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DEVELOPMENT AND VALIDATION OF THE OBSTETRIC VIOLENCE TYPIFICATION SCALE (ETVO-Br)

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ABSTRACT:

Background and Purpose: This study aimed to develop and validate the Obstetric Violence Typification Scale. **Methods:** The study was conducted in five sequential steps: defining the topic, generating an initial pool of items, specifying the measurement and response format, performing face and content validation with a panel of experts, and revising the instrument according to the evaluators' feedback. **Results:** From an integrative review, legal documents, and input from 60 obstetric nurses, 720 statements were produced and refined to 75 items across five dimensions. Validation with 31 experts confirmed clarity and relevance, and a pre-test with 20 professionals supported applicability. **Conclusions:** The final tool includes sociodemographic data, a definition of obstetric violence, and a Likert scale, enabling assessment and monitoring of violent situations in childbirth.

KEYWORDS: Violence; Gender-Based Violence; Human Rights; Women's Rights; Patient Advocacy

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DEVELOPMENT AND VALIDATION OF THE OBSTETRIC VIOLENCE TYPIFICATION SCALE (ETVO-Br)

INTRODUCTION

Obstetric violence (OV) is a cross-cutting and complex phenomenon, internationally considered a public health issue (Branco et al., 2024; Buckwalter, 2025; Ferrão et al., 2025; Leite et al., 2024; Paiz et al., 2024; Robles Rosa & Jódar Martínez, 2024; Saloto et al., 2024; Tavares et al., 2025). Despite global interest in the topic, there is a lack of consensus on its definition and terminology, with the use of terms such as “disrespect and abuse” and “mistreatment during childbirth” (Buckwalter, 2025; Ferrão et al., 2025; Leite et al., 2024; Paiz et al., 2024).

Defined it as a set of actions and/or omissions that violate care during prenatal, childbirth, postpartum period, and abortion, including physical, verbal, psychological, sexual, institutional, and structural violence (Ferrão et al., 2025; Paiz et al., 2024). It is widely recognized as a specific form of gender-based violence (Finuoli, 2024; Guilar-Bernal et al., 2024; Marcos-Garcés et al., 2025; Robles Rosa & Jódar Martínez, 2024; Rusu et al., 2024).

Globally, studies have demonstrated its prevalence in varied settings, such as in Africa, Latin America, North America, Asia, Europe, and the Middle East, with incidents ranging from 65% to 100% in some studies (Branco et al., 2024; Ferrão et al., 2025; Fraser et al., 2025; Marcos-Garces et al., 2025; Paiz et al., 2024). Often, these practices are normalized, hindering their identification by the victims and even by some healthcare professionals (Branco et al., 2024; Ferrão et al., 2025; Marcos-Garcés et al., 2025; Paiz et al., 2024). The consequences of OV are serious, negatively impacting the dignity, privacy, and physical and mental integrity of women, with serious repercussions for maternal and infant health, including an increased risk of postpartum depression and

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post-traumatic stress disorder (Branco et al., 2024; Ferrão et al., 2025; Paiz et al., 2024; Robles Rosa & Jódar Martínez, 2024; Saloto et al., 2024).

In Brazil, the practice of OV is alarming (Leite et al., 2024). Even with the existence of legislation protecting women's rights, in obstetrics these rights are widely neglected. These are violations of women's dignity during pregnancy, childbirth, and the postpartum period, invalidating their choices, their bodies, and their reproductive health (Barros & Barros, 2024). The excess of interventions without consent and/or proper indication in Brazilian maternity hospitals normalizes obstetric violence and increases maternal and neonatal risks (Abdul Nour et al., 2024). Therefore, the topic of OV has been rendered invisible to society, culturally camouflaged within Brazilian history (Barros & Barros, 2024).

In terms of legislation, Venezuela was a pioneer in adopting the term in 2007, defining it and specifying the constitutive acts of OV (Ferrão et al., 2025; Finuoli, 2024; Leite et al., 2024). In other contexts, such as in Peru, it is recognized as a form of gender-based violence at the national level (Marcos-Garcés et al., 2025). In Spain, Catalonia has incorporated OV as a form of gender-based violence in its Law No. 17/2020 (Medina-Castellano, 2023). The Inter-American Court of Human Rights (IACHR) has also addressed the concept, identifying specific practices as OV and highlighting the need to criminalize this type of violence (Buckwalter, 2025).

