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Article

Rethinking Birth as a Comprehensive Right in the Fight against Obstetric Violence in Brazil

Repensando o Nascimento como um Direito Integral na Luta contra a Violência Obstétrica no Brasil

Reconsiderando el Nacimiento como un Derecho Integral en la Lucha contra la Violencia Obstétrica en Brasil

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Abstract

Objective: To analyze the impact of the absence of federal legislation and regulations on the mitigation of obstetric violence in Brazil through a critical analysis, with emphasis on legal regulation. **Methodology:** Initially, a narrative review with a qualiquantitative and exploratory-descriptive approach was conducted on the databases of the Virtual Health Library and the Scientific Electronic Library Online, between 2018 and 2023. Articles were selected using Medical Subject Headings descriptors such as “obstetric violence” and “violence against women”, combined with the boolean operator “AND”. Subsequently, a documentary search was conducted to consult the current state legislation in Brazil and identify gaps. **Results:** A considerable gap was identified regarding obstetric violence and limited awareness of women's autonomy rights, which are evident concerns. Regarding the analyzed state laws, 14 mention “obstetric violence” and 8 address “humanization of childbirth”. Of these, 19 are informative, 28 are preventive, and 2 are punitive. Final **Considerations:** The lack of consensus in defining obstetric violence and the scarce training of healthcare professionals result in obsolete practices. The high rate of unnecessary cesarean sections and the lack of studies on quilombola and Indigenous women are concerning. In the legal sphere, the lack of understanding by judges and the fragmentation of state legislation represent significant challenges. It is crucial to adopt

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a multidisciplinary approach and clear public policies to prevent this violence and ensure safe and woman-centered childbirth care.
Keywords: Sexual and Reproductive Rights; Humanized Birth; Women's Health; Gender Violence; Obstetric Violence.

Resumo

Objetivo: analisar o impacto da ausência de legislação federal e normativas na mitigação da violência obstétrica no Brasil, por meio de uma análise crítica, com ênfase na regulação legal. **Metodologia:** inicialmente, realizou-se uma revisão narrativa de abordagem qualiquantitativa e exploratória-descritiva nas bases de dados da Biblioteca Virtual em Saúde e da Scientific Electronic Library Online, no período entre 2018 e 2023. Os artigos foram selecionados utilizando descritores do Medical Subject Headings, como "obstetric violence" e "violence against women", combinados através do operador booleano "AND". Posteriormente, foi conduzida uma pesquisa documental buscando consultar a legislação estadual vigente no Brasil e identificar possíveis lacunas. **Resultados:** Identificou-se uma lacuna considerável em relação à violência obstétrica e à conscientização limitada sobre os direitos à autonomia das mulheres, que são preocupações evidentes. Em relação às legislações estaduais analisadas, 14 fazem menção à "violência obstétrica" e 8 abordam a "humanização do parto". Dessas, 19 têm caráter informativo, 28 são preventivas e 2 são punitivas. **Considerações Finais**: A ausência de consenso na definição da violência obstétrica e a escassa capacitação dos profissionais de saúde resultam em práticas obsoletas. A elevada taxa de cesarianas desnecessárias e a carência de estudos sobre mulheres quilombolas e indígenas são preocupantes. No âmbito jurídico, a falta de compreensão por parte dos magistrados e a fragmentação das legislações estaduais representam desafios significativos. Torna-se crucial adotar uma abordagem multidisciplinar e políticas públicas claras para prevenir essa violência e assegurar uma assistência ao parto segura e centrada nas necessidades das mulheres.
Palavras-chave: Direitos Sexuais e Reprodutivos; Parto Humanizado; Saúde da Mulher; Violência de Gênero; Violência Obstétrica.

Resumen

Objetivo: Analizar el impacto de la ausencia de legislación federal y normativas en la mitigación de la violencia obstétrica en Brasil mediante un análisis crítico, con énfasis en la regulación legal. **Metodología:** Inicialmente, se realizó una revisión narrativa con enfoque cualicuantitativo y exploratorio-descriptivo en las bases de datos de la Biblioteca Virtual en Salud y la Scientific Electronic Library Online, entre 2018 y 2023. Se seleccionaron artículos utilizando descriptores del Medical Subject Headings como "obstetric violence" y "violence against women", combinados con el operador booleano "AND". Posteriormente, se realizó una búsqueda documental para consultar la legislación estatal vigente en Brasil e identificar posibles lagunas. **Resultados:** Se identificó una brecha considerable en relación con la violencia obstétrica y la conciencia limitada de los derechos de autonomía de las mujeres, que son preocupaciones evidentes. En cuanto a las leyes estatales analizadas, 14 mencionan "violencia obstétrica" y 8 abordan la "humanización del parto". De estas, 19 son informativas, 28 son preventivas y 2 son punitivas. **Consideraciones Finales:** La falta de consenso en la definición de la violencia obstétrica y la escasa formación de los profesionales de la salud resultan en prácticas obsoletas. La alta tasa de cesáreas innecesarias y la falta de estudios sobre mujeres quilombolas e indígenas son preocupantes. En el ámbito legal, la falta de comprensión por parte de los jueces y la fragmentación de la legislación estatal representan desafíos significativos. Es crucial adoptar un enfoque multidisciplinario y políticas públicas claras para prevenir esta violencia y garantizar una atención al parto segura y centrada en las necesidades de las mujeres.
Palabras clave: Derechos Sexuales y Reproductivos; Parto Humanizado; Salud de la Mujer; Violencia de Género; Violencia Obstétrica.

