






She who must not be named: obstetric violence, Brazil going against the global trend

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Abstract

Obstetric violence is an old problem wrapped in a relatively new term — and it is precisely the term that is troubling. In 2014, the World Health Organization acknowledged that worldwide women experience disrespectful and abusive treatment during childbirth. Since then, international recognition of the concept has advanced unequivocally: the Inter-American Court of Human Rights explicitly recognized the concept in its jurisprudence (2022), the Parliamentary Assembly of the Council of Europe classified it as gender-based violence (2019), and the European Parliament's Committee on Women's Rights recognized it as institutional and gender-based violence in 2024, while global academic production on the topic has grown markedly. However, in Brazil, the scenario moves to the opposite direction. Data from the Nascir no Brasil II (Born in Brazil II) survey reveal a 65.3% prevalence of obstetric violence in the State of Rio de Janeiro, while the Federação Brasileira das Associações de Ginecologia e Obstetrícia (Febrasgo) (Brazilian Federation of Gynecology and Obstetrics Associations), the Associação Médica Brasileira (AMB) (Brazilian Medical Association), and the Conselho Federal de Medicina (CFM) (Federal Council of Medicine) have publicly united to reject the term and to oppose legislative initiatives aimed to classify it as a crime. This article reflects on the importance of naming obstetric violence, analyzes international advances and the Brazilian setback, and defends that silencing the name does not erase the violence — it merely protects those who perpetuate it.

Key words *Obstetric violence, Gender based violence, Reproductive rights, Humanized childbirth, Human rights*



Introduction

The history of obstetric violence is, to a large extent, the history of obstetrics itself as a medical specialty. When, in the 17th century, barber surgeons began to compete with midwives for the control over childbirth, a model was established that transformed women into patients and childbirth into a procedure—a model that, three centuries later, J. Marion Sims would take to the extreme by developing gynecological surgical techniques while operating on enslaved Black women without anesthesia, and that DeLee would consolidate by proposing, in 1920, the prophylactic forceps and routine episiotomy as standard practice.^{1,2} What is today called obstetric violence has its roots in this foundational logic: the pathologization of the female body and the subordination of women's autonomy to the authority of the professional.

The term was officially coined in 2007, in Venezuela, as a legal category.³ But the phenomenon it designates predates its naming by centuries—and it is precisely the act of naming that is troubling. There is little disagreement in the literature that disrespectful and violent practices against women in the obstetric care services are widely documented around the world.^{4,5} What remains in dispute is not the existence of the problem, but what to call it. And this dispute is no small matter: when one says “disrespect,” it suggests a lack of politeness; when one says “abuse,” it invokes individual conduct. However, by naming obstetric violence, one acknowledges a structural violation of human rights.

The most widely adopted definition describes obstetric violence as “the appropriation of women's bodies and reproductive processes by healthcare professionals, expressed through dehumanized treatment, abusive medicalization, and the pathologization of physiological processes, resulting in a loss of autonomy and a negative impact on quality of life.”⁶ Its manifestations include procedures performed without consent, denial of analgesia, preventing the presence of a companion of choice, verbal and psychological abuse, imposed cesarean sections or episiotomies, inappropriate use of oxytocin, fundal pressure (Kristeller maneuver), and restrictions on food and movement.^{4,5} This violence permeates both the public and private sectors and lies at the intersection of institutional violence and gender-based violence.⁶

As a legal construction, the concept took hold in Latin America beginning in the 2000s, anchored in the convergence of feminist movements and activism for the humanization of childbirth—both denouncing imposed medicalization as a violation of reproductive autonomy.^{4,5} Following Venezuela (2007), Argentina incorporated the concept into its Legislation for the comprehensive protection of women in 2009, and Mexico included it in