However, the criminalization of OV is a subject of controversy (Buckwalter, 2025; Yeniocak et al., 2024). Healthcare professionals and medical organizations reject the term "obstetric violence," considering it inappropriate, biased, and unfair because the word "violence" implies malice or intent to cause harm, which, according to them, does not apply to all situations and could unduly criminalize medical practice

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(Buckwalter, 2025; Ferrão et al., 2025; Finuoli, 2024; Leite et al., 2025; Martínez-Galiano et al., 2023; Medina-Castellano, 2023; Yeniocak et al., 2024).

They often prefer terms like "disrespect and abuse" or "mistreatment" (Buckwalter, 2025; Finuoli, 2024; Leite et al., 2025; Medina-Castellano, 2023; Paiz et al., 2024; Yeniocak et al., 2024). On the other hand, proponents of the term argue that it is essential to give voice to victims and make it clear that this is a violation of human and reproductive rights (Buckwalter, 2025; Leite et al., 2025; Marcos-Garces et al., 2025; Robles Rosa & Jódar Martínez, 2024; Yeniocak et al., 2024). In Brazil, despite the existence of policies aimed at humanizing childbirth, such as the Humanization Program in Prenatal Care and Birth (PHPN), the *Rede Cegonha* (Stork Network), and the *Rede Alyne* (Alyne Network), there is no specific law criminalizing OV (Saloto et al., 2024). The cases are generally analyzed from the perspective of crimes against medical ethics or patient welfare (Buckwalter, 2025; Ferrão et al., 2025; Saloto et al., 2024). Although some Brazilian states and municipalities have regulations to combat OV, they do not directly criminalize it (Branco et al., 2024; Leite et al., 2025). The difficulty in typifying OV is also due to the lack of a validated instrument to measure it objectively, and to the fact that many women, due to misinformation or normalization of practices, do not recognize themselves as victims (Branco et al., 2024; Marcos-Garces et al., 2025; Paiz et al., 2024; Saloto et al., 2024).

In this context, health advocacy, which according to the WHO is one of the pillars of health promotion and is essential for transforming social and institutional settings, plays a fundamental role in addressing obstetric violence by promoting the defense of women's human, sexual, and reproductive rights. This practice seeks to give voice to users of health services, influence public policies, and ensure that obstetric care is guided by respect, autonomy, and equity (World Health Organization, 1998). In light

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of the above and considering the challenges identified, this study aimed to describe the process of developing and validating an instrument for typifying obstetric violence from a human rights and healthcare advocacy perspective, focusing specifically on health professionals as the target respondent population.

METHODOLOGY

The study was conducted following the steps proposed by DeVellis (2017) for instrument development. Five stages were carried out: (1) defining the theme and construct; (2) generating the initial pool of items; (3) establishing the measurement and response format; (4) conducting face and content validation with expert reviewers; and (5) revising the content based on the evaluators' feedback. Figure 1 summarizes the steps applied in this study.