Introduction

Brazil's trajectory over the last three decades has been marked by significant demographic, socio- economic and urban infrastructure transitions, directly influencing citizen's quality of life. In the field of health, the country has undergone a transition to a unified health system, marked by substantial changes in health policies and the notable growth of primary care. The creation of the Unified Health System (UHS) is the result of the struggle for the Brazilian Health Reform, which involved intense political disputes and the active participation of social movements in social control bodies. However, despite the progress made, significant challenges remain, especially about maternal and obstetric health care [1–2].

In this context, obstetric violence (OV) emerges as a critical issue and is defined as a set of actions perpetrated against women throughout all stages of pregnancy. These actions include sexual, physical, psychological, and verbal aspects, as well as omissions, discrimination, and unnecessary interventional procedures. Not only does OV show a failure in the health system, but it also constitutes a violation of human rights, reflecting gender prejudices and cultural hierarchies. It should be noted that this form of violence affects poor, Black women with low levels of education, who are users of the public health system[3–5].

> The term "obstetric violence", originating from the women's movement is currently used to typify and group together various forms of violence, aggression and omissions practiced during pregnancy, childbirth, the puerperium and in abortion care. It includes physical, psychological, and verbal abuse, as well as procedures considered in medical literature to be unnecessary and harmful, including caesarean sections without clinical evidence. Other terms, such as institutional and gender-based violence, violence in childbirth and violence in obstetric care, circulate in the same semantic field to express aggression and negligence during the pregnancy-puerperium cycle. In this sense, it is possible to infer that obstetric violence "represents the dehumanization of care and the perpetuation of the cycle of female oppression by the health system itself.[5]

Despite the growing recognition of OV as a serious public health problem, Brazil still lacks specific federal legislation. This gap not only discourages reporting, but also perpetuates women's vulnerability to this scenario. Faced with these challenges, it is essential to emphasize the increase in social and academic awareness of this issue, highlighting the urgent need for investments in education and training. Such investments are essential to effectively prevent this type of violence, guaranteeing full respect for women's rights[3, 4, 6].

Given this context, it is essential to analyze the impact of the absence of federal legislation and the lack of regulations to promote the mitigation of these practices in Brazil. Therefore, the scope of this study lies in the critical analysis of the situation of OV in Brazil, with emphasis on its legal regulation.

Methodology

To conduct this review and documentary research, a priori, we based our research on essential questions: "What is the impact of the absence of federal legislation and the lack of regulations to promote the mitigation of OV in the Brazilian scenario?" and "How do regional disparities and the

lack of comprehensive legislation influence the manifestation of OV in Brazil?". These questions were elaborated according to the Population, Intervention, Comparison, Outcome (PICO) model, a versatile framework for constructing research questions in various areas[7].

The application of the PICO model offers an organized approach, allowing the formulation of research questions that direct the search for crucial information. A well-designed research question not only guides the identification of essential evidence, but also maximizes the retrieval of this evidence from databases. In addition, this method precisely focuses the scope of the research, preventing unnecessary searches and ensuring the relevance of the information collected[7].

In the methodological context, we highlight the complementarity between quantitative and qualitative approaches, as well as between objectivity and subjectivity, which should not be reduced to a simple dichotomy. It is preferable to understand them as a continuum, in which these approaches complement each other rather than oppose each other. Furthermore, the analysis of social relations, one of the main focuses of this study, must consider their totality, including more "ecological" and concrete aspects, as well as exploring their most essential meanings. In this sense, a quantitative investigation can raise questions that require a more in-depth qualitative analysis, and vice versa. Therefore, the integration of these approaches has significantly enriched the understanding of the complex and multifaceted phenomena addressed throughout this research[8-11].

