FIOCRUZ | Brasília

Cadernos Ibero-Americanos de Direito Sanitário
Cuadernos Iberoamericanos de Derecho Sanitario

ISSN: 2358-1824

Article

Between educational booklets and reporting channels: the role of Brazilian State Public Defender's Offices in addressing obstetric violence

Entre cartilhas e canais de denúncia: a atuação das Defensorias Públicas Estaduais brasileiras frente à violência obstétrica

Entre cartillas educativas y canales de denuncia: la actuación de las Defensorías Públicas Estatales brasileñas frente a la violencia obstétrica

Milena de Almeida Bittencourt Fondello[1]
Conselho Municipal de Saúde, Pindamonhangaba, SP, Brazil.
https://orcid.org/0009-0008-5042-596X
milenafondello@usp.br

Fabiana Santos Lucena[2]
Instituto de Saúde, São Paulo, SP, Brazil.
https://orcid.org/0000-0002-3928-1300
fabiana.lucena@isaude.sp.gov.br

Rita Kawana Duarte Queiroz[3]
Pontifícia Universidade Católica de São Paulo, São Paulo, SP, Brazil.
https://orcid.org/0009-0000-9139-8752
rita.kawana@gmail.com

Anna Carolina Lanas Soares Cabral[4]
Defensoria Pública do Estado de São Paulo, São Paulo, SP, Brazil.
https://orcid.org/0009-0000-9064-0578
acabral@defensoria.sp.def.br

Abstract

Objective: to describe and analyze the role of Brazilian State Public Defender's Offices in addressing obstetric violence, focusing on the production of educational materials, the availability of specific reporting channels, and the presence of Specialized Centers for the Promotion and Defense of Women's Rights. **Methodology:** this qualitative, documentary research was conducted through the analysis of official websites of State Public Defender's Offices. **Results:** specialized Centers were identified in 18 Public Defender's Offices and, in five others, equivalent structures with similar functions. Among the 27 federal units, 11 provide informational booklets on obstetric violence, mostly

[1] Master's student in Nursing in Primary Health Care in the Unified Health System, Universidade de São Paulo, São Paulo, SP, Brazil. Municipal Health Councillor, Conselho Municipal de Saúde, Pindamonhangaba, São Paulo, SP, Brazil.
[2] Ph.D in Public Health, Universidade de São Paulo, São Paulo, SP, Brazil. Scientific researcher, Instituto de Saúde, São Paulo, SP, Brazil.
[3] Graduated in Psychology, Pontifícia Universidade Católica de São Paulo, São Paulo, SP, Brazil.
[4] Master in Philosophy, Pontifícia Universidade Católica de Valparaíso, Valparaíso, Chile. Diploma revalidated by the Universidade de São Paulo, São Paulo, SP, Brazil. Psychologist, Public Defender Agent, Defensoria Pública do Estado de São Paulo, São Paulo, SP, Brazil.

concentrated in states with these Centers, suggesting that their presence contributes to the production and dissemination of educational materials on the subject. The thematic gaps in these publications — rarely addressing abortion or institutional racism — reveal persistent challenges in understanding the structural dimensions of obstetric violence and in formulating effective institutional responses. Experiences such as the State Committee for Confronting Obstetric Violence in Amazonas and the Protocol for Action in Cases of Obstetric Violence in Paraná illustrate distinct yet complementary approaches to strengthening qualified listening, intersectoral collaboration, and data production. **Conclusion:** the role of State Public Defender's Offices in addressing obstetric violence remains under construction. The findings highlight the importance of expanding institutional visibility of the issue and strengthening listening and accountability mechanisms to ensure a State response to one of the most persistent forms of women's rights violations.
Keywords: Obstetric Violence; Public Defender Legal Services; Public Health; Women's Health; Reproductive Rights.

Resumo

Objetivo: descrever e analisar a atuação das Defensorias Públicas Estaduais brasileiras no enfrentamento à violência obstétrica, a partir da produção de materiais educativos, da oferta de canais específicos de denúncia e da presença de Núcleos Especializados de Promoção e Defesa dos Direitos das Mulheres. **Metodologia:** trata-se de uma pesquisa qualitativa, de caráter documental, realizada nos sites oficiais das Defensorias Públicas Estaduais, buscando identificar documentos de natureza institucional que tratem do enfrentamento da violência obstétrica. **Resultados:** verificou-se a existência desses Núcleos Especializados em 18 Defensorias Públicas e, em outras cinco, estruturas com atribuições semelhantes. Dentre as 27 unidades da federação, 11 disponibilizam cartilhas sobre violência obstétrica, concentradas nas Defensorias que possuem Núcleos Especializados, sugerindo que a presença desses núcleos contribui para a produção e a divulgação de materiais informativos sobre o tema. As lacunas temáticas dessas publicações — que raramente tratam de situações de abortamento ou de racismo institucional — revelam desafios persistentes na compreensão de dimensões estruturais da violência obstétrica e na formulação de respostas efetivas. Experiências como o Comitê Estadual de Enfrentamento à Violência Obstétrica no Amazonas e o Protocolo de Atuação em Casos de Violência Obstétrica do Paraná ilustram caminhos distintos e complementares de fortalecimento da escuta qualificada, da articulação intersetorial e da produção de dados. **Conclusão:** a atuação das Defensorias Públicas Estaduais no enfrentamento à violência obstétrica permanece em processo de construção. Os achados indicam a importância de ampliar a visibilidade institucional do tema e de fortalecer mecanismos de escuta e responsabilização do Estado frente a uma das mais persistentes formas de violação de direitos das mulheres.
Palavras-chave: Violência Obstétrica; Defensoria Pública; Saúde Pública; Saúde da Mulher; Direitos Sexuais e Reprodutivos.

Resumen

Objetivo: describir y analizar la actuación de las Defensorías Públicas Estatales brasileñas en el abordaje de la violencia obstétrica, considerando la producción de materiales educativos, la oferta de canales de denuncia y la existencia de Núcleos Especializados de Promoción y Defensa de los Derechos de las Mujeres. **Metodología:** investigación cualitativa y documental, realizada mediante el análisis de los sitios web oficiales de las Defensorías Públicas Estatales. **Resultados:** se identificaron Núcleos Especializados en 18 Defensorías Públicas y, en otras cinco, estructuras con funciones semejantes. Entre las 27 unidades federativas, 11 cuentan con cartillas informativas sobre violencia obstétrica, concentradas en aquellas con Núcleos Especializados, lo que sugiere que su presencia favorece la producción y difusión de materiales educativos. Las lagunas temáticas de estas

publicaciones — que raramente abordan situaciones de aborto o racismo institucional — evidencian desafíos persistentes en la comprensión de las dimensiones estructurales de la violencia obstétrica y en la formulación de respuestas institucionales. Experiencias como el Comité Estatal para el Enfrentamiento de la Violencia Obstétrica en Amazonas y el Protocolo de Actuación en Casos de Violencia Obstétrica en Paraná ilustran caminos distintos y complementarios para fortalecer la escucha cualificada, la articulación intersectorial y la producción de datos. **Conclusión:** la actuación de las Defensorías Públicas Estatales frente a la violencia obstétrica sigue en construcción. Los hallazgos destacan la importancia de ampliar la visibilidad institucional y de reforzar los mecanismos de escucha y rendición de cuentas del Estado ante una de las formas más persistentes de violación de los derechos de las mujeres.
Palabras clave: Violencia Obstétrica; Defensoría Pública; Salud Pública; Salud de la Mujer; Derechos Sexuales y Reproductivos.

Introduction

The term obstetric violence was first used conceptually and legally in Venezuela in 2006[1] and, just as it has been used in Brazil, it describes various forms of violence that occur during pregnancy, childbirth and the puerperium, as well as in moments related to abortion situations[2]. Its occurrence has an impact on maternal and neonatal morbidity and mortality, and is imbricated in hierarchical power relations between health professionals and service users, manifesting itself through unnecessary, coercive or humiliating practices, with direct consequences for women's physical and psychological integrity. It's important to note that, although it goes by other names, such as mistreatment during pregnancy and childbirth, it's a phenomenon that happens to women all over the world[2] not just in Latin American countries, and is considered a violation of human rights.