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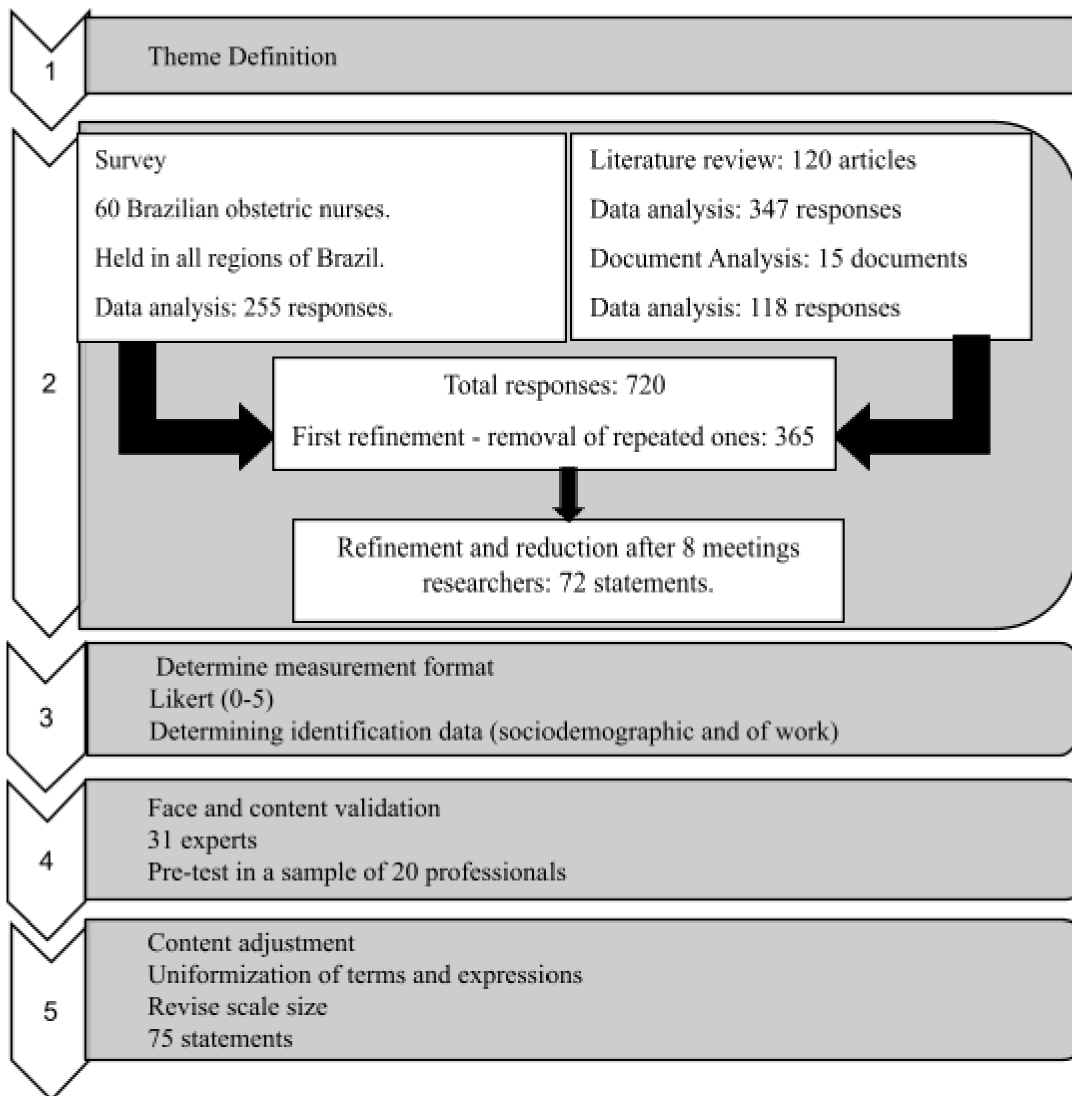

Figure 1

Schematic representation of the five stages applied in the development of the instrument

The study has national scope and includes the participation of health professionals, obstetrics specialists, and legal professionals working on issues of gender-based violence, reproductive justice, and/or health advocacy.

After determining the phenomenon – the instrument for typifying OV – the second stage was carried out, which consists of generating a set of items. In other words, three methods of material collection were considered at this stage: a) *Survey*

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answered by obstetric nurses from the five regions of Brazil; b) Integrative review containing national and international articles that addressed the concept and examples of OV; c) Official documents, guidelines, and national and international legislation on the subject. All results were unified to compose this stage; d) Determination of the measurement format: the five-point Likert scale was adopted; e) Face and content validation: conducted by expert judges and through pre-testing with the participants; f) Inclusion/exclusion of items: in this stage the instrument was consolidated with the statements.

The study was approved by the Human Research Ethics Committee of the originating institution and followed the guidelines set forth in resolution 466/2012 of the National Health Council, Brazil, whose Certificate of Presentation for Ethical Review (CAAE) number is 77506024.0.0000.0121.

RESULTS

The results describe in detail the five sequential steps carried out during the development of the OV typifying instrument, from the initial definition of the construct to the final refinement of the items.

STAGE 1 - Determining the phenomenon

For the definition of the phenomenon under study, Obstetric Violence, the authors' prior experience with the topic was essential, as it enriched the scope of the research and guided the methodological construction of the construct in a well-founded and conceptual manner, incorporating perspectives from different fields of knowledge and areas of expertise.

STAGE 2 - Generate a set of items

To generate the set of items that compose the instrument, three data sources were considered:

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a) **Survey:** Data collection was carried out in 2024, using an online form (Google docs)® answered by 60 obstetric nurses (ON) from the five regions of Brazil, indicated by the Brazilian Association of Obstetricians and Obstetric Nurses-ABENFO, through a meeting of presidents, in which they were specifically invited to participate and indicate ONs from their states. Participation was contingent upon having at least one year of experience in childbirth and delivery care. Initially, the questionnaire consisted of sociodemographic questions, and subsequently, participants were asked to list instances of OV they had experienced in their daily lives. A total of 255 situations described as OV were generated.

b) **Integrative review**: Articles published in the last five years were selected from electronic data sources. Search strategies used descriptors and their respective synonyms combined with Boolean operators (AND and OR) and adapted according to the specificities of each data source. After reading the articles in full, 120 national and international articles describing the concept and examples of OV were selected, resulting in 347 statements identified as OV.

c) **Official documents, guidelines and legislation:** 13 national documents, one document from the United Nations (UN), and one document from Venezuela. Documents were selected that described the concept of OV, specific laws from different countries with consolidated legislation on OV, and Brazilian states that contemplated OV or laws on the humanization of childbirth. After reviewing the documents in their entirety, only those addressing the concept of OV were included. Based on these documents, 118 statements emerged that were identified as OV.