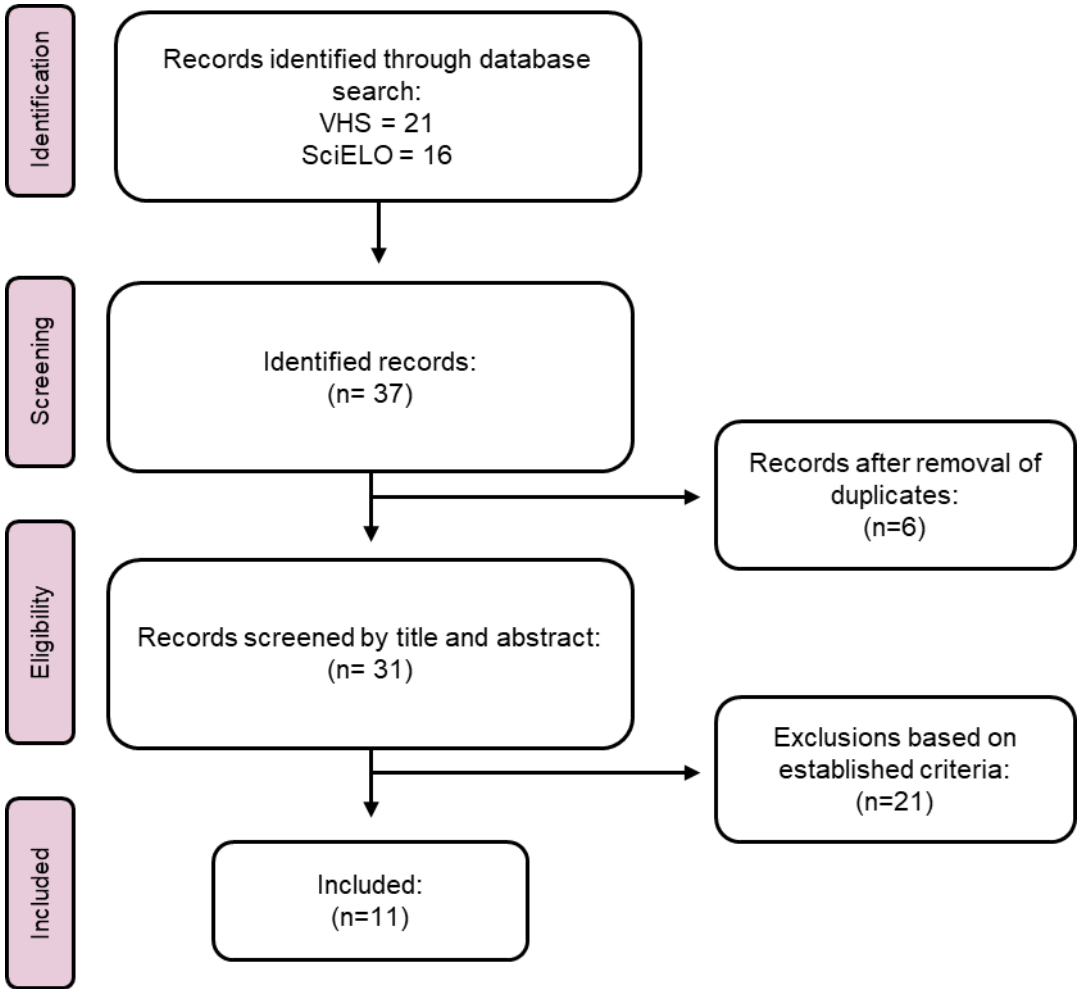
Search strategy

The research, conducted in August 2023, adopted a qualitative-quantitative and exploratory-descriptive approach to further investigate the subject. Fully available articles were included, strictly related to the scope of the study, and published in Portuguese, English or Spanish, indexed in the Virtual Health Library (VHL) and Scientific Electronic Library Online (SciELO) databases, between 2018 and August 2023. The selection of articles used descriptors from the Medical Subject Headings (MeSH), "obstetric violence" and "violence against women", combined using the Boolean operator "AND".

Studies of the clinical practice guide type were automatically excluded, as they did not contain significant qualitative or descriptive research components crucial to this review. Likewise, diagnostic, etiology and screening studies were excluded due to the lack of a substantial contribution to the narrative and exploratory review. Additionally, duplicates and studies that went beyond the proposed theme were excluded, as well as those with duplicity, considering that the focus is OV, avoiding studies linked to violence against women in the gestational phase that, although pertinent, are not align with the specific objectives outlined.

A total of 37 studies were found, 21 in the VHL and 16 in SciELO. Of these, 11 studies met the established eligibility criteria and were included in the first part of the study, which we believe was fundamental, to conducting the review. The stages in the process of selecting articles for the narrative review are shown in detail in the flowchart in Figure 1.

