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Obstetric Violence in the United Kingdom and Brazil: A Comparative Analysis

Vitória Nery de Brito

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Supervised by:
Dr. Kalika Mehta
Prof. Dr. Carmen Simone Grilo Diniz

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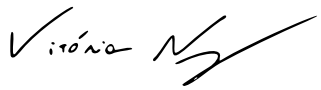

Vitória Nery de Brito
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I dedicate this to my dear mother in loving memory.

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List of Abbreviations

Abrasco: Associação Brasileira de Saúde Coletiva

AT: Author's Translation

BAME: Black, Asian and Minority Ethnic

CEDAW: Committee on the Elimination of all Forms of Discrimination Against Women

EC: European Commission

EIPMH: European Institute of Perinatal Mental Health

EP: European Parliament

Fiocruz: Fundação Oswaldo Cruz

MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

NCT: National Childbirth Trust

NGO: Non-Governmental Organisation

NHS: National Health Service

NMPA: National Maternity and Perinatal Audit

OBI: Other Birthing Individuals

OR: Obstetric Racism

OV: Obstetric Violence

PHB: Planned Home Birth

PTSD: Post-Traumatic Stress Disorder

ReHuNa: Rede pela Humanização do Parto e Nascimento

SUS: Sistema Único de Saúde

UN: United Nations

VAWG: Violence Against Women and Girls

WRA: White Ribbon Alliance

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In memory of Anna Nery (1814 – 1880),
recognised as Brazil's first nurse and a brave war volunteer
whose humanitarian contributions continue to inspire generations.

1.
Introduction

Following conception and pregnancy, childbirth symbolises the primary and essential event igniting human life. Throughout time, it has been shaped and interpreted differently by societies, invariably concerning every human being: past, present, and future. As much as it is a physiological phenomenon, it is also a cultural and social one (Cruz 2023, 9).

In Brazilian Portuguese, the popular expression *ganhar neném* (to win or to gain a baby) is used to celebrate the culmination of the *trabalho de parto* (labour), thereby expressing the sentiment that a baby is a precious gift bestowed upon the mother who gave birth to it. It reflects the cultural perception of childbirth as a celebratory and empowering experience for women, other birthing individuals, and those around them (Davis-Floyd 2022, 1; Kitzinger 2012, 302; McCallum and Reis 2005, 335).

Taking this cultural nuance as a starting point, when a birthing person experiences, whether intentionally or not, violence or abuse by those assisting them during any part of the process, the joyful connotation of the moment is overshadowed by emotional distress or physical pain (frequently both). This often strips the experience of its intended transformative, dignified, and humanised essence, resulting in lasting negative implications. These are not only devastating, but raise the concern that, as Lloyd deMause puts it, “Violence done to babies [and their mothers] always returns on the social level.” (deMause 2002, 45).

As such, this study emphasises the need for a critical examination of the phenomenon of “Obstetric Violence” (OV) as a human rights violation, particularly within institutional maternity care, through an interdisciplinary lens that accounts for its colonial roots and the complex interplay of intersectional and gender-based factors.

Many societies fail to recognise the problem of routine, invasive, excessive, or unnecessary non-evidence-based interventions and practices in prenatal, labour, birth, postpartum, and abortion experiences — except for those who are victims of such malpractice or observe it first-hand. As a consequence, the marginalised public discourse around it contributes to the absence of scientific consensus on the appropriate terminology to describe the problem (or vice versa). This, in turn,

systematically hinders the recognition of the underlying causes that motivate human rights violations of this nature.

Therefore, actively communicating the meaning of these experiences through language and rediscovering the social aspects of obstetrics and childbirth may provide insight into how giving birth is, extensively, a political act (Hall 1997, 28; Kitzinger 2012, 301). This captures the primary motivation behind this research.

Through examining the multidimensional drivers, impacts, and societal perceptions of OV, this work compares how countries representatives of the 'Global North' and 'Global South' — the United Kingdom and Brazil — acknowledge and respond to the issue.[1]

Two factors contributed to the selection of these countries. The first refers to the primary basis of comparison: the universal healthcare systems in both territories, particularly in light of the UK's National Health Service (NHS) serving as the benchmark for Brazil's Unified Health System (SUS) in its inception in 1988 (Leal et al. 2023, 1339), and how each structures their childbirth assistance models. In scrutinising these systems through a postcolonial lens, insightful perspectives can be gained to the overall debate: by juxtaposing a colonising nation with a colonised one, though they are not associated directly in this regard, it becomes possible to examine how the lingering effects of structural racism are manifested particularly in the healthcare sphere (Lokugamage et al. 2020, 267). The second factor is simple: it owes to language accessibility and cultural ties, often employed by single researchers (Dannemann 2019, 414).