In Brazil, despite the growing mobilization of users, professionals and researchers, obstetric violence still faces institutional resistance to being recognized as a form of gender violence and a violation of sexual and reproductive rights[3]. Part of this resistance is related to disputes over the terminology itself: the use of the term “obstetric violence” is often contested by health sectors, especially due to its critical association with the excessive medicalization of childbirth[3]. Although certain acts are clearly identifiable as abusive, others are confused with routine medical procedures, making it difficult to define the boundaries between acceptable practices and violations of rights[3].

Obstetric violence can manifest itself in various ways, affecting the experience of childbirth and the physical and emotional integrity of women. Its main categories include: the delay, refusal, neglect or omission of care; the imposition of interventions without consent; interventions carried out on the basis of partial or distorted information; the absence of confidential or private care; verbal and psychological violence; arbitrary restrictions on the presence of a companion during childbirth; and the refusal of pain relief measures. These different types of violence reveal not only individual failings, but also institutional patterns that compromise respect for women's rights and the humanization of obstetric care[4].

In 2010, a survey was carried out by the Perseu Abramo Foundation which showed that one in four women had suffered some kind of violence during childbirth, among the most frequent being: painful touch examinations; not receiving pain relief; shouting; procedures carried out without informing the woman; name-calling and humiliation[5]. The Birth in Brazil 2 survey, in 2025, published results for the state of Rio de Janeiro, indicating an alarming prevalence of 65.3% of obstetric violence, with emphasis on inadequate vaginal touch (46.2%), negligence (31.5%) and psychological abuse

(21.7%)[6]. Despite the relevance of these findings, we still don't have up-to-date national data revealing the real extent of rights violations during pregnancy, childbirth, the puerperium and in abortion situations.

Obstetric violence is configured as structural and collective violence, rooted in a social order that legitimizes oppression and manifests itself in multiple forms, affecting not only women and newborns, but also intersex people, trans men, non-binary people and people with other gender identities, who are exposed to discrimination and violence from the first contact with health services[7]. It is important to note that the context of obstetric violence is embedded in a model of care marked by excessive interventions, often detached from the best scientific evidence that should guide care practice. Childbirth care remains strongly centered on medical authority, with little appreciation of physiology and women's role. There is often rigid control of time and the imposition of dynamics that disregard the individual rhythms of labor and childbirth, which contributes to the production of institutional violence and violations of rights[8].

Diniz[9] coined the expression “Brazilian perinatal paradox” to describe a central characteristic of obstetric care in the country: the coexistence of two forms of obstetric violence, which manifest themselves in different ways depending on race, social class and territory. On the one hand, white, urban, middle-class women are often subjected to an excessive use of reproductive technologies, such as caesarean sections scheduled without clinical indication, early inductions and interventions that disrespect the physiological timing of childbirth. On the other hand, black and more socially vulnerable women more often face neglect, omission of care, refusal of analgesia and authoritarian practices such as shouting, threats, humiliation and/or procedures carried out without consent.

It is, therefore, a system that, far from selectively protecting some bodies, systematically violates the integrity and autonomy of all, even if it does so in different ways. Obstetric violence, in this context, is not limited to intentional acts of cruelty, but is inscribed in the way the system organizes childbirth care in a hierarchical, exclusionary and technocratic way. The “paradox” shows that both hypermedicalization and abandonment are complementary expressions of care focused on controlling the pregnant body and erasing reproductive desires and rights. Thus, institutional accountability cannot be limited to the ethical-professional field, but must also be confronted on a legal level as a violation of fundamental human rights[9].

It is necessary to draw attention to some of the care indicators of this model of childbirth care, in which we reached the mark of 60.6% of cesarean sections for the first time in 2024[10]. This model of care has contributed to the persistence of high and stagnant maternal morbidity and mortality rates in Brazil over the last two decades. Between 2000 and 2019, around 8,300 women died every 5 years as a result of complications related to pregnancy and childbirth, which corresponds to a Maternal Mortality Ratio of 57.3 per 100,000 live births[11]. Maintaining this high level of preventable deaths is not only a serious public health problem, but also a violation of fundamental rights, especially women's rights to life, health and dignity.

Characterized by practices that violate human rights, obstetric violence goes beyond the limits of the health field and requires specialized responses from the justice system. Public Defenders' Offices are autonomous institutions of important importance and express the duty of the state to promote and guarantee rights, offering legal advice and judicial or extrajudicial defense, especially to vulnerable populations, in a comprehensive and free manner. With the capacity to receive complaints and promote structural changes, these institutions play a strategic role in tackling this serious public health problem.

Their work can play a decisive role in preventing and breaking the cycle of silencing and impunity that has historically marked this type of violence[12].

In some Brazilian states, the "Specialized Centers for the Promotion and Defense of Women's Rights (NUDEM)" stand out as internal sectors of the State Public Defender's Offices which are spaces for promoting women's rights and confronting the various forms of gender-based violence. Their main lines of action include offering legal advice, receiving complaints and liaising with the health care network, as well as carrying out rights education activities for women, students and health professionals, and producing information materials[12]. However, although these actions have the potential to strengthen more integrated and effective protection networks, their actual implementation still faces institutional limitations and territorial inequalities, which compromises the reach and effectiveness of these initiatives[13]. There are still few studies analyzing how the Ombudsman's Office has acted to combat obstetric violence and, above all, whether this action has been consolidated as an effective instrument for guaranteeing women's rights[14].

The aim of this article is to describe and analyze the actions of the Brazilian State Public Defender's Offices, through the Centers for the Promotion and Defense of Women's Rights (NUDEM), in confronting obstetric violence, focusing on the production of educational materials and the availability of specific reporting channels, based on an analysis of the content published on their official websites. The aim is also to understand whether the information provided is accessible to the general public and whether it guides women and society on this type of violence - including content on forms of prevention, reporting channels, seeking support and access to justice.

Methodology

This is a documentary study based on the official websites of the Brazilian State Public Defenders' Offices. The source and object of investigation were the published documents themselves, understanding them as constitutive and constituted of a given historical moment[15].

The search was carried out between July 4 and 23, 2025, using the terms "NUDEM", "Specialized Centers", "Women's Defense Center" and "obstetric violence". The survey was conducted by two researchers, with subsequent cross-checking of the data collected.

Only documents of an institutional nature were considered, published on the official websites of the State Public Defender's Offices and with authorship explicitly identified as institutional. These materials covered both general information on obstetric violence and guidance on reporting channels. All the content selected was systematized in a spreadsheet containing the state or federal unit, the existence of a NUDEM, the link to access the NUDEM, the results of the search for the term "obstetric violence", as well as information documents and reporting channels.

The study takes obstetric violence not only as an object of investigation, but also as an analytical category, supported by critical literature from the fields of public health, human rights and gender studies. From this perspective, obstetric violence is understood as an expression of inequalities of gender, class and race, and of the asymmetries of power present in society, which are reflected in obstetric care[4,7,9]. This concept constituted the theoretical framework that guided the interpretation of the documents, in dialog with national and international productions on the subject.

The data was analyzed using the thematic analysis approach proposed by Minayo[15] involving the stages of floating reading, constitution of the corpus, formulation of hypotheses, exploration and interpretation of the material. The recording units were coded and organized into thematic categories.