Data were compiled and linked to the results emerging from the survey responses, the integrative review, and the analysis of guidelines and policies for addressing OV, to consolidate data triangulation and promote the elaboration and

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refinement through meetings and discussions with the project researchers, aiming at synthesizing the responses and grouping and regrouping the categories formed.

At this stage, content could be generated with the questions in affirmative format, using clear and precise language, to give substance to the construct and exhaust the possibilities in the construction of the instrument, validating its reliability and consistency. The results were unified, totaling 720 statements. For selection and exclusion of repeated statements, eight meetings were held with the project coordinator, a doctoral student, eight specialist researchers, and two undergraduate research fellows.

Methodological rigor was the cornerstone for ensuring that the selected statements addressed the phenomenon of OV during labor and delivery. The instrument organization followed the chronological order of the birthing process, excluding statements related to abortion and the postpartum period. Redundant items were selected and removed from the instrument, and common practices were classified into groups, obtaining a final construct according to the domain of content investigated, excluding possible divergences, similarities, and misinterpretations.

From this set of materials, the dimensions were listed to assist in the elaboration of the scale items, successive refinements were made, and the instrument was constituted. Item reduction was guided by criteria of redundancy, conceptual overlap, clarity, and theoretical relevance to the construct. The allocation of items into domains was performed by consensus among researchers, based on conceptual adherence to the definitions established for each domain. After the completion of this second stage, it was possible to obtain the first version of the construct, with all the sets of items initially integrated.

STAGE 3 – Determining the measurement format

The five-point Likert scale of intensity and frequency was chosen, using a

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measure of agreement ranging from strongly agree to strongly disagree. The choice was made in conjunction with the construction of the scale items so that the final format would be consistent with the object of study and because it is a scale widely used in the nursing and health field, considering the possibility of assessing the dimensions that permeate participants' attitudes toward a given phenomenon.

STAGE 4 – Validation of the instrument's face and content.

Stage 4 involved the face and content validation of the instrument. Face validation assessed the clarity, comprehensibility, and conciseness of the items, whereas content validation examined the relevance, representativeness, and adequacy of the statements in relation to the construct of obstetric violence (OV). This process included identifying ambiguous wording, determining the need for rephrasing or restructuring items, and verifying whether the instrument adequately incorporated sociodemographic information, a brief conceptual introduction to OV, and clear completion instructions. Validation was conducted in two phases.

In the first phase, corresponding to expert judgment, a purposive panel of 31 specialists—including nurses with expertise in ethics, obstetrics, neonatal care, nursing faculty, an obstetrician, and legal professionals—evaluated the instrument. Experts, coded as E1, E2, and so on, rated each item using a four-point scale (1 = inadequate; 2 = partially adequate; 3 = adequate; 4 = fully adequate), based on 17 evaluative criteria distributed across the domains of objectives, structure and presentation, and relevance. The results showed high levels of agreement. In the objectives domain, 97.6% of experts stated that the instrument addresses the needs for identifying OV during labor and birth; 97.6% considered the statements suitable for the educational process of health professionals; and 99.96% agreed that the items encourage reflection and discussion on violent practices occurring during labor and delivery. Additionally, 83.3% validated

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statements supporting the development of strategies to address OV; 70.92% identified conceptual inconsistencies in certain items; and 61.25% noted the absence of elements important for contextualizing the phenomenon.

These findings resulted in a systematic revision conducted by the research team, which removed redundant items, merged overlapping statements, and excluded content related to prenatal or postpartum care, as the instrument focuses exclusively on the labor and birth period. Regarding structure and presentation, 93.53% of experts considered the language appropriate for the target audience, and 87.01% reported that the language encourages interaction and engagement in the educational process. Furthermore, 77.34% indicated that the statements followed a logical sequence and had adequate grammatical correctness; 96.77% found the items clear and objective; and 96.72% approved the font size and layout. Based on these recommendations, the instrument was reorganized chronologically according to the physiology of childbirth, improving conceptual flow and usability. In the relevance domain, 93.5% of experts reported that the statements facilitate learning on OV; 96.76% stated that the instrument encourages the exchange of information among professionals; 99.99% agreed that the content stimulates interest in the topic; and 99.99% affirmed that the statements present essential information for identifying violent practices during labor and birth. After incorporating all suggestions, the consolidated version of the instrument included 75 statements.