Federal Legislation in 2014, while several Mexican States criminalized it in their penal codes.³ In Brazil, although there is no specific Federal Law, State Laws such as those in Santa Catarina (Law No. 17,097/2017) and Pernambuco (Law No.16,499/2018) define and criminalize obstetric violence.^{7,8} The Law in Pernambuco, for example, defines it as “any act committed by health professionals that involves negligence in care, discrimination, or verbal, physical, psychological, or sexual violence against pregnant women, women in labor, and puerperal women.”⁸

Resistance to the Term

Paradoxically, the social and legal recognition of the term co-exists with stubborn resistance to its adoption. The World Health Organization (WHO) exemplifies this ambivalence: it acknowledges that women suffer abuses during childbirth that violate their rights, but opts for the phrasing “abuses, disrespect, and mistreatment during childbirth in health care facilities” rather than naming the violence as obstetric.⁹ The paradox becomes evident when this choice is contrasted with its own definition of violence: the intentional use of force or power, actual or threatened, capable of resulting in psychological harm, disability, injury, or death.¹⁰ In this conception, intentionality refers to the deliberate use of force or power, not in the intention to cause harm.

This resistance is not accidental. It has an epistemological foundation: naming is an act of power. For Foucault,¹¹ modern clinical practice was constituted precisely through the capacity to classify, name, and hierarchize the body and its sufferings; an operation that did not describe the disease, but produced it as an object of knowledge and intervention.¹¹ The medical perspective is not objective; it is a perspective that orders, that confers legitimacy upon what it names and denies existence to what it silences. When one refuses to name a practice as violence, one is not being more precise: one is exercising power over what can be said and, therefore, over what can be seen.

When medical institutions reject the term “obstetric violence,” they are not merely disputing semantics: they are refusing to recognize women as bearers of a legitimate experience of harm.¹² This refusal has a name in political philosophy: misrecognition, or false recognition. Its effects on women's subjectivity and health are no less significant than the effects of the physical procedures that the term designates.

Miranda Fricker, a philosopher, in “Epistemic Injustice: Power and the Ethics of Knowing” (2007), offers perhaps the most precise analytical framework for this debate. Fricker distinguishes two types of epistemic injustice: testimonial—when someone's testimony is discredited due to identity-based prejudice—and

hermeneutic—when someone lacks the conceptual resources necessary to interpret and communicate their own experience.¹³ Obstetric violence produces both. Women who report pain, humiliation, or non-consensual procedures frequently face systematic disbelief from professionals and institutions (testimonial injustice). And, for decades, they lacked a concept to name what they had experienced (hermeneutic injustice). The coining of the term “obstetric violence” is, in this sense, an epistemic act of reparation: it provides women with the conceptual resource that had been denied them. Suppressing the term is, literally, to restore hermeneutic injustice.

The symbolic dimension of this dispute is captured precisely by Pierre Bourdieu’s sociology. The medical field operates through a set of dispositions and practices that become naturalized. Bourdieu called this *doxa*: the set of tacit assumptions that agents in a field accept without question precisely because they do not recognize them as assumptions, but as the order of things.¹⁴ Systematic episiotomy, vaginal examinations without consent, the restraint of the body during labor, practices that persisted for decades not as violence, but as “obstetric conduct.” Symbolic violence operates precisely in this way: by convincing the victim herself that what is done to her is done by her and for her own good. To name these practices as violence is to break with the *doxa* of the field. And that is why the reaction is so intense: it is not a matter of debating a term, but of threatening the epistemic authority that sustains the field.

Judith Butler, in “Excitable Speech: A Politics of the Performative” (1997), reminds us that words not only describe acts, but also constitute them and inscribe them into networks of power and recognition.¹⁵ To name obstetric violence is not to inflame a debate; it is to perform an act of language that confers public existence upon a harm which, without a name, remains private, individual, non-generalizable, and therefore non-political, non-legal, and not subject to collective redress. Resistance to naming is, in this framework, resistance to the publicization of a harm that one wishes to keep within the sphere of the private and the contingent.