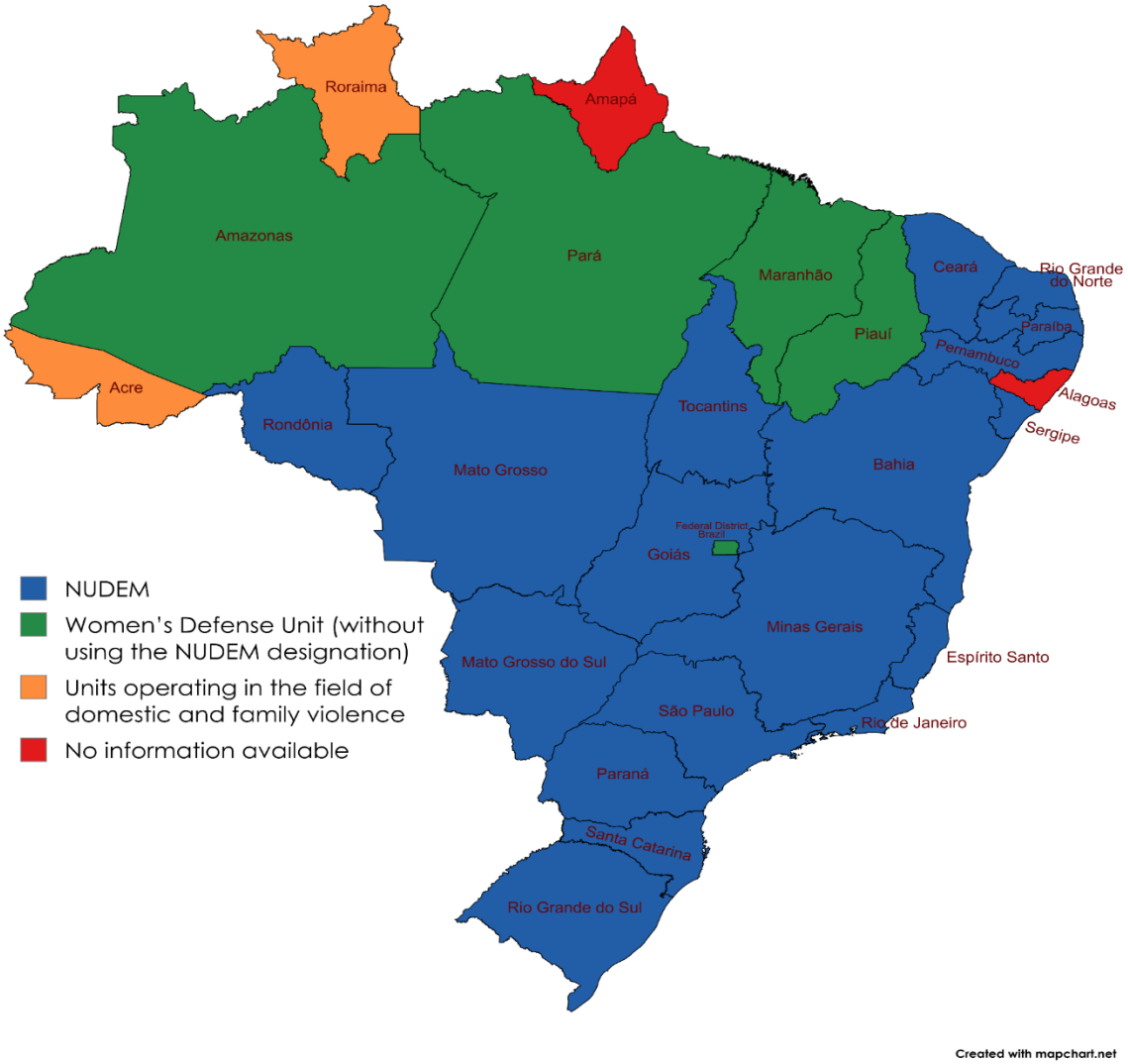
As this is documentary research based on information in the public domain, there was no direct involvement of human beings and no need to submit the study to the Research Ethics Committee. Even so, the ethical principles set out in Resolution 510/2016 of the National Health Council were observed[16].

Results and discussion

This section seeks to analyze the actions of the State Public Defenders' Offices in promoting and defending women's rights and, specifically, combating obstetric violence, based on the documents published on their official websites.

Figure 1 shows the distribution of State Public Defender Offices according to the existence of Specialized Units for women's rights, including variations in nomenclature and related areas of activity. It can be seen that most of the Defender Offices have these structures formally set up. No information was found on the existence of Specialized Units in Amapá and Alagoas. The states of Acre and Roraima, on the other hand, have centers focused on domestic and family violence, but it is not clear whether these structures have a specific gender focus or whether they include other vulnerable populations, such as the elderly, children and adolescents.

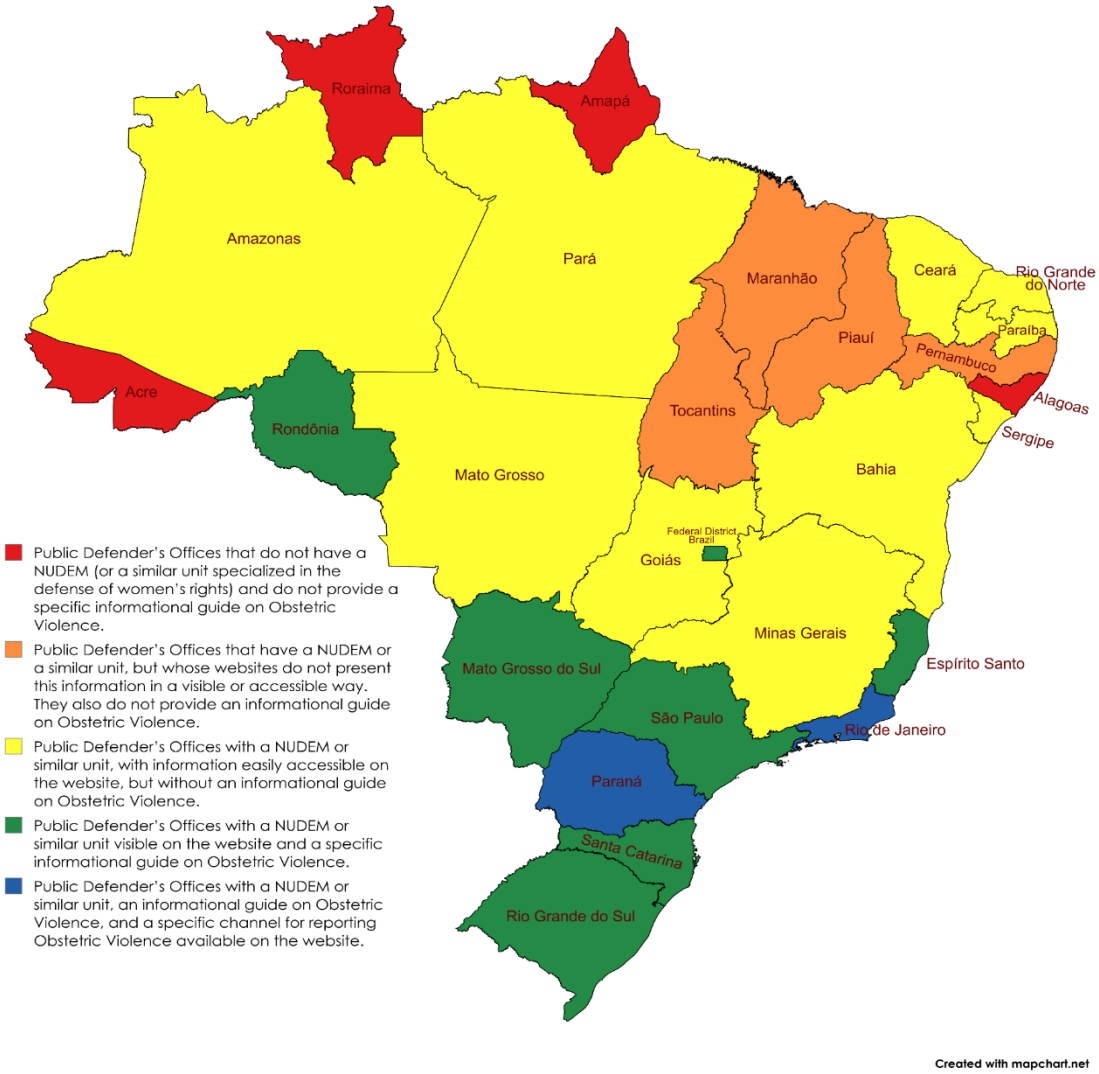
Figure 1. Presence of Specialized Centers for Women's Rights in the Public Defender's Offices in the units of the federation



Source: Own elaboration, 2025.