Figure 1. Flowchart of the selection and screening of included studies.



Source: Own authorship.

Furthermore, given the clear imperative to consult current state legislation in Brazil to identify potential local gaps, in addition to the narrative review, we conducted documentary research on the portals of the National Congress and state Legislative Assemblies. This stage aimed to identify legislative proposals, bills and debates relating to OV, using the keywords “obstetric violence”, “humanized childbirth” and “humanization of childbirth”. The state regulations were selected based on an analysis of the headings and, in the presence of multiple laws in the same state, all of them were incorporated into the survey. They were classified as follows: a) informative in nature, those that provide concepts and definitions, describing the types of conduct and their impacts; b) preventive in nature, which establish objectives aimed at preventing and combating, and may or may not indicate actions to be implemented; and c) punitive in nature, which aim to hold perpetrators of violence accountable, including health managers, clinical directors or those responsible for health establishments. The analysis of these documents complemented the study, providing an up-to-date view of the political discussions surrounding this crucial issue.

Results and Discussion

Literature review

The results showed a significant gap in the production of legal studies on OV. Of the few articles found on the subject, only two addressed specific legal issues, highlighting the lack of analysis in this field[12,13].

A detailed analysis revealed that most existing studies focus on women's reports, as well as a total lack of studies from the North and Midwest regions of the country[4]. This lack of information, as well as awareness of one is right to autonomy, is a notable and worrying aspect identified in the literature reviewed, totaling seven articles[14–20].

On the other hand, only two studies addressed the perspectives and challenges of health professionals, especially obstetricians, in relation to identifying and dealing with conscientious objection, highlighting corporatism and the ethical difficulties faced by this category[21–22].

The characteristics of the studies included in this review are remarkable, with 11 articles meeting the eligibility criteria for inclusion in this study, covering a variety of research designs, including six observational studies[12,14,15,18–20] two prognostic studies[17,21] two cross-sectional studies[16,22] and a literature review[13]. It is important to note that all the selected studies originated in Brazil, reflecting the local to the analysis of OV in specific structural contexts.

State legislation

As far as legislation is concerned, these were identified according to previously defined categories, covering informative, preventive and/or punitive nature, some of which may have a dual or triple nature, as can be seen in Table 1. It is important to note that these categories are not mutually exclusive.

Table 1. Classification of state legislation according to its nature.

States	Law	Nature of Laws		
		Informative	Preventive	Punitive
Acre	Law No. 3.169/2016	✓	✓	
Amapá	Law No. 2.713/2022		✓	
Amazonas	Law No. 4.848/2019	✓	✓	
Ceará	Law No. 16837/2019	✓	✓	
Distrito Federal	Law No. 6144/2018	✓	✓	
	Law No. 6290/2019		✓	
Espírito Santo	Law No. 11.212/2020		✓	
Goiás	Law No. 19.790/2017	✓	✓	
	Law No. 21.858/2023			

[4] The North Region has 17.3 million inhabitants, representing 8.5% of the country's total population, while the Center-West Region has 16.3 million inhabitants, corresponding to 8.0% of the national population. Women are the majority in all of Brazil's major regions, accounting for 51.5% of the population. 45.3% identify as mixed-race, 10.2% Black and 0.8% Indigenous. This discrepancy is worrying, given the significant population of these regions[9].

Maranhão	Law No. 12.188/2023	✓	✓	
Mato Grosso	Law No. 10.676/2018		✓	
	Law No. 11.492/2021		✓	
Mato Grosso do Sul	Law No. 5.217/2018	✓	✓	
	Law No. 5.568/2020	✓	✓	
	Law No. 5.491/2020		✓	
Minas Gerais	Law No. 23.175/2018	✓	✓	
Pará	Law No. 9.666/2022		✓	
Paraíba	Law No. 10.548/2015	✓	✓	
	Law No. 12.002/2021		✓	
Paraná	Law No. 19.701/2017	✓	✓	✓
Pernambuco	Law No. 16.499/2018	✓	✓	✓
Piauí	Law No. 7.750/2022	✓	✓	
Rio de Janeiro	Law No. 9.238/2021.		✓	
Rondônia	Law No. 4.173/2017	✓	✓	
Roraima	Law No. 1.378/2020	✓	✓	
Santa Catarina	Law No. 18.322/2022	✓	✓	
São Paulo	Law No. 17.431/2021	✓	✓	
Tocantins	Law No. 3.385/2018	✓	✓	
	Law No. 3.674/2020	✓	✓	

Source: Own authorship.