The second phase consisted of pre-testing the revised version with the target audience, comprising 20 nurses, including postgraduate obstetrics students, coded as F1, F2, and so on. This phase aimed to assess clarity, practical usability, and acceptability. The instrument included sociodemographic data, a brief definition of OV accompanied by a five-point agreement scale, and 75 statements distributed across five categories:

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physical (items 1–21), institutional (22–50), social (51–58), moral (59–62), and psychological OV (63–75). Participants described the instrument as practical, accessible, and easy to understand, noting that it reflects common situations of clinical practice and captures both explicit and subtle manifestations of OV. They also highlighted its relevance for professional training and team awareness, emphasizing that the conceptual descriptions provided at the beginning of each block enhanced comprehension and contributed to consistent responses.

STAGE 5 – Consider adding/removing items from the instrument

After the fourth stage, three unclear items were removed and six new items were added, resulting in a 75-item instrument organized into five dimensions of obstetric violence: physical, institutional, social, moral, and psychological. The instrument begins with sociodemographic and professional information, followed by an introductory text defining obstetric violence and providing response instructions. Items are assessed using a Likert-type agreement scale. After the fifth stage, the instrument—ETVO-Br (Brazilian Scale for the Typification of Obstetric Violence)—was finalized.

TABLE 1: Obstetric Violence Typification Scale – Brazil (ETVO-Br), 2026.

Identification data:
Date of birth (day/month/year): ________/______/________
City (residence): **State**____________
Sex: Man ( ) Woman ( ) Non-binary ( ) I prefer not to answer ( ) Other: ____________
Have children: ( ) Yes ( ) No
Have religious beliefs: ( ) Yes ( ) No
City where you work:

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Year of graduation:

Courses completed:

Specialization in Obstetric Nursing ( ) Yes ( ) No
Residence ( ) Yes ( ) No Which___________________________________
Other specializations: ____
Master's degree ( ) Yes ( ) No **PhD** ( ) Yes ( ) No
Registered the title with the Regional Nursing Council (COREN) ( ) Yes ( ) No

How long have you worked in Obstetrics?(years/months):

Consider your current role in Obstetrics:

Institution: ( ) public ( ) private ( ) mixed ( ) philanthropic

Level: Federal ( ) State ( ) Municipal ( )

Time of work (year/months)_____________________________Weekly workload:__________________________
Type of relationship: permanent ( ) temporary ( )

Existence of an Ethics Committee in the institution: Yes ( ) No ( ) I don't know ( )

Meetings take place in your work unit (administrative, scientific, between teams)? ( ) Yes ( ) No

Physical obstetric violence:

Any act that offends the physical integrity or health of another. It can be practiced using physical force: To hit, kick, cut, mutilate, push, pinch, squeeze, bite, burn. (Brazilian Penal Code)

Any behavior that offends physical integrity or health. (Maria da Penha Law)

This occurs when a person in a position of power over another causes or attempts to cause non-accidental harm through the use of physical force or some type of weapon that may or may not cause external, internal, or both types of injuries. (Ministry of Health, 2002)

Statements	**I strongly disagree**	**I disagree more than I agree**	**I neither agree nor disagree**	**I agree more than I disagree**	**I completely agree**
1-Perform restraint of lower or upper limbs during childbirth					
2- Practice aggression or physical force during labor and delivery.					
3- Keep the woman deprived of liberty and restrained during labor and delivery.					
4- Force the cervix to accelerate dilation					
5- Perform unnecessary vaginal examinations, and without consent.					
6- Perform the Kristeller maneuver during childbirth.					
7- Perform an episiotomy without clinical justification and without consent.					
8- Do not allow the woman to walk around during labor.					
9- Perform amniotomy routinely to accelerate labor and without consent					
10- Use forceps improperly or without consent					
11- Adopt the use of forceps or vacuum extraction indiscriminately, without clinical justification.					
12- Accelerate/push the delivery of the placenta without respecting the physiological time.					
13- Initiate the cesarean section before the anesthesia takes effect.					