Figure 2 deepens this analysis by relating the presence of specialized centers to the existence of information materials and channels for reporting obstetric violence. The mapping considered three main aspects: (i) the presence of NUDEM - or equivalent structure - with information accessible on institutional websites; (ii) the availability of information booklets on obstetric violence; and (iii) the existence of a specific channel for complaints. Based on the combination of these three aspects, five institutional arrangements were defined which reveal important disparities in the work of public defenders' offices, as described in the figure.

Figure 2. Presence of Specialized Women's Rights Units in Public Defenders' Offices and booklets on obstetric violence in the federative units.



Source: Own elaboration, 2025.

Among the 26 states and the Federal District, only 11 federal units (Rondônia, Bahia, Mato Grosso, Mato Grosso do Sul, Federal District, Espírito Santo, Rio de Janeiro, São Paulo, Paraná, Santa Catarina and Rio Grande do Sul) have both an identifiable specialized unit and specific information materials on obstetric violence. In the states that do not have centers for the defense of women's rights - such as Acre, Roraima, Amapá and Alagoas - no booklets or educational materials on the subject were identified. Similarly, in the Ombudsman's Offices whose websites do not provide accessible information about these centers (the case of Maranhão, Piauí, Tocantins and Pernambuco), no specific publications on the subject were identified either.

Across the country, only the Public Defender's Offices of Rio de Janeiro and Paraná provide specific reporting channels for cases of obstetric violence, both on their websites and in their booklets. In the others, the guidelines are limited to the Public Defender's Office, the Medical or Nursing Councils, or the national reporting numbers (180 and 136), which demonstrates the lack of proper institutional reception and referral flows for these cases.

One wonders to what extent the absence of NUDEM - or equivalent formally constituted bodies - weakens the role of the Public Defender's Office in promoting and defending women's rights. This institutional gap can also compromise the ability to confront obstetric violence, since the lack of specialized centers tends to limit the provision of specific mechanisms for receiving and reporting complaints and reduce the visibility of the issue.

Obstetric violence as an expression of the hegemonic childbirth care model

The hegemonic model of childbirth care was consolidated in the 20th century, based on transformations in the social and medical meaning of the pregnant and parturient body, based on medical-surgical, male and hospital obstetrics, which was established based on the conception that women's bodies were naturally defective and therefore needed correction. This logic, anchored in the centrality of the figure of the doctor - conceived as the one who “saves” women from the supposed risks of pregnancy - legitimized the introduction of practices and instruments of intervention which, to a large extent, were built on experimentation on women's bodies in a context of social subalternity[17]. These practices, in addition to lacking scientific backing, often result in physical and emotional damage, interfering with the physiological course and the role of women during the labor process, as described in Table 1[4].

Table 1. Harmful childbirth care practices and associated reasons

Harmful or ineffective practices	Reason
Routine intravenous infusion in labor/ Routine prophylactic venous catheterization.	Decreases mobility, “binds” the parturient to the bed. Increases discomfort. Glucose solution can increase the possibility of neonatal hypoglycemia.
Indiscriminate use of oxytocin	Can lead to increased uterine activity with consequent fetal hypoxia. Oxytocin alone does not reduce the possibility of caesarean section in women with epidural analgesia.

Amniotomy to speed up labor	Amniotomy alone seems to reduce the duration of labor, but increases the possibility of caesarean section.
Lithotomy position (gynaecological examination position)	Vertical positions, unlike horizontal positions such as the lithotomy position, reduce labor time and are not associated with increased interventions or negative effects. The benefits of the upright position for woman and fetus are well described.
Episiotomy	Increases the risk of third and fourth degree perineal laceration, infection and hemorrhage, without reducing long-term complications of pain and urinary and fecal incontinence. Its routine use is constantly being discouraged.
Kristeller maneuver	Associated with severe perineal lacerations and neonatal ICU admission for the baby. It should be avoided.
Food and water restriction	Prolonged restriction can lead to discomfort for the parturient. It is recommended that women be free to ingest liquids and other light foods during labor.
Restricting body movements	Makes it harder to cope with pain. Increases the chance of needing analgesia. Increases the chance of caesarean section. Increases the duration of labor.
Preventing the presence of a companion	The presence of a companion is highly protective against all forms of violence during hospitalization.

Source: Tesser et al. [4].

The excess of interventions cannot be understood only as a technical evolution, but as a product of power relations crossed by gender. The constitution of modern medical knowledge was linked to the marginalization and disqualification of women's knowledge. The exclusion of women's knowledge in childbirth care dates back to the witch-hunt period, when there was a systematic persecution of those who held ancestral and medicinal knowledge. Midwives and healers were progressively marginalized and women, stripped of their leading role, were subjected to the exclusive care of medicine[17].

Davis[18] also shows that this logic is inseparable from racism, by showing how obstetric care hierarchizes bodies and reserves for black women experiences marked by greater violence and risk. Thus, gender and race appear as structuring dimensions of society and of biomedical rationality itself.

Health training institutions have played a central role in reproducing this model, based on the logic of teaching about bodies, in which the need to train procedures takes precedence over women's autonomy and integrity, naturalizing violations of rights in the name of professional training[19].

This same hegemonic framework has structured the justice system, whose legal interpretations of childbirth care have been shaped by inequalities in gender relations and a biomedical understanding of obstetric care. Thus, complaints of obstetric violence are part of an institutional framework that not only reproduces the invisibility of violations, but also reinforces the selectivity of which bodies are (or are not) recognized as worthy of protection, favoring impunity and contributing to the naturalization of violence in the judicial sphere.

In Brazil, the absence of legislation that defines or typifies obstetric violence means that its reparation depends on general provisions of the legal system, such as the Civil Code, the Federal Constitution and the Consumer Defense Code, requiring proof of guilt - negligence, recklessness or malpractice. Despite academic efforts - exemplified in Table 2, proposed by Tesser et al.[4] which seeks to delimit the understanding of obstetric violence based on corresponding rights - a legal gap persists which reinforces the invisibility of this form of violence. The absence of a definition not only makes it difficult to recognize the violation, prove the damage and hold the agents involved accountable, but also restricts the formulation and implementation of effective public policies to prevent and deal with it, contributing to the maintenance of impunity and the silencing of victims[20,21].

Table 2. Examples of obstetric violence by category and corresponding right

Category	Corresponding right	Examples of situations of obstetric violence
Delay, refusal, negligence or omission of care	Right to health, timely and comprehensive access (CF/88, art. 196; PNAISM, 2004)	Unjustified delay, refusal or omission of emergency care, including abandonment or negligence in assisting the parturient woman, lack of adequate monitoring and disregard of signs of maternal or fetal distress, even in the face of repeated requests.
Imposition of non-consented interventions; interventions	Right to autonomy and free and informed consent (Law	Episiotomy performed on women who have not verbally

accepted on the basis of partial or distorted information	No. 8.080/90; Companion Law No. 11.108/2005)	or in writing consented to this intervention; disrespect or disregard for the birth plan; use of the Kristeller maneuver; imposition of the lithotomy position.
Non-confidential or private care	Right to confidentiality and privacy	Maternity hospitals that maintain collective labor wards, often without a screen separating the beds, and which also claim a lack of privacy to justify disrespecting the right to a companion.
Verbal and psychological violence	Right to dignity, respect and psychological integrity (CF/88, art. 1, III; Maria da Penha Law)	Disrespectful forms of communication with women, such as underestimating and ridiculing their pain or demoralizing their requests for help; sexual humiliation, swearing, shouting, intimidation and threats.
Arbitrary restrictions on the presence of a companion	The right to a companion of one's choice during the entire period of hospitalization (Law No. 11.108/2005)	Prevent the entry of a companion; allow only at specific times.
Refusal of pain relief	Right to access methods of analgesia and humanized care	Deny available pharmacological analgesia; prohibit non-pharmacological methods of pain relief, such as bathing or movement.