Paulo Freire, author, taught us that naming the world is a prerequisite for transforming it.¹⁶ In *Pedagogia do Oprimido* (Pedagogy of the Oppressed), naming is the act of foundational critical consciousness: without a name, there is no object; without an object, there is no struggle. The suppression of a term is not a gesture of scientific prudence; it is a political gesture aimed at maintaining invisibility. When Brazilian medical entities invest institutional energy in silencing the name, they are, consciously or unconsciously, investing in maintaining women’s silence about what was done to them.

The *Federação Brasileira das Associações de Ginecologia e Obstetrícia* (Febrasgo) (Brazilian Federation of Gynecological and Obstetrics Associations) formally opposed the use of the term in 2022. The rhetorical reversal is revealing: by claiming that naming the violence constitutes “violence against the obstetrician,” these entities substitute the professional for the victim—a maneuver that, in itself, highlights the power asymmetry that the concept exposes.¹⁷ Thus, care related acts during childbirth and puerperium that stem from a power dynamic between healthcare systems, professionals, and patients and during which procedures are imposed on women in a way that infringes upon their autonomy and creates a risk of physical, emotional, or psychological harm, meet all the criteria to be classified as violence.

The adjective “obstetric” describes the care setting in which the violence occurs—not the agent who perpetrates it. Obstetric nurses, nursing technicians, anesthesiologists, managers, and the healthcare system itself can be vectors of this violence, which often results from systemic failures at multiple levels of care.^{5,18} Labeling the violence as “obstetric” does not, therefore, imply blaming a specific professional category.

It is equally true, however, that some professionals—especially obstetricians—perceive the term as stigmatizing, a sentiment documented in various contexts and one that cannot be summarily dismissed. Nevertheless, the question arises: why is a designation referring to the care setting readily interpreted as an individual accusation? One possible answer lies in the recognition—albeit implicit—that potentially violent practices are structurally, rather than exceptionally, embedded in the routine of care. Recognizing this ambivalence does not require abandoning the term, but rather deepening the debate: shifting the focus from individual blame to a critical analysis of the institutional, cultural, and organizational conditions that allow these practices to persist.

This reaction also exposes the corporatism of a specialty that has historically claimed a monopoly on childbirth care and which, by perceiving the term as an attack, reveals less concern for women than for the preservation of a prerogative it regards as exclusively its own.

Discourse Analysis, in the French tradition, reminds us that silence is a constitutive part of enunciation. The words one chooses not to use reveal as much about the ideological project of the discourse as those one chooses to utter. When medical entities focus so much energy on suppressing a term, the question that arises is: whom does this silence serve?

The world recognizes: international progress

While in Brazil the discussion remains stifled by corporate interests, international recognition of obstetric violence as

a legal and human rights category has advanced decisively in recent years.

The most significant milestone was the ruling by the Inter-American Court of Human Rights in the case of *Brítez Arce et al. vs. Argentina* (November 2022, notified in January 2023).¹⁹ The Inter-American Court—whose decisions are binding on all States Parties, including Brazil—recognized the concept of “obstetric violence” in its jurisprudence, defining it as a form of gender-based violence perpetrated by healthcare providers against pregnant women during access to health services during pregnancy, childbirth, and the postpartum period.¹⁹ The Court held the Argentine State responsible for the violation of the rights to life, personal integrity, and health, and ordered awareness campaigns and training for professionals. The message is clear: obstetric violence is a human rights violation, and States have an obligation to prevent it, punish it, and refrain from committing it.

In Europe, the Parliamentary Assembly of the Council of Europe recognized obstetric violence as gender-based violence in its Resolution 2306 of 2019,²⁰ and the European Parliament’s Committee on Women’s Rights commissioned a comprehensive study that recognized obstetric violence as institutional and gender-based violence in 2024.²¹ In 2019, the United Nations (UN) Special Rapporteur on Violence against Women, Dubravka Simonovic, published a report dedicated to the topic, explicitly using the term “obstetric violence” and classifying it as a serious violation of human rights.²² Global academic literature has followed this trajectory: systematic and integrative reviews in high-income countries have documented the phenomenon in the United States, Europe, and the Middle East,¹⁸ while studies have demonstrated that obstetric violence is the primary predictor of postpartum quality of life.