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14- Failure to provide labor analgesia when necessary.					
15- Disregard complaints of pain and other signs and symptoms reported by the woman.					
16- Keep a woman fasting without justification					
17- Failure to provide non-pharmacological methods for pain relief during labor.					
18- Refuse a request for pain relief during childbirth.					
19- Mistreat women who do not have good hygiene.					
20- Perform procedures that may increase pain as a form of punishment.					
21- Allow the woman to fast for hours (beyond the surgical requirement) while awaiting a cesarean section.					

Institutional obstetric violence

It is that exercised in/by the public services themselves, through action or omission. This can even include the broader issue of lack of access to poor quality services. It covers abuses committed due to unequal power relations between users and professionals within institutions. (Ministry of Health, 2002)

These consist of actions by public agencies that subject victims [...] to unnecessary, repetitive, or invasive procedures, leading to revictimization. (Brazilian Penal Code)

Statements	I strongly disagree	I disagree more than I agree	I neither agree or disagree	I agree more than I disagree	I completely agree
22- Adopt pubic hair removal as a routine.					
23- Apply an enema before or during labor.					
24- Perform routine venipuncture without clinical justification.					
25- Administer glucose or saline solutions without clinical justification during labor and delivery.					
26- Prevent the woman from freely positioning herself during labor.					
27- Restrict the woman to the lithotomy position during childbirth.					
28- Clamp the umbilical cord prematurely, without clinical justification, in healthy newborns.					
29- Prevent skin-to-skin contact in the first hour of life of healthy newborns.					
30- Perform airway suctioning on a newborn without clinical justification.					
31- Force women to accept institutional norms and routines to the detriment of their well-being.					
32- Not offer a shower to the woman due to lack of physical/structural space.					
33- Perform transfers between healthcare institutions without justification.					
34- Not allow the presence of a companion during labor, delivery, or cesarean section, including the pre-anesthetic and anesthetic period					
35- Violate reproductive rights by accelerating deliveries to free up hospital beds.					
36- Deny access to medical records and information					
37- Perform unnecessary interventions, without clinical justification, for the opportune purpose of teaching.					
38- Interfere with a woman's choice of preferred companion.					

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39- Restrict the role of the obstetric nurse during labor and delivery, if the woman wishes to be cared for by this professional.					
40- Failure to provide specialized professional and technological resources, thus jeopardizing the woman's or the newborn's safety.					
41- Use induction methods without clinical justification to accelerate labor.					
42-Allow women to seek healthcare services on their own (direct search) to give birth.					
43- Disregard obstetric and humanized Good Practices in the care of women and newborns, favoring the institutional and medicalized model.					
44-Disregard the birth plan					
45- Engage in scientifically contraindicated practices for economic, social, or domination purposes.					
46-Perform a cesarean section without the woman's consent or agreement.					
47- Impose or subject a woman to sterilization, insertion of an IUD, or any other contraceptive method, without information and/or consent immediately after childbirth.					
48- Not respect the woman's privacy during the physical examination and vaginal examination.					
49- Not respect the woman's choices regarding newborn care that differ from the Service's routine.					
50-Failure to provide an adequate environment due to overcrowding.					

Social Obstetric Violence

When one group imposes itself on another, disregarding differences and seeking to force submission [...]. It can affect people in various ways, with detrimental physical and mental effects on the victims. It occurs primarily against Black people, LGBTQIA+ individuals, women, Indigenous people, human rights defenders, and children and adolescents. [...]

Statements	I strongly disagree.	I disagree more than I agree	I neither agree or disagree	I agree more than I disagree	I completely agree.
51- Practice abuse of power based on economic, social and political issues, disrespecting women's dignity and autonomy.					
52- Discriminate against women because of their age.					
53- Shame a woman because of her parity history.					
54- Disrespect a woman's freedom of cultural or religious expression.					
55- Discriminate against women with any type of disability					
56- Practice any type of racism against women in labor and childbirth.					
57-Disrespect women due to their sexual orientation, gender identity, homelessness, mental health disorders, indigenous women, women from rural areas, quilombola women, and religious culture.					
58-Discriminate against women based on their marital status (conjugality)					

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Moral Obstetric Violence

Any conduct that constitutes slander, defamation, or libel, such as name-calling or attributing untrue facts. An act is considered immoral when it violates the moral standards of a society, that is, when it goes against what is considered right or wrong. Someone who knows the moral rules but intentionally violates them. (Brazilian Penal Code)

Understood as any conduct that constitutes slander, defamation, or libel. (Maria da Penha)