Source: Adapted from Tesser et al. [4]

A study published in 2024, with the aim of understanding the criteria used in second-degree court decisions to reject or accept cases related to obstetric violence, identified that the vast majority of court decisions are only found using the search term medical error, and of 174 cases, only 15 have the term obstetric violence in their records. The study also shows that less than half of these (76 cases) were upheld, resulting in hospitals and health professionals being held responsible. Even in cases that resulted in fetal or maternal death, compensation was not guaranteed[20].

Another study that analyzed the position of the judiciary in five court decisions handed down between 2019 and 2020, related to obstetric violence, revealed a reproduction of the naturalization of this practice by the judicial system. In all the cases analyzed, the appeals were dismissed, based on judgments based on expert reports drawn up by medical professionals and documents produced by health services[22]. This trend highlights the difficulty of legally recognizing obstetric violence and the persistent legitimization of practices that often perpetuate women's vulnerability in this context[20,22].

The case of Alyne Pimentel, a young black woman from the periphery who died after successive negligent obstetric care, is an emblematic illustration of this logic. Faced with the ineffectiveness of Brazilian justice mechanisms, the case was judged internationally and recognized by the Committee for the Elimination of Discrimination against Women (CEDAW) as a human rights violation, resulting in recommendations to the Brazilian state to confront maternal mortality as an expression of structural inequalities and to take responsibility for its prevention[23]. In response to this history and the persistence of inequalities in obstetric care, in 2024 the federal government restructured the Stork Network, a policy aimed at maternal and child care, which was renamed the Alyne Network - in honor of the victim and as a symbolic gesture to reaffirm the state's commitment to reducing maternal mortality, especially among black women[24]. It is therefore understood that obstetric violence and the judicial response to it are historical products of the way in which obstetrics and the justice system have been consolidated in a society marked by gender inequalities, structural racism and a state which, as part of the capitalist system, has functioned more as a support for established institutions than as an effective guarantor of women's rights. Transforming the training of health and legal professionals, putting pressure on the legal system and building public policies that give visibility to obstetric violence are stages in an ongoing process of struggle, in which the mobilization of women's movements has been fundamental in challenging hegemonic structures and opening up paths to change.

The role of the Women's Movement in advancing innovative proposals

Although more strongly affected by racial inequality, the invisibility of obstetric violence affects women in all their diversity. This scenario is evident in different spaces of denunciation and demand organized by feminist movements. One example was the public hearing held in 2015 in the state of Amazonas, where several women recounted their experiences of pain, suffering and negligence during care. At the end, one of the representatives at the table said that it was not possible to identify any women in the auditorium with sequelae related to obstetric violence. This statement makes explicit the invisibility and contempt faced by women during their reproductive lives[25].

Paradoxically, this same hearing resulted in an innovative experience: the creation, in 2016, of the Committee to Combat Obstetric Violence of the Public Defender's Office of the State of Amazonas. The committee arose from the complaint of a user of the health system, who not only reported the violence she had suffered, but also mobilized other women and members of the local social movement. This complaint revealed a scenario of systematic obstetric violence in Manaus and led to the immediate opening of an administrative process to investigate the facts[25].

From this mobilization, relevant institutional actions were triggered, such as the signing, in 2016, of an Intersectoral Technical Cooperation Agreement, which involved justice system bodies, health institutions, universities, trade associations and social movements, showing the broad and plural articulation around the fight against obstetric violence[25].

Currently, the Committee is still active, and its actions include guiding training processes in the health sector, improving care in maternity hospitals and promoting education and social awareness activities on obstetric violence. It is, therefore, an inspiring initiative, with the potential to be replicated in other units of the federation, as a model of articulated confrontation, committed to the defense of women's rights [25,26].

Also, as an offshoot of the Committee's actions, the Amazonas State Public Defender's Office launched the "Vigilância da Violência Obstétrica – Vivo+"[27] project in 2024. in partnership with the State Health Department and the Health Surveillance Foundation. The initiative aims to produce data on obstetric care, with a view to supporting improvements in the services provided and the implementation of public policies. After giving birth and while still in hospital, women are invited to fill in a form with questions about the care they received. The project was developed in response to the under-reporting of complaints identified through the Committee's work.

This experience shows how institutional action can be driven by the pressure and articulation of the women's movement, which has played a central role in making obstetric violence visible in different contexts. In Brazil, as in several other countries, complaints about poor care during pregnancy, childbirth and the postpartum period have been stimulated for decades by an active social movement that includes feminist collectives, health professionals, users and their families, representatives of the state and federal ombudsman's offices and public prosecutors' offices, popular health movements, public managers and researchers. In addition to social mobilization, organizations such as ReHuNa and Rede Parto do Princípio have played an important role in formulating theory and advising on public policies aimed at women's rights during childbirth. This is a collective effort based on innovation, creativity and qualified political advocacy[28].

Reporting channels

This study also highlighted the lack of specific official channels for reporting obstetric violence. In a context of increasing digitalization of public services, these channels are important tools for generating institutional data, making it possible to identify the number of cases that reach the Public Defender's Office and the measures adopted in each situation (such as opening cases, guidance, reception, among others). Although it was not possible to ascertain whether the channels identified by this research have ensured the total quantification of cases received, their implementation represents a relevant institutional strategy for producing quantitative and qualitative data. This can contribute to both transparency and the implementation of policies to promote women's rights and improve administrative practices.

The provision of generic channels for reporting obstetric violence, such as Disque Saúde and the Central de Atendimento à Mulher, in a scenario marked by the invisibility of this form of violence, can compromise the quality of care - especially when carried out by non-specialized professionals or those without adequate training on the subject. This can lead to situations not being identified as violations occurring during obstetric care, making it difficult both to receive care and to respond effectively to women's needs.

Currently, only two Public Defenders' Offices - in Paraná and Rio de Janeiro - have specific forms for this type of violence. In the case of Rio de Janeiro, the creation of the tool only came about through coordination with civil society, especially the Rio de Janeiro Doulas Association (AdoulasRJ).

This lack of effective digital mechanisms constitutes a process of silencing that also manifests itself in the virtual environment. As a result, no information is produced about the complaints and the accountability of services and the state for the violations committed is weakened.

This scenario deepens the obstacles to the so-called critical route[29], a concept that describes the fragmented and barrier-ridden path faced by women seeking to break the cycle of violence. In the case of obstetric violence, institutionalized ignorance - expressed by the lack of clear information on the websites of various ombudsmen's offices about what characterizes this form of violence, how to report it or which networks to turn to - directly compromises the rights to information, protection and access to justice, acting as a potential inhibitor to seeking help in relation to the violence suffered[30]. Digital opacity, therefore, is not just a technical obstacle, but a structural barrier that contributes to maintaining impunity and the invisibility of these violations.

Primers on Obstetric Violence

Table 3 shows the main themes found in institutional booklets with content related to obstetric violence.

Table 3. Themes covered in the institutional booklets on obstetric violence made available by the Public Defender's Offices

	Definition and examples	Birth plan	Unnecessary cesarean sections	Doula	Abortion	Racism
Bahia	yes	no	yes	no	yes	no
Rondônia	yes	yes	yes	yes	no	no
Mato Grosso	yes	no	no	no	no	no
Mato Grosso do Sul	yes	yes	yes	yes	no	no
Distrito Federal	yes	no	no	no	no	no
São Paulo	yes	yes	yes	no	yes	no
Rio de Janeiro	yes	yes	yes	yes	no	yes
Espírito Santo	yes	no	no	yes	no	no

Paraná	yes	yes	yes	yes	yes	yes
Santa Catarina	yes	yes	yes	yes	yes	no
Rio Grande do Sul	yes	no	no	no	no	no

Source: Own elaboration, 2025.

A thematic analysis of the eleven booklets on obstetric violence identified on the websites of the State Public Defender's Offices identified the following as the most recurrent topics: definition and examples of obstetric violence; approaches to abortion; birth plans; racism; the presence and role of doulas; and criticism of unnecessary caesarean sections.

All the booklets analyzed present a definition of obstetric violence, usually accompanied by examples linked to practices and situations observed in obstetric care. The subject of abortion appears in four of them - Bahia, São Paulo, Paraná and Santa Catarina - and is mentioned as a possible context for this type of violence.