The editorial “Who is afraid of obstetric violence?”, published in this journal in 2020,²³ and the letter published in *The Lancet* in the same year,²⁴ have become international references advocating for the use of the term. Both texts are cited in articles published in journals such as *Hypatia*, *Feminist Anthropology*, *Violence Against Women*, and *Sexual and Reproductive Health Matters*, among others, demonstrating that support for the term resonates within the international scientific community. The subsequent response published in this journal on medical education and obstetric violence reinforced the need to reform professional training as a path toward transformation.

The Brazilian Context: Data, Legislation, and Reactions

Bills are currently pending in the National Congress that seek to classify obstetric violence as a crime. Bill 2,373/2023, authored by Representative Laura Carneiro (PSD/RJ), addresses obstetric violence in women’s healthcare, proposing the inclusion of Article 149-B in the

Penal Code with a penalty of 1 to 3 years of imprisonment.²⁵ Bill 1,763/2025, sponsored by Representative José Guimarães (PT/CE), expands the types of criminal offenses and establishes penalties of up to 15 years, depending on the severity of the injury.²⁶ In March 2026, a motion for urgent consideration was filed for Bill 2,373/2023, signaling the concrete possibility of a vote.

The empirical justification for this legislation is undeniable. Data published from the national study “*Nascer no Brasil II*” (Born in Brazil II)—conducted in 395 maternity hospitals across all Brazilian States, with over 23,000 participants—revealed a 65.3% prevalence of obstetric violence among women treated in maternity hospitals in the State of Rio de Janeiro, with data collected between 2021 and 2023 in 29 public and private maternity hospitals.²⁷ The most prevalent types were inappropriate vaginal examinations (46.2%), negligence (31.5%), and psychological abuse (21.7%). The Kristeller maneuver, contraindicated by the *Diretrizes Nacionais de Assistência ao Parto Normal do Ministério da Saúde* (Ministry of Health National Guidelines for Normal Childbirth Care) since 2017 and discouraged by the WHO, was still reported. Women with lower levels of schooling, who were unemployed, and who received care in the public sector had higher prevalence rates—evidence that obstetric violence is rooted in the social and racial inequalities that shape access to healthcare in the country.

Faced with these data, the argument that “Brazil already has sufficient legal instruments to punish negligence, malpractice, or professional misconduct” sounds, at best, naive; at worst, cynical. If these instruments worked, two-thirds of women in Rio de Janeiro would not report obstetric violence a decade after the first edition of *Nascer no Brasil*²⁸ (Born in Brazil). This reality does not merely speak: it screams! And it has been screaming for far too long for us to still pretend not to hear it.

March 2026: The Coordinated Response

On March 11, 2026, eight days after the submission of the urgent motion for Bill 2,373/2023, *Febrasgo*, the *Associação Médica Brasileira* (AMB) (Brazilian Medical Association), and the *Conselho Federal de Medicina* (CFM) (Federal Council of Medicine) simultaneously published joint documents taking a stand against “the criminalization of obstetrics” and in favor of “safe and respectful childbirth.”²⁹ For the first time, the three entities formally united in a joint document on the subject.

The central arguments of these statements merit careful analysis, as they represent the most complete expression of “narcissistic resistance” to the term, as previously described by Katz et al.²³ in 2020. Read together, the two documents construct a narrative that operates along three

axes: the substitution of the object of the law with the entire professional field, the instrumentalization of women as hostages, and the evocation of fear as a justification for inaction. Each of these axes deserves to be examined in light of what they say and, above all, what they silence.

The first argument is that the Bills “criminalize obstetrics.” This is a precise rhetorical maneuver: substituting the object of the law (acts of violence) for the entire field of the specialty. Obstetrics is not criminalized; what is criminalized are acts that violate a woman’s physical or psychological integrity during pregnancy, childbirth, or the postpartum period. The confusion between the specialty and violence says more about those who make this claim than about the legislation in question.