Of the states that have specific legislation, it was possible to find laws in states from different regions of Brazil: Northern Region (n=7) (Amazonas[23], Pará[24], Acre[25], Roraima[26], Rondônia[27], Amapá[28], and Tocantins[29,30]), Central-West Region (n=4) (Goiás[31,32], Mato Grosso[33], Mato Grosso do Sul[34-36], and the Federal District[37,38]), Northeastern Region (n=5) (Ceará[39], Maranhão[40], Paraíba[41,42], Pernambuco[43], and Piauí[44]), Southeastern Region (n=4) (São Paulo[45], Rio de Janeiro[46], Espírito Santo[47], and Minas Gerais[48]), and Southern Region (n=2) (Paraná[49] and Santa Catarina[50]). State laws were not found only in the states of Bahia, Sergipe, Rio Grande do Sul, and Rio Grande do Norte (n=4).

Regarding the use of the term "obstetric violence", 14 states employ it in the summary or text, and eight use the expression "humanization of childbirth" or "humanized childbirth". Among these, 19 laws have an informative character, 28 have a preventive character, and two have a punitive character.

Nineteen state laws that address the concepts of OV, exemplify, and describe both this form of violence and the humanization of childbirth were classified as having an informative nature. The 28 state laws of a preventive nature establish intervention and prevention actions, including the institution of days or weeks dedicated to combating OV and promoting the humanization of childbirth, as well as the requirement to post informational signs. The two punitive laws are limited to warnings and fines.

Terminology and Health Professionals' Perspective

In the literature, there is a lack of consensus regarding the terminology and definition that best represent acts of disrespect, abuse, mistreatment, and violence against women during the pregnancy and postpartum periods. The most common terms include "Disrespect and abuse during childbirth in health facilities", "Mistreatment of women during childbirth in health facilities", and "Obstetric violence"[51,52].

However, the term "obstetric violence" has faced resistance among health professionals, especially in Brazil, due to its association with the medicalization of childbirth. While some acts can be clearly identified as violence, others are related to routine medical procedures, raising questions about the ideal definition of childbirth care. This lack of consensus on the terminology and definition of these acts, coupled with the absence of a validated instrument to measure them, makes epidemiological studies complex and difficult to compare[17, 51-55].

As shown in a study by Terribile and Sartorão Filho[22] there is a difficulty associated with the use of OV terminology, with 73.9% of the participating obstetricians expressing concern about its use. Within this group, 68.9% believe that it seems inadequate, biased, and unfair. In addition, 70.5% considered that its dissemination in the media could be detrimental to the doctor-patient relationship. On the other hand, only 25.1% disagreed that its use could be harmful.

In many cases, health professionals do not identify certain behaviors as forms of OV due to factors that arise during medical education. As highlighted by Pantoja[56] teaching is formal, traditional, and individualistic, lacking stimuli to promote changes. This results in the lack of development of a deeper doctor-patient relationship, the absence of practices implemented in health units from the beginning of the course and the lack of effective contact with the community. These factors lead to the naturalization of routine or traditional practices and a lack of awareness of women's rights during childbirth, as well as a shortage of adequate training on the subject. The difficulty in accepting and recognizing this violation can create significant obstacles to the implementation of effective prevention and intervention measures[21,53,55,57].

> Currently, from the point of view of Western medicine, positivism is established as the hegemonic paradigm of knowledge, which results in increasing disciplinary specialization and fragmentation of knowledge. This model prioritizes the biological dimension of the human being to the detriment of knowledge and subjectivity, as well as separating the physical and abstract domains[56].

In addition, there are positions associated with class protectionism, in which a paternalistic perspective can be seen both in the opinion of the Federal Council of Medicine (FCM) and in the order of the Ministry of Health (MH), showing a lack of harmony with contemporary demands for women's autonomy[53,54,58]. A more humanized approach to obstetric care, considering the needs and concerns of patients, is essential, and the decision about childbirth should be shared between doctor and patient[59]. Rego[60] adds that this is the time for a medical practice based on dialog, understanding and

mutual respect, representing a significant criticism of the rhetorical and conservative approach, highlighting the need for interdisciplinary and critical bioethics.

Childbirth Care in Brazil: Between Data and Experiences

Considering the Brazilian panorama, it is pertinent to start the analysis from the perspective of women's experiences. One of the few sources available is the "Birth in Brazil" survey, conducted with 23,940 puerperal women in 266 hospitals in all the country's states between 2011 and 2012. Among the various findings of this survey, it stands out that the rate of caesarean sections in the country is more than three times higher than that recommended by the World Health Organization (WHO), reaching 51.9% in total, with 42.9% in the public sector and 87.9% in the private sector, while the ideal rate of caesarean sections should be around 15% of births[20,61–64].