The birth plan, as an instrument of the pregnant woman's autonomy, was addressed in six booklets: Rondônia, Mato Grosso do Sul, São Paulo, Rio de Janeiro, Paraná and Santa Catarina. The issue of obstetric racism, on the other hand, was only discussed in the booklets from Rio de Janeiro and Paraná.

With regard to the presence of a doula during childbirth - a figure whose role differs from that of a legal companion - seven booklets (Rondônia, Mato Grosso do Sul, Rio de Janeiro, Espírito Santo, Paraná and Santa Catarina) recognize its importance and highlight this right. With regard to unnecessary caesarean sections, five booklets (Mato Grosso, Distrito Federal, Espírito Santo and Rio Grande do Sul) did not critically address the excess of surgical interventions. In this respect, the booklet from Espírito Santo stands out, as it recognizes both the imposition of cesarean sections and normal childbirth as forms of obstetric violence.

The booklets from the states of Mato Grosso, Distrito Federal and Rio Grande do Sul limit themselves to presenting definitions and examples of obstetric violence, without going into the other topics. Paraná's booklet covers all the topics analyzed, while Rio de Janeiro's is silent on the subject of abortion, and Santa Catarina's on racism. The booklets from the states of Mato Grosso, Distrito Federal and Rio Grande do Sul only present definitions and examples of obstetric violence, without going into depth on other topics. Although the São Paulo booklet does not directly address issues related to obstetric racism and the role of doulas, the state has specific materials on the right to health for black women, as well as on the Birth Plan and monitoring during labor, delivery and the immediate postpartum period.

Various studies have shown that the care provided to women undergoing abortion has often been marked by violations of rights, revealing the naturalization of discriminatory practices and professional conduct guided by religious and moral values, in disagreement with the principles of health care and human rights[31,32].

In this context, critical attention should be paid to bills proposing the mandatory display of posters or information signs about abortion in health facilities, such as in the municipality of Rio de Janeiro, where Bill No. 2486/2023 (later sanctioned as Law No. 8.936/2025)[33] even required posters with anti-abortion messages, such as: "Did you know that the unborn child is discarded as hospital waste?" and "Abortion can lead to consequences such as infertility, psychological problems, infections and even death".

The messages in these materials show an ideological and moralizing bias, incompatible with the duty of the state, as laid down in the principles of the Unified Health System. It is an approach that reinforces stigma, ignores the legal and health foundations of abortion care and compromises access to reproductive rights.

The current scenario has been marked by the progressive curtailment of access to legal abortion in Brazil, evidenced by the closure of specialized services, such as the Vila Nova Cachoeirinha Municipal Hospital in São Paulo in 2023[34], and by the recent attempt to ban legal abortion and the recent attempt to ban the fetal asystole procedure - recommended by the WHO for abortions after the 22nd week[35]. At the same time, Bill 1904/2024 is currently before the House of Representatives, which equates abortions carried out after this gestational stage with the crime of homicide, providing for a sentence of up to 20 years and imposing harsher punishment on the pregnant woman than on the perpetrator of sexual violence in cases of rape[36].

There is also a need for the information materials produced by Public Defenders' Offices to contain information on obstetric racism, understood as a combined action of structural racism and gender violence in the reproductive field, reflected in care practices which, implicitly or explicitly, define who deserves to be cared for and who is neglected[18].

In obstetric care, racism carries a historical legacy of violence, torture and experiments on the bodies of black women, considered more resistant in the colonized reading of our society, which hierarchizes humanity by defining humans (whites) and subhumans (blacks and indigenous people)[37].

Leal et al.[38] found that black women had worse indicators of prenatal care and childbirth, including fewer appointments and tests, fewer previous links to maternity hospitals, less guidance received and more restricted access to analgesia during labor. Preliminary data from the Birth in Brazil 2 survey[39] reinforces this scenario, pointing to poorer quality of care and more unfavorable obstetric outcomes for black women. Similarly, D'Orsi et al.[40] showed that obstetric violence disproportionately affects black women from the Northeast region who have less schooling and undergo vaginal delivery - highlighting the structural impact of racism on health services. There is therefore a racial gradient in obstetric care in Brazil, marked by significant inequalities between black and white women[38,39,40].

Thus, obstetric violence cannot be dissociated from its institutional, gender and racial dimensions. Excessive medicalization, the dehumanization of care and power asymmetries between professionals and users form a structural pattern of violations[41].

Institutional initiatives: the example of Paraná

Another relevant finding of this study refers to the Protocol for Action in Cases of Obstetric Violence, drawn up by the Public Defender's Office of Paraná, with the aim of providing technical and legal support for public defenders and civil servants in dealing with situations related to this specific

type of violence. Considering the context of the invisibilization and naturalization of obstetric violence, the protocol is a fundamental tool for qualifying the reception and institutional action[42].

The document includes essential legal guidance, including introductory notions about the applicable legal framework, guidelines for qualified listening to women, guidance on the documentation needed to file lawsuits for moral and material damages, as well as examples of recurring situations faced by users and defenders during the legal process[42].

This is a very important initiative, especially given the difficult legal recognition of obstetric violence and the persistent legitimization of institutional practices that often perpetuate women's vulnerability. These women often face obstacles in getting their complaints accepted and recognized in legal proceedings. The protocol therefore represents an advance in the institutionalization of the response to obstetric violence, and can be used by other Ombudsman's Offices and legal professionals, contributing to the dissemination of good practices and the strengthening of action in defence of reproductive rights[42].

Final considerations

Obstetric violence remains a serious violation of rights, marked by institutional invisibility and the difficulty of holding the Brazilian state to account. The lack of specific legislation recognizing it as gender violence, coupled with the scarcity of proper reporting channels that produce institutional data, imposes concrete obstacles to access to justice and reflects the systematic denial of women's sexual and reproductive rights.

The Public Defenders' Offices have played an important role in promoting and defending these rights, especially through the Centers for the Promotion and Defense of Women's Rights (NUDEMs) and similar structures, present in most states and the Federal District. However, the fact that only eleven states have specific booklets on obstetric violence reveals an institutional process that is still being consolidated.

The low incidence of content on obstetric racism and obstetric violence in abortion situations hinders access to redress, especially for black women and those in situations of greater socioeconomic vulnerability, who continue to be the most impacted by both violent practices and the institutional negligence that silences them.

Despite these important gaps, the innovative experiences mapped point to promising paths for institutional strengthening. The creation of the State Committee to Combat Obstetric Violence in Amazonas and the provision of specific reporting channels by the Ombudsman's Offices in Rio de Janeiro and Paraná reveal the potential of practices that move towards qualified listening, enabling greater access to justice, inter-institutional coordination and the production of data based on the complaints received. Many of these initiatives are driven by the mobilization of women's movements, whose work has been fundamental in denouncing violence, formulating proposals and demanding institutional commitment to reproductive rights in the country.

Against this backdrop, it would seem appropriate to promote coordination between the State Public Defender's Offices on this issue, with a view to sharing innovative initiatives, building common guidelines and strengthening existing actions. This dialogue could be a strategic way to promote collective guidelines and institutional policies that ensure greater visibility, coherence and effectiveness of actions.

Improving the Defenders' websites, making existing initiatives, materials and contributions visible and accessible - including information on care networks and preventive guidelines - is a fundamental measure to ensure the right to information and expand access to justice.

This study has some limitations that should be taken into account. The criteria established for data collection may have limited the scope of the findings, as they did not consider other possible sources or forms of action. Future research involving a broader and more diversified analysis could contribute to a greater understanding of the role of public defenders in tackling obstetric violence in Brazil.

Acknowledgements

I would like to thank the team at the Specialized Centre for the Promotion and Defence of Women's Rights (NUDEM) of the Public Defender's Office of the State of São Paulo for their availability and valuable contributions during the meetings held during the research.

Referências

1. Quattrocchi P, Magnone N, editores. Violencia obstétrica en América Latina: conceptualización, experiencias, medición y estrategias. Remedios de Escalada: Universidad Nacional de Lanús; 2020.