Statements	I strongly disagree.	I disagree more than I agree	I neither agree or disagree	I agree more than I disagree	I completely agree.
59- Repress, mock, or prevent a woman from expressing herself according to her culture (singing, praying, etc.)					
60- Ridicule a woman during a normal delivery due to breech presentation.					
61- Not allow the woman to touch her genitalia during the expulsive phase of labor.					
62-Judge or determine the pain threshold attributed by ethnic or racial characteristics					

Psychological Obstetric Violence

Characterized by behaviors such as threats, coercion, humiliation, manipulation, blackmail, ridicule, restriction of the right to come and go, among others. (Brazilian Penal Code)

Any action or omission that causes harm to a person's self-esteem, identity, or development, including devaluation and ridicule (Ministry of Health, 2002).

Any conduct that causes emotional harm, diminished self-esteem, disruption of development or control of actions, behaviors, beliefs, and decisions, through threats, coercion, humiliation, manipulation, isolation, constant surveillance, persecution, insults, blackmail, violation of privacy, ridicule, [...] that causes harm to psychological health and self-determination. (Maria da Penha).

Statements	I strongly disagree	I disagree more than I agree	I neither agree or disagree	I agree more than I disagree	I completely agree
63- Restrict the woman's autonomy of movement, vocalization, or cries during childbirth.					
64- Force the woman to perform directed pushing to accelerate labor.					
65- Force a woman to establish a bond with a newborn and/or breastfeed.					
66- Use derogatory language during labor and delivery					
67- To make disrespectful remarks related to a woman's sexuality during labor and delivery.					
68- Make disrespectful remarks related to a woman's body.					
69- Not offer emotional support to the woman and leave her alone during labor.					
70- Blame the woman for unfavorable childbirth outcomes.					

71- Threaten the woman with abandonment of care due to an alleged lack of cooperation.					
72- Disrespect a woman who expresses a desire to keep her placenta, without clinical justification.					
73- Treat women in an infantilizing and patriarchal way.					
74- Press a woman to perform a procedure					
75- Not provide the woman with information about her newborn.					

Note. Developed by the authors (2026).

DISCUSSION

The typification of Obstetric Violence is essential to enable its legal or criminal formalization, as the lack of such specificity hinders accountability for the phenomenon (Marques da Guia Costa et al., 2023). Since there is no consistency in identifying OV, due to resistance and denial on the part of professionals, it reinforces disrespectful and abusive behaviors towards women (Perrotte et al., 2020).

There are studies addressing OV in women's perception (González-de la Torre et al., 2023; Hernández-Martínez et al., 2024). In this case, one of the studies carried out the cultural adaptation and validation of an existing 14-item scale on OV in the Spanish context and evaluated its psychometric properties. AV final 13-item version of the OV Scale was produced, with a total score ranging from 0 (no perception of OV) to 52 (maximum perception of OV). The results showed that some women reported experiencing OV to varying degrees, ranging from practices performed without prior consent to disrespectful treatment by healthcare professionals (González-de la Torre et al., 2023). Another study developed and validated an instrument to assess a woman's perception of whether she experienced abuse or disrespect during childbirth, "Maternal Questionnaire for Assessing Abuse and Respect in Childbirth" (CARE-MQ). It was concluded that the CARE-MQ is a valid and reliable instrument for assessing women's perception of the use of regional analgesia, type of delivery, episiotomy, presence of

severe lacerations, skin-to-skin contact, length of hospital stay, and postpartum surgical intervention, situations of abuse and/or disrespect that a woman may have experienced during childbirth in a Spanish population (Hernández-Martínez et al., 2024).

In the present study, it was possible to analyze the listed variables of obstetric care correlated with the dimensions of violence against women (physical, institutional, social, moral, and psychological), allowing the validation of the instrument in terms of identifying, measuring, and monitoring obstetric practices that are normalized in hospital routines and culturally accepted, but which violate human and reproductive rights. The presence of gaps in our understanding of this phenomenon is linked to deficiencies in institutional infrastructure, service organization, professional training, and women's perceptions, going beyond political, social, and scientific issues (Tavares et al., 2025).

A study conducted with 133 obstetrics residents in Türkiye assessed their perceptions of mistreatment of women in labor. The results served as an educational resource to raise awareness about inadequate routine practices, with a significant impact on clinical practice and on the understanding of public policies and WHO recommendations (Yeniocak et al., 2024). Research involving the development of validation instruments must follow a rigorous methodology. In this study, this included content and face validation, cultural and linguistic adaptation, conceptual clarity, operational definitions of violence, social consensus, and legislative backing. These criteria make the instrument robust and enable the quantification and visibility of abusive practices.