Another relevant finding from the survey is that approximately 72% of Brazilian women expressed their desire for a normal birth at the beginning of their pregnancy, although less than 43% had this type of birth. This discrepancy is even more evident in the private network, where the percentage of caesarean sections reaches 90%, while in the public network it is almost 45%[20,61–64].

An analysis of more recent and specific studies conducted in different regions shows that most of them were found in the Northeast (n=3). The one conducted by Medeiros and Nascimento[18] in a Basic Health Unit (BHU) in the semi-arid region of Rio Grande do Norte revealed that most of the interviewees were not familiar with the term "obstetric violence", which made it difficult to clearly identify the violence they had suffered. However, their narratives revealed signs of negligence and OV, including the lack of a companion, painful examinations, and violation of rights.

The researchers Oliveira et al.[19] presented worrying data, revealing that all 291 women interviewed in teaching hospitals in the municipality of Maceió (AL), intended for high-risk pregnancies during 2018, were victims of at least one form of OV. These forms varied widely, both in vaginal and caesarean deliveries. Abusive practices included food and water restriction, intravenous administration of synthetic oxytocin, failure to offer non-pharmacological methods of pain relief, exposure to consecutive vaginal touches by different professionals, amniotomy, as well as total restriction of movement and change of position, trichotomy and gastric.

Anunciação et al.[14] also revisited a worrying reality for women from disadvantaged socio-economic backgrounds in São Luís (MA), characterized by low levels of education and a lack of information about available health services. One alarming aspect highlighted was the delay in care, often associated with the need to visit different health units in search of adequate assistance during labor. Negligence on the part of health professionals also emerged as a significant cause of neonatal death, indicating deficiencies in decision-making and the provision of appropriate medical care.

In the Southeast, which covers the other part of the most recent studies in the search (n=2), a similar situation can be observed, as reported by the authors Dornelas et al.[15] more specifically in the municipality of Ribeirão Preto, where 66.2% of women were exposed to situations of abuse, disrespect and mistreatment (ADM), as highlighted by the authors, who avoided using the appropriate terminology. It is noteworthy that only 8.3% of the women claimed to have perceived these situations. In this context, the violation of Federal Law No. 11.108 was also particularly evident [65] which, in its article 19, guarantees the presence of a companion with the parturient woman during the entire period of labor, delivery and immediate postpartum, in which case there is similarity with the studies by Oliveira et al.[19].

Through the “Senses of Birth” exhibition held in Minas Gerais (BH), it was possible to analyze the childbirth experiences of women who visited the event, which revealed a 12.6% OV rate, as reported by Lansky et al.[16,66]. However, it is important to note that this figure may be underestimated due to women's lack of knowledge about abusive practices. Furthermore, the difficulty in recognizing them is associated with a lack of information and a culture of submission in childbirth care. Also noteworthy is the negative influence of socioeconomic factors and marital status on reporting (Figure 2).

Figure 2. It is essential to expand the debate on birth-related issues in Brazil. Obtaining a critical analysis of the hypermedicalization of childbirth, the diminishing role of women and the commercialization of childbirth is precisely the objective proposed by the “Senses of Birth” exhibition.

Source: Sense of Birth exhibition[67].

Finally, in addition to the lack of nationwide data on traditional health practices and the conceptions of the body and health present in Indigenous and quilombola communities, the scant information available also reveals cases of harmful childbirth practices, revealing a clear example of institutional racism[68]. In this scenario, there is a misalignment between the principles of health policies, which are geared towards modern individualism, and the community and relational

perspectives of these leaders. This disparity results in biomedical interventions that do not consider the sociocultural particularities of women, damaging their health and well-being[69–72].

Legal Perspectives for Promoting Comprehensive Women's Health in Brazil

In the legal sphere, increasing access to information has played a crucial role in changing attitudes, reflected in the increase in complaints and lawsuits related to OV. Although there is a growing debate on the subject, it is still little discussed and invisible. This form of violence manifests itself at an extremely delicate time, during pregnancy and childbirth, impacting not only the rights and dignity of parturient women, but also those of the unborn child. It is important to note that the highest incidence of this type of violence occurs in public hospital environments, where the users are Black and low-income women. However, when analyzing court cases, we see that magistrates are unfamiliar with the issue, which sometimes results in the judiciary itself mitigating women's rights[5,13].

Analyzing 84 judgments from southern Brazil, the authors Schiocchet and Aragão investigated 12 judgments in their entirety. The results revealed that most lawsuits are related to civil liability and the recognition of moral damage, with an emphasis on cases involving medical professionals. Within this context, "normative stereotypes" and "persuasive definitions" were identified in various discursive categories, highlighting limitations in legal argumentation and in the coherence of the decisions evaluated.