2. Bohren MA, Vogel JP, Hunter EC, Lutsiv O, Makh SK, Souza JP, et al. The Mistreatment of Women during Childbirth in Health Facilities Globally: a Mixed-Methods Systematic Review. PLoS Med [Internet]. 2015 [cited Jul 26, 2025];12(6):e1001847. Available from: https://doi.org/10.1371/journal.pmed.1001847

3. Pantoja JC, Batisti MB, Pereira MCAR. Repensando o nascimento como um direito integral na luta contra a violência obstétrica no Brasil. Cad Ibero-Am Direito Sanit [internet]. 2024 [cited Jul 26, 2025];13(2):41-61. Available from: https://doi.org/10.17566/ciads.v13i2.1233

4. Tesser CD, Knobel R, Andrezzo HFA, Diniz SG. Violência obstétrica e prevenção quaternária: o que é e o que fazer. Rev Bras Med Fam Comunidade [Internet]. 2015 [cited Jul 15, 2025]10(35):1-12. Available from: https://doi.org/10.5712/rbmfc10(35)1013

5. Fundação Perseu Abramo. Mulheres brasileiras e gênero nos espaços público e privado. Fundação Perseu Abramo: São Paulo; 2010. 301p. Available From: https://apublica.org/wp-content/uploads/2013/03/www.fpa_.org_.br_sites_default_files_pesquisaintegra.pdf

6. Leite TH, Marques ES, Leal MC, Domingues RMSM, Nakamura-Pereira M, Theme-Filha MM, Baldisserotto ML, et al. Violência obstétrica no estado do Rio de Janeiro: Pesquisa Nascer no Brasil II. Rev Saúde Pública [Internet]. 2025 [cited Jan 26, 2026];59(S1):e6s. Available from: https://doi.org/10.11606/s1518-8787.2025059006536

7. Tempesta GA, França RL. Nomeando o inominável: a problematização da violência obstétrica e o delineamento de uma pedagogia reprodutiva contra-hegemônica. Horizontes Antropológicos [Internet]. 2021 [cited Jan 26, 2026];27(61):257-290. Available from: https://doi.org/10.1590/S0104-71832021000300009

8. Leal MC, Pereira APE, Domingues RMSM, Theme-Filha MM, Dias MAB, Nakamura-Pereira M, Bastos MH, Gama SGN. Intervenções obstétricas durante o trabalho de parto e parto em mulheres brasileiras de risco habitual. Cad Saúde Pública [Internet]. 2014 [cited Jul 29, 2025];30(Suppl 1):S17-S32. Available from: https://doi.org/10.1590/0102-311X00151513

9. Diniz CSG. Gênero, saúde materna e o paradoxo perinatal. Rev Bras Crescimento Desenvolv Hum [Internet]. 2009 [cited Jul 20, 2025];19(2):313-326. https://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S0104-12822009000200012

10. Brasil. Ministério da Saúde. DATASUS. Painel de monitoramento de nascidos vivos segundo classificação de risco epidemiológico [Internet]. Brasília: Ministério da Saúde; 2014-2024 [cited Jul 15, 2025]. Available from: https://svs.aids.gov.br/daent/centrais-de-conteudos/paineis-de-monitoramento/natalidade/grupos-de-robson/

11. Martins AL, Coelho CC, Soares VMN. Mortalidade materna no Brasil: comove, mas não mobiliza. In: Senapechi E, Peres L, editores. Dossiê de 30 anos da Rede Feminista de Saúde: democracia, saúde das mulheres, direitos sexuais e direitos reprodutivos [Internet]. Curitiba: CRV; 2021 [cited Jul 22, 2025] p. 51-72. Available from: https://www.redesaude.org.br/wp-content/uploads/2021/12/Dossie%CC%82-de-30-anos-da-Rede-Feminista-de-Sau%CC%81de_Livro-Digital.pdf

12. Defensoria Pública do Estado de São Paulo. NUDEM – Núcleo Especializado de Promoção e Defesa dos Direitos das Mulheres: página institucional [Internet]. São Paulo: Defensoria Pública do Estado de São Paulo [cited Mar 9, 2025]. Available from:

https://www.defensoria.sp.def.br/nucleos-especializados/pagina-inicial-nucleos-especializados/promocao-e-defesa-dos-direitos-das-mulheres

13. Cavalcante PR. Contribuições da psicologia no acesso à justiça: reflexões sobre a atuação de psicólogas/os na Defensoria Pública do Estado de São Paulo [Dissertação na internet]. São Paulo: Universidade de São Paulo; 2015 [cited Jul 13, 2025]. Available from: https://www.teses.usp.br/teses/disponiveis/47/47134/tde-07082015-112201/publico/cavalcante_me.pdf

14. Lewin APOCM, Prata ARS. Da atuação da Defensoria Pública para promoção e defesa dos direitos da mulher. Rev Dig Dir Adm [Internet]. 2016 [cited Jul 30, 2025];3(3):525-541. Available from: https://doi.org/10.11606/issn.2319-0558.v3i3p525-541

15. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 14ª ed. São Paulo: Hucitec; 2010.

16. Brasil. Conselho Nacional de Saúde. Resolução nº 510, de 7 de abril de 2016. Dispõe sobre a pesquisa em Ciências Humanas e Sociais e dá outras providências [Internet]. Brasília (DF): Ministério da Saúde; 2016 [cited Sep 23, 2025]. Available from: https://bvsms.saude.gov.br/bvs/saudelegis/cns/2016/res0510_07_04_2016.html

17. Vieira EM. A medicalização do corpo feminino. Rio de Janeiro: Editora Fiocruz; 2002.

18. Davis DA. Obstetric racism: the racial politics of pregnancy, labor, and birthing. Med Anthropol [Internet]. 2018 [cited Jul 8, 2025];38(7):560-73. Available from: https://doi.org/10.1080/01459740.2018.1549389

19. Diniz CSG, Niy DY, Andrezzo HFA, Carvalho PCA, Salgado HO. A vagina-escola: seminário interdisciplinar sobre a violência contra a mulher no ensino das profissões de saúde. Interface [internet]. 2016 [cited Sep 20, 2025];20(56):253-259. Available from: https://doi.org/10.1590/1807-57622015.0736

20. Barroso ABM, Andrade MD. Violência obstétrica: há responsabilização judicial pela "dor necessária" do parto? RDFD [Internet]. 2024 [cited Jul 30, 2025];29(1):115-150. Available from: https://doi.org/10.25192/ISSN.1982-0496.RDFD.V.29.N.I.2292

21. Oliveira JS, Novais TG. A tipificação penal da violência obstétrica: limites e possibilidades para a proteção jurídica da mulher no Brasil. REASE [Internet]. 2024 [cited Jul 30, 2025];10(11):5280-5296. Available from: https://doi.org/10.51891/rease.v10i11.16953

22. Brito CMC, Oliveira ACGA, Costa APCA. Violência obstétrica e os direitos da parturiente: o olhar do Poder Judiciário brasileiro. Cad Ibero-Am Direito Sanit [Internet]. 2020 [cited Jul 30, 2025]; 9(1):120-140. Available from: https://doi.org/10.17566/ciads.v9i1.604

23. Committee on the Elimination of Discrimination against Women. Alyne da Silva Pimentel Teixeira (deceased) v. Brazil, Communication nº. 17/2008, UN Doc. CEDAW/C/49/D/17/2008. 2011. Available from: https://www.globalhealthrights.org/wp-content/uploads/2013/08/Pimentel-Brazil-2011.pdf

24. Conselho Nacional de Saúde (Brasil). Rede Alyne: novo programa busca reduzir mortalidade materna no Brasil [Internet]. Brasília: CNS; 2024 [cited Oct 29, 2025]. Available from: https://www.gov.br/conselho-nacional-de-saude/pt-br/assuntos/noticias/rede-alyne-novo-programa-busca-reduzir-mortalidade-materna-no-brasil

