth and its benefits, and behaviors to be adopted in the face of violence.

Then, the knowledge assessment tool was applied again after the educational intervention to evaluate the effects of the educational activity.

The data collected were organized in Microsoft Office Excel 2016 and analyzed using Jamovi® software version 1.6.15. Measures of central tendency and dispersion were used. The results were presented in tables.

The research complied with ethical principles in conducting research with human beings, being submitted to the Brazil platform and approved by the Research Ethics Committee of the University of International Integration of Afro-Brazilian Lusophony under opinion no. 7,126,430.

RESULTS

All CHA participating in the study were female. The average age was 46 (SD: 11.07) years and the average length of service was 14.20 (SD: 13.28) years. The profile of the participants is presented in Table 1.

Table 1 - Characterization of the study participants' profile. Redenção, CE, Brazil, 2025.

Variables	n	%
Skin color		
Brown	19	95,0
White	1	5,0
Education		
Completed elementary school	4	20
High school	10	50
Technical education	1	5
Complete upper	2	10
Incomplete higher education	1	5
Postgraduate studies	2	10
Marital Status		
Married	12	60
Single	5	25
Divorced	1	5
Widow	1	5
Stable Union	1	5

Source: Survey data.

None of the participants had participated in any educational activities on obstetric violence. Before the educational intervention, 80% (n=16) had heard of obstetric violence and 60% (n=12) knew what obstetric violence meant. Of the participants, 45% (n=9) knew someone or had a patient who had reported experiencing obstetric violence. When asked if the topic of obstetric violence was addressed in

any way at their workplace, 90% (n=18) answered no, but all (100%) considered this topic important in their professional practice. When asked if they felt capable and confident in identifying cases of OV and providing information about the topic to the population, 5% (n=1) felt capable, 65% (n=13) felt partially capable, and 30% (n=6) felt not capable. The data are presented in Table 2.

Table 2 - Number of correct answers before and after. Redenção, CE, Brazil, 2025.

Action/Procedure	Before		After		Variation (%)
	n	%	n	%	
Denying care to women or imposing difficulties during prenatal care.	19	95	20	100	5
Preventing immediate skin-to-skin contact between the baby and the mother after birth without giving the woman a clear reason.	19	95	20	100	5

Action/Procedure	Before		After		Variation (%)
	n	%	n	%	
Insults, humiliation, embarrassing comments based on color, race, ethnicity, religion, sexual orientation, age, social class, number of children, etc.	19	95	20	100	5
Prohibit the companion who is freely chosen by the woman.	19	95	20	100	5
Make breastfeeding difficult in the first hour.	17	85	20	100	15
Unnecessary cesarean section without informing the woman about its risks.	19	95	20	100	5
Voice changes, threats, and name-calling.	17	85	20	100	15
Intestinal cleansing during labor.	9	45	20	100	55
Restricting or preventing the mother's movement during labor.	13	65	20	100	35
Kristeller maneuver (pressure on the woman's belly to push the baby out).	12	60	20	100	40
Oxytocin ("smile to stimulate contraction") without the need to accelerate labor.	14	70	20	100	30
Episiotomy (cutting of the vagina) without necessity, without anesthesia, or without informing the woman	17	85	20	100	15
Trichotomy (removal of pubic hair).	9	45	20	100	55
Tying up the woman during childbirth or preventing her from moving and not allowing her to choose her birthing position, forcing her to give birth lying on her back with her legs raised.	17	85	20	100	15
Preventing women from eating and drinking water during labor.	5	25	20	100	75
Touching performed repeatedly, by more than one person, without the woman's consent or knowledge.	17	85	20	100	15
Denying anesthesia, even during normal childbirth.	15	75	20	100	25

Source: Survey data.

DISCUSSION

Sociodemographic data show the predominance of women among community health workers (CHA), reinforcing the feminization of this profession and its relevance in addressing obstetric violence (OV). Among CHWs, the predominance of women can be justified by the fact that this is a profession that plays a fundamental role in health care within the community, which is in line with the social and historical construction of care in most societies as something intrinsic to women, as evidenced in other health professions.⁷ With regard to age and length of service, the data collected showed significant experience. Although this experience may favor mature performance, ingrained practices can hinder the adoption of new knowledge, highlighting the need for continuous training. Regarding education, most have completed high school, but some have only elementary school or technical qualifications,

which can hinder the understanding of complex topics such as OV. This reinforces the importance of accessible and adapted educational actions, such as the workshop in this study, which prioritized clarity and practical applicability.

The results showed a significant gap in the previous training of CHAs, since none of the participants had previously participated in educational activities on OV. This scenario reflects the absence of structured initiatives to address a relevant topic in professional practice, since all CHAs consider OV important for their work. It is worth noting that when women are properly guided, they are less likely to suffer obstetric violence.⁸ This shows the importance of addressing the topic in professional practice.

However, the lack of adequate training compromises the confidence and competence of these professionals, as demonstrated by the low percentage of participants who felt fully trained. This disparity between the importance attributed

to the topic and the lack of confidence to act in identifying and confronting OV reinforces the need for targeted educational interventions, such as those carried out in this study, to effectively train and empower CHAs.

The educational intervention proved to be highly effective in promoting uniformity among CHAs in practices related to obstetric violence. After the training, all participants correctly recognized the situations presented as obstetric violence, regardless of the practice analyzed.