It was noted that the absence of solid reasoning and the tendency to use these stereotypes compromises the integrity of the legal system, making it vulnerable and jeopardizing access to justice for pregnant women affected by OV. Thus, these results highlight the need for a more critical and careful approach on the part of the courts, with a view to ensuring greater consistency and fairness in decisions relating to this sensitive issue[12].

As far as state legislation is concerned, some states are lacking and that there are persistent difficulties in using the right terminology. This is often replaced by "humanization of childbirth", a concept that encompasses behaviors, procedures, actions, and knowledge aimed at the healthy development of labour and birth procedures, through respect for individuality and the promotion of women's value. However, there is a gap in the structural aspect that addresses and perpetuates OV. At the same time, there are reports of countless women who are unaware of what they have experienced during childbirth, a moment that should be experienced positively and not adversely.

There is an attempt to ensure comprehensive protection of women's health by explicitly analyzing the effort to veto Mato Grosso do Sul's Law 5.491/2020. The FCM's opinion and the MH's order were used, which define a clear form of violation, considering the "proliferation" of laws on "obstetric violence" in Brazil[54,58,60,74]. This attempt at a veto completely disregards the reports and data that have existed for years, not only in Brazil, but also around the world. For example, in Venezuela, the Ley Orgánica sobre el Derecho de las Mujeres a una Vida Libre de Violencia[77], as well as being a pioneer in recognizing the term, which has existed since 2000 in Latin America[75] also defined and described OV[76,77].

> Obstetric violence is understood as the appropriation of women's bodies and reproductive processes by health personnel, which manifests itself in dehumanizing treatment, an abuse of medicalization and pathologization of natural processes, resulting in the loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting on women's quality of life (our translation). [77]

The first country to enact legislation aimed at humanized childbirth in 2004, then also addressing OV in 2009, as a response to the alarming cases of rape against women, each with its own regulation, was Argentina. The first of these is Law 25.929/2004, known as the Humanized Childbirth Law, which establishes a series of women's rights during pregnancy, childbirth, and the postpartum period[78]. The second piece of legislation is Law 26.485/2009, which deals with gender-based violence and specifically includes OV[79]. In addition, since 2009, public policies such as Maternidad Segura y Centrada en la Familia have been implemented to improve the perinatal experience[80,81].

> Obstetric violence: is violence practiced by health personnel on women's bodies and reproductive processes, manifested in inhumane treatment, an abuse of medicalization and pathologization of natural processes, according to Law 25.929. [79]

In Mexico, the Ley General de Acceso de las Mujeres a una Vida Libre de Violencia[82] effective since 2007, operates at federal level[5]. However, it lacks a specific mention of OV, and there is currently a bill in the process of being signed into law, a situation which is like that in Brazil. It is important to note that the support of midwives was fundamental in promoting changes in obstetric care in response to social concerns about this specific form of violence. This movement highlighted patterns of structural violence that influenced medical practices and attitudes towards women. Many doctors, in collaboration with midwives and activists, recognized the need for reforms in hospital systems that impact the treatment of women[80,83].

Thus, at the national level, an analysis of current Brazilian legislation reveals a fragmented approach to OV, highlighting the lack of a precise definition and specific preventive measures. Although the Brazilian Penal Code contains provisions applicable to cases of OV, such as physical and verbal aggression that can occur during childbirth, there is a lack of precise delimitation of the concept.

On the other hand, although some states have specific legislation, either to deal with OV or to promote the humanization of childbirth, there is a diversity of approaches to maternal health and childbirth care. Often, these regulations do not fully meet women's needs. While recognizing the importance of these measures, there is a notable lack of complementation in several of them, which do not adequately consider regional specificities, especially in relation to indices and inequality in the distribution of health services, as well as insufficient ongoing training and professionals who are still protected by corporate interests, rather than being aligned with contemporary demands for comprehensive women's health.

For more than two decades, Brazil has been neglecting the issue since the situation is already recognized as a public health problem. Bill 2373/2023[84] is pending in the Chamber of Deputies as a current attempt to deal with this issue. However, since 2014, Bill 7633/2014[85] has been stalled since 2014, showing a decade of delay in Brazilian legislation to address harmful childbirth practices. However, for it to become an effective agenda, it is necessary to involve a considerable number of actors, making its concept intersubjective. This integration is fundamental to establishing a clear definition of harmful childbirth practices and implementing effective public policies to prevent them [17].

[5] Additionally, among the 10 federated states in Mexico that have legislation on gender-based violence against women, only three of them classify OV: Chiapas, Veracruz, and Guerrero.