25. Comitê de Enfrentamento à Violência Obstétrica no Amazonas. Violência obstétrica no Amazonas: histórico e audiência pública [Internet]. 2025 [cited Jul 30, 2025]. Available from: https://express.adobe.com/page/3Eee8ziTAzn59/

26. Fórum Brasileiro de Segurança Pública. Comitê de enfrentamento à violência obstétrica no Amazonas [Internet]. 2016 [cited Jul 30, 2025]. Available from: https://forumseguranca.org.br/iniciativas/comite-de-enfrentamento-a-violencia-obstetrica-no-amazonas/

27. Defensoria Pública do Estado do Amazonas. Defensoria, SES-AM e FVS lançam projeto pioneiro para monitorar casos de violência obstétrica [Internet]. Manaus: Defensoria Pública do Estado do Amazonas; 2024 [cited Jul 30, 2025]. Available from: https://defensoria.am.def.br/2024/08/22/defensoria-ses-am-e-fvs-lancam-projeto-pioneiro-para-monitorar-casos-de-violencia-obstetrica/

28. Diniz M. Prefácio. In: Lucena FS, Amanda A, organizadoras. Concepção, gravidez, parto e pós-parto: perspectivas feministas e interseccionais [Internet]. São Paulo: Secretaria de Estado da Saúde de São Paulo; 2024 [cited Jul 30, 2025]. Available from: https://www.saude.sp.gov.br/resources/instituto-de-saude/homepage/pdfs/temas35-concepcaogravidezpartoeposparto_digital.pdf

29. Heise LL. Violence against women: the hidden health burden. Washington: World Bank; 1993. World Bank Discussion Paper 255.

30. Faria CP, Vergara S. Justiça reprodutiva e institucionalização do cuidado: notas sobre as práticas das Defensorias Públicas. In: Diniz D, Rondon G, organizadoras. Direitos reprodutivos em disputa: políticas, conflitos e práticas. Brasília: ANIS/UnB; 2021. p. 121-138.

31. Moreira MA, Souza AS, Oliveira PM, Souza MX, Araújo Junior JC, Ribeiro PS. Violencia obstétrica en el proceso del aborto. Enfermería (Montev) [Internet]. 2023 [cited Jul 30, 2025]. Available from: https://doi.org/10.22235/ech.v12i2.3166

32. Coutinho RZ, Guimarães FF, Ferreira MES, Mateus VFD, Souza FG. Violência obstétrica no abortamento: tipificação de relatos de mulheres que tiveram perdas gestacionais em Belo Horizonte - MG entre 2018 e 2021. Rev Latinoam Población. 2025 [cited Jul 15, 2025];19:e202428. Available from: https://doi.org/10.31406/relap2025.v19.e202428

33. Rio de Janeiro (Município). Lei nº 8936, de 12 de junho de 2025. Dispõe sobre a obrigatoriedade de afixação de cartazes ou placas informativas acerca do aborto nos locais que menciona no âmbito municipal. Diário Oficial do Município do Rio de Janeiro. Rio de Janeiro; 12 jun. 2025.

34. Audi A. Prefeitura de São Paulo suspendeu serviço de aborto legal sem denúncias de irregularidades. Agência Pública [Internet]. May, 1 2024 [cited Jul 30, 2025]. Available from: https://apublica.org/2024/05/prefeitura-de-sp-suspendeu-servico-de-aboro-legal-sem-denuncias-de-irregularidades/

35. Schreiber M. Como Conselho Federal de Medicina se tornou pivô dos embates sobre aborto legal no Brasil. BBC News Brasil [Internet]. Jun 21, 2024. Available from: https://www.bbc.com/portuguese/articles/crgg3lp5pddo

36. Brasil. Projeto de Lei nº 1904/2024. Altera o decreto-lei nº 2.848 de 7 de dezembro de 1940. Brasília: Câmara dos Deputados; 2024.

37. Góes EF, Ferreira AJF, Ramos D. Racismo antinegro e morte materna por COVID-19: o que vimos na Pandemia? Ciência & Saúde Coletiva [Internet]. 2023 [cited Jul 30, 2025];28(9):2501-2510. Available from: https://doi.org/10.1590/1413-81232023289.08412022

38. Leal MC, Gama SGN, Pereira APE, Pacheco VE, Carmo CN, Santos RV. A cor da dor: iniquidades raciais na atenção pré-natal e ao parto no Brasil. Cad Saúde Pública [Internet]. 2017 [cited Jul 30, 2025];33(Supl 1):e00078816. Available from: https://doi.org/10.1590/0102-311X00078816

39. Leal MC, Granado S, Bittencourt S, Esteves AP, Caetano K. Nascer no Brasil II: pesquisa nacional sobre aborto, parto e nascimento 2022-2023: dados preliminares da pesquisa para oficina: morte materna e mulheres negras no contexto do SUS. Rio de Janeiro: FIOCRUZ; 2023 [cited Aug 1, 2025]. Available from: https://nascernobrasil.ensp.fiocruz.br/wp-content/uploads/2023/11/Dados-preliminares-da-pesquisa-Nascer-no-Brasil-2.pdf

40. D'Orsi E, Brüggemann OM, Diniz CSG, Aguiar JM, Gusman CR, Torres JA, et al. Desigualdades sociais e satisfação das mulheres com atendimento ao parto no Brasil: estudo nacional de base hospitalar. Cad Saúde Pública [Internet]. 2014 [cited Jul 5, 2025];30(Supl 1):S154-S168. Available from: https://doi.org/10.1590/0102-311X00087813

41. Diniz CSG, Salgado HO, Andrezzo HFA, Carvalho PGC, Carvalho PCA, Aguiar CA, Niy DY. Violência obstétrica como questão para a saúde pública no Brasil: origens, definições, tipologia, impactos sobre a saúde materna e propostas para sua prevenção. J Hum Growth Dev [Internet]. 2015 [cited Jul 10, 2025];25(3):377-384. Available from: http://dx.doi.org/10.7322/jhgd.106080

42. Defensoria Pública do Estado do Paraná. Núcleo de Promoção e Defesa dos Direitos das Mulheres (NUDEM). Protocolo de atuação em casos de violência obstétrica – Alyne Pimentel [Internet]. Curitiba: Defensoria Pública do Estado do Paraná; 2022 [cited Jul 30, 2025]. Available from: https://www.defensoriapublica.pr.def.br/sites/default/arquivos_restritos/files/documento/2022-05/copia_de_protocolo_nudem_sobre_vo_-_alyne_pimentel.pdf

Editorial information

History

Received: August 7, 2025
Revised: November 5, 2025
Accepted: December 19, 2025

Evaluation process

Double-blind peer review.

Open peer review

The options for opening the peer review process, including the publication of reviewers' reports, disclosure of identities and interaction between authors and reviewers, were not made available for this article.

Preprint

The manuscript is not a preprint.

Similarity check

This article was submitted to textual similarity checking using the CopySpider software.

Author contributions

M.A.B. Fondello: conception/design of the article, data analysis and interpretation, drafting the article, critical revision of the article and approval of the final version.
F.S. Lucena: conception/design of the article, data analysis and interpretation, drafting the article, critical revision of the article and approval of the final version.
R.K.D. Queiroz: data analysis and interpretation, drafting the article and approval of the final version.
A.C.L.S. Cabral: conception/initial design of the article, data analysis and interpretation, critical revision of the article and approval of the final version.

Conflict of interest

The authors declare that they have no personal, commercial, academic, political or financial conflicts of interest in relation to this article.

Funding

Not applicable.

Research ethics approval

Not applicable.

Availability of research data

Not applicable.

Declaration of use of Artificial Intelligence (AI) tools

Not applicable.

Publisher

Fundação Oswaldo Cruz (Fiocruz), Health Law Program, Brasília, DF, Brazil

How to cite (Vancouver)

Fondello MAB, Lucena FS, Queiroz RKD, Cabral ACLS. Between educational booklets and reporting channels: the role of Brazilian State Public Defender's Offices in addressing obstetric violence. Cad. Ibero-Am. Direito Sanit. 2026;15:e2026006. doi: 10.17566/ciads.e2026006