The second argument is that the legislation “will drive physicians out of the delivery room and leave women without care.” This is, possibly, the most revealing of the three. It is a form of institutional blackmail that uses women themselves—the supposed beneficiaries of these entities’ concern—as hostages. The logic is: if you hold us accountable, you will be left without care. Applied to any other field, this logic would be unacceptable. No one would argue that classifying domestic violence as a crime “will drive husbands out of their homes and leave families helpless”—and the parallel is not rhetorical: gender-based violence is gender-based violence, regardless of the setting in which it manifests.

The third argument is that of “defensive medicine”: professionals would be afraid to act in emergencies, would hesitate to perform necessary procedures, and, ultimately, more women would die. This argument disregards the fact that obstetric violence is not the result of acting in emergencies, nor does it propose to limit clinical practice when it is duly justified. No Bill criminalizes emergency cesarean sections or the active management of labor when necessary. This is a political movement aimed at challenging a paternalistic culture that renders women invisible in decision-making, disregards their consent, and relies on misinformation and pathologizes physiological events to impose unnecessary interventions—aspects that, far from compromising patient safety, are themselves risk factors. There is also a performative contradiction worth noting. The same FEBRASGO that in 2026 takes a stand against the term “obstetric violence” maintains on its website a campaign to end violence against women and an unprecedented survey on the needs of those on the front lines of women’s healthcare. The question that arises is simple: if FEBRASGO recognizes violence against women as a problem, why does it refuse to acknowledge that this violence also occurs in the obstetric setting? The answer likely lies less in the protection of women and more in the protection of a structure.

Structural violence: gender, race, and class

Obstetric care does not operate in a vacuum: it is embedded in health systems whose hierarchies reproduce the gender, racial, and class asymmetries of the society that sustains them.^{4,5} The violence that results from this is, therefore, simultaneously structural and interpersonal—an obstetric expression of a patriarchal system that shapes both social relations and care practices.^{4,5} Professionals who individually present themselves as caregivers practice their craft within an institutional culture that normalizes violent practices and constructs justifications devoid of evidence to avoid recognizing them as such.

A pregnant woman experiences violence when her social status deprives her of adequate access to care during pregnancy. This violence manifests itself when, as a poor woman, she is denied quality prenatal care; when, as a Black woman, her complaints of pain are systematically dismissed; when, as a young woman with low educational attainment, her decisions are disregarded. Vulnerability is intensified not only by the condition of pregnancy but by the woman’s social position in an unequal society.

Data from the *Nascer no Brasil II* (Born in Brazil II) study confirm this intersectionality: the highest prevalence of obstetric violence is found among women with lower levels of schooling, who are unemployed, recipients of government programs, and treated at the public sector.²⁷ Black women face additional barriers in accessing healthcare, exacerbated by the normalization of institutional racism in obstetric services.³⁰ Obstetric violence is therefore not an isolated problem of individual conduct: it is the obstetric expression of a society that violates women in multiple ways.

The pandemic caused by SARS-CoV-2, between 2020 and 2022, dramatically exacerbated these practices. Many women were subjected to interventions without clinical justification, such as an increase in cesarean sections, separation of the mother–newborn dyad, and restrictions on the right to a companion—measures frequently adopted under the pretext of public health safety, but contrary to international recommendations. The WHO (2021) advised that women with suspected or confirmed infection should receive respectful, woman centered care, with continued skin-to-skin contact and breastfeeding, and did not recommend mother–baby separation except in cases of severe maternal illness.³¹ In Brazil, the pandemic exposed and intensified structural inequalities in obstetric care, with a disproportionate impact on Black and low-income women.³¹

Medical education: where violence is perpetuated

Predominant medical education still reproduces in the specialty interventionist legacy: technocratic, focused

almost exclusively on technical aspects, it relegates women's subjectivity to a secondary level.² It is in this context that practices such as prophylactic forceps use in primiparous women and routine episiotomy have become normalized.