This aspect is essential not only to prevent the rape and death of women and children daily in Brazil. This is exemplified by the case of Alyne Pimentel, a young Black woman, poor and a mother, who suffered a preventable maternal death due to complications in her delivery, which took place in an institution affiliated with UHS. Her complaint was the first on maternal mortality to be recognized by the Committee on the Elimination of all Forms of Discrimination Against Women (CEDAW) of the United Nations (UN). In addition, it is crucial to repair the damage caused by the violation of the rights to health and access to justice[86,87].

Medicalization of Childbirth: Reflections on Power and Gender

Medicine, by holding what Jordan[88] defines as "authorized knowledge", has the power to regulate the lives of human beings from the moment of birth, as highlighted by Foucault[89]. In this process of determining which bodies need medical care and which situations and people can be considered normal, it directly contributed to the dissemination of the idea, during the 20th century, that childbirth is in all cases a medical event, requiring continuous monitoring and professional intervention, which is known as medicalization[90,91].

Medicalization is influenced by gender stereotypes ingrained in society, especially in patriarchal contexts, in which control over women's sexuality and reproduction is crucial to their subordination[90,92]. In this context, growing evidence indicates that misogynistic and sexist attitudes among health professionals directly affect the quality of care, reflecting gender stereotypes that shape medical practices, especially in obstetrics[93,94].

Medical discourse, with its institutional power to regulate life and define concepts of health and illness, reflects the underlying power structures. Just as in Foucault's vision[95] where power is conceived as a network of devices and relationships that manifest themselves in various social contexts, including the fields of medicine and health. In this context, obstetric power-knowledge, which shapes practices and discourses on childbirth and perinatal care, can be seen as an expression of biopower, in which control and regulation is exercised over women's lives during the process of pregnancy and childbirth. In this way, established reproductive hierarchies and the dominant model are maintained[96].

These practices are not just isolated cases, but part of a system of power that reproduces differentiated bodies. Marginalized women are particularly vulnerable to this violence, not as a side effect, but as a constitutive aspect of the phenomenon. The Foucauldian view challenges the idea that power is only exercised in a coercive and explicit way, highlighting its more subtle and internalized manifestations, which influence women's perception of their bodies and reproductive rights[95,96].

Thus, by framing OV within this conceptual framework, we can understand how it is rooted in asymmetrical power relations and knowledge systems that shape and control women's bodies during the process of pregnancy and childbirth. In childbirth care, medical authority often invalidates women's knowledge of their own bodies, determining when labor begins and controlling the process in a hierarchical way.

Final Considerations

The lack of consensus on the definition and terminology of OV, combined with the difficulties faced by health professionals, results in the normalization of habitual and obsolete practices. This highlights a lack of awareness of women's rights during childbirth, along with little training on the

subject, which can make it difficult to implement effective prevention and intervention measures. Therefore, a medical transition based on dialog, understanding, and mutual respect is fundamental to meeting the contemporary demands of OV.

In addition, the hegemonic structural process of knowledge in Western medicine, which prioritizes the biological dimension to the detriment of women's subjectivity and experience, maintains a remarkably paternalistic resistance and perspective, misaligned with female autonomy and the need for a more humanized approach in obstetric care.

Regarding the available data, there is a high rate of caesarean sections, often performed without clinical need, along with difficulties in identifying situations of OV and a scarcity of studies on quilombola and Indigenous women. The prevalence of these practices is intrinsically linked to issues of race, gender, and social class, the latter being an aggravating factor in women's exposure to this type of violence. However, the determination of the social position of parturient women is currently the result of a historical process in which gender and race have been used as a basis for social stratification.

In the legal context, despite the increase in complaints and lawsuits related to these practices, there is a lack of understanding and knowledge on the part of magistrates, which can compromise the integrity of the legal system and harm women's rights.

When examining existing state legislation, one notices a fragmented bias towards OV, with not all states having precise definitions and specific preventive measures. This further highlights the urgency of a clear definition and effective public policies for its prevention. These measures aim not only to prevent cases like that of Alyne Pimentel and countless women whose names remain unknown, but also to repair the damage caused by the violation of the rights to health and access to justice.

In short, the fight against OV requires a multidisciplinary and intersectoral approach. Only through recognition, awareness-raising, and collective action will it be possible to guarantee safe childbirth care centered on women's needs and rights.

Conflict of interest
The authors declare that there is no conflict of interest.

Authors' contribution
Pantoja CJ played an integral role in the conception, analysis, interpretation, writing and critical revision of the article's content, culminating in the approval of its final version. Batisti MB played a role in the analysis, interpretation, writing and critical revision of the article's content, culminating in the approval of its final version. Pereira MCAR played an integral role in the conception, analysis, interpretation, writing and critical revision of the article's content, culminating in the approval of its final version.

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