This result reflects the positive impact of well-planned interventions focused on overcoming knowledge gaps, often resulting from a lack of initial and continuing training on the subject in the context of Primary Health Care. The training and practice of health professionals play a crucial role in perpetuating or mitigating obstetric violence.⁹

The aspects most impacted by the intervention highlighted practices that, prior to training, were less recognized by CHAs, such as the prohibition of food during labor, intestinal lavage, and trichotomy. These practices, although widely questioned by scientific literature, still persist in many hospital settings, reinforcing the relevance of training to deconstruct ingrained knowledge and promote the humanization of childbirth. Thus, it is important that professionals receive training and continuing education to adopt evidence-based practices and have knowledge about human and reproductive rights, as well as about the various forms of violence prevention that can occur in health services.⁹

In addition, improved recognition of practices such as restriction of movement and unnecessary use of oxytocin indicates that the intervention was able to focus attention on aspects that are often neglected. By addressing these specific gaps, the training not only expanded the theoretical repertoire of CHAs, but also enhanced their role as educators and advocates for maternal health in the communities where they work, promoting the dissemination of accurate information and awareness of women's rights. The replication of similar interventions in other contexts is essential to amplify the impact and consolidate health care based on rights and respect for women's dignity.

Before the educational intervention, there was low awareness among healthcare professionals about actions such as preventing feeding, movement of women in labor, and performing intestinal lavage during labor, which had a significantly lower proportion of correct answers. However, the intervention resulted in a significant improvement, making these practices more visible and recognized as forms of obstetric violence, with 100% correct answers in the post-test. This change in perception is fundamental to promoting more respectful and dignified care for women during childbirth.

In addition, cesarean sections, often performed unnecessarily, are also not recognized as obstetric violence. Brazil has a high rate of cesarean sections, often without medical justification, reflecting the fear of normal childbirth, fueled by health professionals who devalue this option. This lack of recognition of cesarean sections as a form of violence contributes to unnecessary interventions, disregarding women's rights and choices.¹⁰ Therefore, it is essential that health professionals be trained to identify and question these practices, promoting more respectful care that is aligned with the rights of women in labor.

In Brazil, obstetric violence (OV) is a significant and alarming problem that has attracted increasing attention in recent years. For a long time, there was an attempt to conceal this violence, as well as its multiple and comprehensive examples. Despite this concealment of violence, including OV, reports have gained strength, showing that obstetric violence is a serious social problem that affects women in labor.⁴ In this context, emphasizing widely recognized aspects of obstetric violence is essential for raising awareness among health professionals. Before the intervention, practices widely recognized as obstetric violence showed high rates of identification among participants, as in the case of the recognition of verbal abuse and unnecessary cesarean sections as forms of OV. Although such behaviors are recognized, there is still a need for a deeper understanding of their implications.

Training in the identification and approach to obstetric violence (OV) is crucial for transforming the practice of community health agents (CHAs). After the educational intervention, a significant change in the perception of training was observed, with an increase in technical knowledge, which in turn positively influenced the CHAs' sense of security when dealing with cases of OV. However, despite advances in knowledge, there are still remaining challenges that can impact the performance of CHAs, such as the need for practical skills and institutional support.

Community health agents, trained to share knowledge with parents and/or guardians, can make a difference in the Brazilian scenario, since they are the most accessible health professionals and closest to families.¹¹ This reinforces the need for continuous and updated training for CHAs. These factors are essential to ensure that training not only expands theoretical knowledge but also results in concrete and effective actions in caring for women during childbirth, promoting more humane and respectful care.

The relevance of continuing education in the training of CHAs is evidenced by the positive impact that specific interventions can have in the short term. The results obtained

after training on OV demonstrate the potential of educational strategies in primary care, contributing to improving the knowledge and practice of professionals. To ensure the continuity of this progress, it is essential to implement regular training to reinforce and expand knowledge about OV, allowing CHAs to stay up to date and prepared to address this critical issue. In addition, the development of specific educational materials for these professionals to work directly with the population is an effective strategy to disseminate information and promote awareness about obstetric violence, strengthening the role of these professionals as agents of transformation in maternal health and the protection of women's rights during childbirth.

The implications for the professional practice of CHAs are significant, especially with regard to the expanded recognition of the knowledge acquired about OV. This knowledge not only enables them to identify and address situations of violence, but also contributes to the implementation of more humane and safer care practices, which are essential for the well-being of women during childbirth. In addition, the leading role of CHAs becomes evident as they position themselves as agents of change in the communities they serve, playing a crucial role in the prevention of OV. By acting as educators and advocates for women's rights, CHAs can positively influence the culture of care, promoting a more respectful and welcoming environment that values the autonomy and choices of women in labor. This transformation not only improves the quality of care but also strengthens the community's trust in health services, creating a virtuous cycle of care and respect.

The limitations of the present study include the small sample size. This restriction in the effective number of participants compromises the generalization of the results to broader populations, since the small number may not reflect the diversity of experiences and knowledge found among agents in varied contexts. In addition, the absence of male CHAs in the study limits the analysis of how different genders perceive and approach this critical issue, revealing a need for future studies that consider a more heterogeneous and representative sample.

CONCLUSION

The educational intervention carried out with community health workers proved to be a significant tool in promoting knowledge about obstetric violence, resulting in a broader perception and better identification of the practices that constitute this violence. The change in attitude among participants, reflected in improvements in knowledge test

results, indicates that structured educational programs are essential for training health professionals, enabling them to act in a more informed and effective manner in protecting women's rights during childbirth. This training not only strengthens the performance of agents but also has a positive impact on the quality of care provided, enhancing the role of these professionals as agents of change in their communities. This study will contribute to more comprehensive and effective educational interventions in the future, which can help build a more humane and respectful health system in relation to the needs of women during childbirth.

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