Regarding the statements measured by the participants, only 18 were divergent in relation to the dimension presented in the instrument, with a predominance of Physical OV n (10), among them the restriction of the parturient free ambulation,

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disrespect for the physiology of childbirth, denial of the provision of analgesia and methods for pain relief. To corroborate this study, it is worth mentioning a cross-sectional survey conducted with 901 Spanish women after childbirth, which had four components as its result: Emotional abuse, at 17.4%, reflects the precarious interpersonal relationships between professionals and women; Inadequate Professionalism, at 10.2%, ranging from communication problems and violation of privacy to the use of inappropriate language or unnecessary techniques; Physical Abuse, at 8.9%, includes the perception of pain due to the action or omission of professionals; and the component Lost Contact, at 8.7%, resulting from the separation of the mother from her partner and/or her baby. In the institutional OV dimension, they differed only in n (7) statements, proving that hospital norms and routines are rigid and imposed in an egalitarian manner, disregarding individualized and equitable care, in addition to precarious and overcrowded environments. Finally, there was a divergence in n (1) statement classified as Psychological OV, understood as the separation of the newborn from its mother, which violates the rights of both the child and the postpartum woman, contradicting the guidelines of the Ministry of Health and WHO.

Some technical issues were also raised, demonstrating the participants' knowledge of obstetric practices, such as conditions that were not observed or interventions performed without respecting physiological conditions, which could also characterize OV, including excessive cesarean sections in supplementary healthcare.

It should be highlighted that ETVO-Br demonstrates good levels of reliability and validity, making it a useful tool in detecting various forms of OV. Therefore, regarding the procedures to ensure the content and face validity of the scale, which included evaluation by expert judges and pre-testing, it was found that the study provides a valid tool for measuring patient advocacy by obstetric nurses, filling a gap

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considering the lack of specific instruments for obstetric practice typified according to the dimensions of violence. Furthermore, the ETVO-Br has proven reliable in measuring other studies, such as the Patient Advocacy Scale for Nurses in Intensive Care – EAPEnf-UTI, in which the degree of agreement was adopted as a measure (Vargas et al., 2023).

The development and validation of ETVO-Br represent a significant advancement in the field of maternal health, providing an innovative tool capable of identifying and classifying OV practices based on criteria grounded in human rights and health advocacy. By enabling the detection of abusive conduct and the measurement of its physical, institutional, social, moral, and psychological dimensions, it strengthens the role of healthcare professionals as advocates for women's rights, in line with WHO recommendations regarding the promotion of respectful labor and childbirth (World Health Organization, 2019). Furthermore, it represents an important advocacy tool in healthcare, since its results can support public policies, educational practices, and training processes aimed at humanizing care and gender equity, contributing to the implementation of the principles of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the main international legal instrument for the protection of women's rights, and of the Sustainable Development Goals SDG 3 – Good Health and Well-being and SDG 5 – Gender Equality (United Nations, 1979; United Nations, 2015).

LIMITATIONS AND STRENGTHS

Although ETVO-Br has demonstrated good levels of reliability and validity, its generalizability is limited because the instrument was developed and validated with a single, specific population. Therefore, it may not be directly applicable to other

contexts, settings, or professional groups without additional testing or adaptation. Future studies should evaluate its performance in diverse cultural and institutional environments, as well as conduct longitudinal analyses to assess its usefulness in monitoring changes in clinical practice and in reducing OV over time. Despite these limitations, ETVO-Br represents an important step forward in making obstetric violence more visible, typified, and systematically monitored, contributing to the protection of women's rights and to the promotion of more humane, safe, and respectful obstetric care.

RELEVANCE TO NURSING PRACTICE

The set of items that emerged in ETVO-Br makes it a tool applicable to different contexts, allowing for the measurement and monitoring of OV. The results highlight the persistent normalization of abusive practices in obstetric care, both in public and private services, emphasizing the need to make visible behaviors that have been previously denied or minimized. Furthermore, ETVO-Br contributes to health advocacy, strengthening the work of professionals and institutions in protecting the human rights of pregnant women, by enabling the identification, prevention, and intervention in practices that compromise the women's physical, psychological, and reproductive safety. Its use can support the training of professionals, the implementation of hospital protocols, and the formulation of public policies aimed at humanizing childbirth, promoting more equitable, ethical, and woman-centered care.

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