The evolution of bioethics guided medicine, however, requires a re-evaluation of this legacy. Autonomy, beneficence, and non-maleficence are not compatible with the uncritical maintenance of practices lacking evidence based support. It is important to distinguish: a cesarean section, for example, is not violent in itself—it becomes so when imposed, performed without indication, or in disagreement with the best available evidence. Combating obstetric violence serves, first and foremost, women but it equally serves professionals, because ethical and evidence based practices require adequate working conditions and horizontal professional relationships.

Feminist Bioethics and the Centrality of Women

The transformation of obstetric care requires breaking away from dehumanizing practices and adopting models that integrate scientific evidence, humanization, and empathy, placing women's dignity and well-being at the center of attention. It is imperative to integrate feminist bioethics into obstetric care, recognizing childbirth as a physiological event that must be conducted with respect for women's autonomy over their own bodies.

Renaming obstetric violence with milder terms does not solve the problem; on the contrary, it undermines its relevance and hinders recognition of the severity of this issue. The term "obstetric violence" allows for an accurate description of the structural essence of this form of violence, addressing it as a violation of women's rights to health, equality, and reproductive autonomy. The naming is not merely semantic: it is an indispensable political and scientific tool for recognizing and addressing the problem.

Final Considerations

Two-thirds of the women treated in maternity hospitals in the State of Rio de Janeiro reported at least one form of obstetric violence. Given this data, it would be reasonable to expect that the representative bodies of Brazilian obstetrics would mobilize their institutional resources to understand and address the problem. What we observe, in March 2026, is the opposite: FEBRASGO, AMB, and CFM are uniting not against violence, but against the name that designates it.

Brazil is moving in the opposite direction from the rest of the world. While the Inter-American Court of Human Rights enshrines the term in its jurisprudence, the Parliamentary Assembly of the Council of Europe and the European Parliament's Committee on Women's

Rights recognize it as gender-based and institutional violence, and global scientific literature consolidates the concept, Brazilian medical organizations are staking their institutional credibility on silencing the term. The joint statement of March 2026 is not an isolated incident: it is the latest chapter in a systematic strategy of denial that has, as an effect—intentional or not—the maintenance of the *status quo*.

Insisting on the suppression of the term does not protect professionals from legal consequences—it protects a structure. And it is the structure, not the nomenclature, that needs to change. A more just obstetric future requires evidence based practices, respect for women's autonomy, and professional training that prepares practitioners to care without inflicting harm. This transformation demands a collective effort: professionals, administrators, academia, and civil society—all moving in the same direction, against violence, not against the term.

That which cannot be named does indeed have a name: obstetric violence. And as Dumbledore taught us, fear of the name only increases fear of the thing itself. If the term causes discomfort in the medical community, one must ask: discomfort in the face of what? Not in the face of the word—in the face of what it reveals.

The discomfort with the name should be, above all, discomfort with the reality it lays bare—and it is from this reality, not the nomenclature, that we need to free ourselves. As Paulo Freire teaches, we must name the world to transform it. May the institutional energy currently invested in silencing the term be redirected toward eradicating the practice that engendered it. Because no woman has ever been hurt by a word. What hurts is the touch without consent, the imposed decision, the confiscated autonomy, the body turned into an object. And against this—against this, yes—all obstetrics should stand united.

Statement on the Use of Artificial Intelligence

The authors used the Claude language model (Anthropic) as an auxiliary tool for gathering and verifying legislative documents, international case law, and gray literature, as well as for editorial review of the manuscript. All content was critically evaluated, verified, and edited by the authors, who assume full responsibility for the final version of the article.

Authors' Contributions

Amorim MMR: conceptualization; project management; supervision; writing—review and editing.

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Brilhante AVM: conceptualization, analysis, writing – revision and editing.

The authors approved the final version of the article and declare that there is no conflict of interest.

Data availability

The entire dataset supporting the results of this study was published in the article itself.

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