Ultimately, a greater emphasis should be placed on investigating the reasons why women and Other Birthing Individuals (OBI) are often and continuously treated in a manner that seems to make them merely containers of new life within institutional settings in these countries, which frequently overlook, neglect, or minimise their voices, wishes, fears, and autonomy (King's College London 2024; Venturi and Godinho 2013, 172-180). In spite of the significant increase in the literature on OV

[1] The distinction between 'North' and 'South', a world division stemming from colonial rule, generally implies structures of domination in which the 'South', in its development asymmetry, relies on the developed, core, and advanced economies of the 'North' (Sud and Sánchez-Ancochea 2022-3, 1124). The construction of the 'South' is, therefore, based on the process of 'othering' of the Asian, African, and Central and South American continents through geographic, racial, economic, and political disparities (Sud and Sánchez-Ancochea 2022-3, 1124). These categories not only reinforce oppression, but also perpetuate understandings of inequalities and add strength to the notion that anything originating from the 'North' is inherently superior. In close connection with the research questions outlined below and with the hypothesis underpinning this study, this work questions the hierarchies between the regions in the context of healthcare management, hence the quotation marks.

over the past few years, a systematic comparison between the UK and Brazil is not yet available. Therefore, by comparing OV cross-nationally, this work aims to identify and assess best practices, problematic areas, improvement opportunities, and how this type of knowledge can be bridged between the two territories for the overall improvement of birth assistance models and acknowledgement of the problem.

To fulfil this purpose, the following is intended within these pages: to dwell on the drivers that result in OV; to provide a multidimensional perspective to a human rights issue; and to understand how and why two territories with different healthcare systems, socioeconomic levels, and political, cultural, and social contexts share similar outcomes to the problem.

To address these gaps, this work poses the following research questions (each emphasising lessons to be learned, actions to be taken, and power relations, respectively):

1. In which ways can interdisciplinary and cross-national research of Obstetric Violence serve as a key example of deeper humanitarian issues in healthcare?
2. How can these key insights be effectively incorporated into strategies to advance broader global health issues?
3. Through the analysis of Obstetric Violence as a human rights violation, how can the comparison of healthcare issues in the United Kingdom and Brazil validate or refute the commonly accepted notion that the 'Global North' addresses healthcare issues more effectively than the 'Global South'?

In order to answer these questions, this study relies extensively on the voices of those who suffered OV through existing published materials, as well as on discussions and unpublished research findings obtained at the V International Conference on Humanisation of Childbirth, held at the University of Brasília in February 2024 (ReHuNa 2024; UnB 2024).[2] Primary sources also include letters from women recounting their birth experiences, such as those from the 1950s retrieved from the Wellcome Collection, in London, which detail instances of medical malpractice and inadequate care in England at the time. Additionally,

[2] During the preliminary stages of this research, semi-structured interviews were carried out with a number of midwives in the UK and Brazil. These exchanges provided valuable contextual information that helped shape the direction of the research. However, given the sensitive nature of these conversations, the healthcare professionals expressed a strong wish not to have them recorded nor to be identified. To ensure respect and adherence to ethical research practices, no content resulting from these interviews has been directly incorporated or quoted in this work. Thus, while the intelligence obtained from these interactions informed the researcher's understanding and approach, they are not presented as official findings within this study.

Brazilian newspaper articles from the 1860s have been used to describe obstetric malpractices with enslaved women.

Secondary literature draws upon disciplines across the humanities, social sciences, and interdisciplinary fields, as well as a mixed-method approach of both qualitative and quantitative analysis. The aim is to cater to non-expert audiences, thereby expanding public discourse beyond traditional boundaries.

This work expresses no hesitation in acknowledging and appreciating the works of women who, for years, through scholarly research and birth rights activism, have played a crucial role in shaping the discourse of violent practices during childbirth through their respective fields of research. Most notably, the contributions of Carmen Simone Grilo Diniz, Daphne Rattner, Robbie Davis-Floyd, Christine McCourt, Amali Lokugamage, and Sheila Kitzinger had a profound impact on this work.

The first part of this work, composed of the first two chapters, draws on gender-based and intersectional premises to discuss the problem. The chapter *Defining, Acknowledging, and Measuring Obstetric Violence*, defends the terminology used throughout the work and questions how effective it is to incorporate several terms to describe the problem, as well as the consequences for raising worldwide awareness and developing measuring methods (Eco 2015, 36).

The second part constitutes the main body of this work, expressed by the chapter *Comparative Analysis*, and to which five dedicated sections are devoted. Each section covers a particular discipline, arranged according to a similar structure: Method, UK, Brazil, and Discussion.

The section *Historical Background* examines archives from colonial times to elucidate supremacist, hierarchical, and racist structures in maternity care which influence medical malpractice and mistreatment today. It also features historical archives from early periods of institutionalisation of medicine to discuss the development of obstetric care professions. This serves as a prelude to discuss the following section.

Healthcare Systems explores how medical training of the main providers within obstetric care in the National Health Service (NHS) and the Unified Health System (SUS) might reflect inadequate cultural safety, humility, and competence components in their syllabi (Lokugamage 2023, 244-5). It also emphasises the importance of discussing the rights of every actor involved in obstetric care.

The *Social Indicators* part analyses statistics that may indicate the prevalence of OV in these countries and what data collection methods reveal about how both countries respond to the issue.

The section on *Media Representation* explores how and to what extent the UK and Brazil report on the problem through different mediums and how this shapes public awareness — either by educating the public, or oversimplifying or sensationalising the problem.

Moving on to the last section in this chapter, *Legal Instruments* discusses from a comparative law perspective how both territories legally respond to OV.

Finally, the last content part refers to the *Synthesis* and the *Conclusion*. In the first, reflections are taken to a deeper level, expressing what the core of these findings is and what these comparisons, and their subsequent similarities and differences, might reveal about deeper humanitarian issues both within healthcare and in the broader social context. The latter summarises how the work fulfils the purpose of its main objectives.

2.
Defining, Acknowledging, and Measuring Obstetric Violence

Conceptual Framework

Obstetric Violence (OV) is a term used to describe harmful practices perpetrated against women, transgender, and non-binary people in their pregnancy, prenatal, birth, postpartum, and abortion experiences within institutional care (Berzon and Shabot 2023, 52; Diniz et al. 2015, 378; Pickles 2024, 1). It is manifested in abusive, coercive, non-consented, neglectful, and highly interventionist conduct by healthcare professionals, who, in breach of their professional duty, violate ethical principles of dignified, respectful, and person-centred care (Sadler et al. 2016, 47; EC 2024, 1; WRA 2023, 2, 19). As a systemic, intersectional issue, it is a legacy of enduring gender-based power imbalances which have historically gone unchallenged.

These (mal)practices, often based on gender and racial discrimination, may be performed by *any* provider involved in obstetrics or midwifery care, i.e. any maternity professional, including obstetricians, midwives, obstetric nurses, doulas, general practitioners, and anaesthetists (Hancock and Rhoden-Paul 2024, 3; Martín-Badia et al. 2021, 1; O'Brien and Rich 2022, 2183). They may be exhibited in subtle or accentuated ways and can be perceived differently by different people in different contexts. It is important to note that violations occurring in institutional childbirth settings that result in physical and psychological harm do not necessarily imply intentionality from the actor, nor does it — intentionality — constitute a reliable indicator for measuring OV, as will be discussed in greater detail later in this section (Sen et al. 2018, 8).

A pivotal report by Bowser and Hill (2010, 9) exploring evidence on violations of respectful maternity care during childbirth categorised seven primary forms of "disrespect and abuse" (one of the forefront terms in the field and which is often used interchangeably with OV): "physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination based on specific patient attributes, abandonment of care, and detention in facilities".

To illustrate what conducts and behaviours these categories include, some findings collected through a mixed method systematic review include more explicit examples of ways through which abuse, disrespect, and violence can be manifested

in facility-based childbirth (Bohren et al. 2015, 8):[3] physical abuse (e.g. slapping, pinching, beating, restraining or tying down during labour); sexual abuse (e.g. rape and other forms of sexual assault by health workers); verbal abuse (e.g. shouting, scolding, calling names, threatening, negative comments, threat of withholding treatment); stigma and discrimination (e.g. discrimination based on specific patient ethnic and cultural attributes or sociodemographic background); lack of informed consent and confidentiality (e.g. non-consented care, vaginal examination in antenatal ward undertaken without consent, shaving of pubic hair without consent, disclosure of HIV status without consent); neglect and abandonment (e.g. delivery without attendant); lack of supportive care (e.g. denied companionship by the partner or relatives); loss of autonomy (e.g. detention in the health facility for various reasons, including failure to pay); lack of resources (e.g. unsanitary or unhygienic beds or facility); lack of privacy (e.g. provision of care without confidentiality and lack of physical privacy); and inadequate facility culture (e.g. request for bribe or inappropriate demands for payment).

Similarly, other forms of violations which can lead to devastating and long-lasting physical and psychological impacts refer to standard non-evidence-based practices. Among the most discussed ones are the overuse or underuse of medications and excessive or insufficient intervention. In this context, further standard routine practices, such as acceleration and induction techniques, can be challenged. For instance, routine episiotomy (an incision between the vagina and the anus to facilitate childbirth) (NHS 2023), routine fundal pressure (also known as the 'Kristeller manoeuvre', which entails "application of manual pressure to the uppermost part of the uterus directed towards the birth canal, in an attempt to assist spontaneous vaginal birth and avoid prolonged second stage or the need for operative birth") (Hofmeyr et al. 2017, 1), and unclearly medically indicated caesarean sections (Smith-Oka 2022, 1). The latter proves to be particularly problematic in the Brazilian context, where 56% of births are performed through caesarean sections — one of the highest in the world (Boerma et al. 2018, 1341; Rocha et al. 2023, 2; Sadler et al. 2016, 48).

Despite records of physical and psychological aggression that women and OBI go through being present throughout history, only in the last few decades has it gained

[3] A facility-based childbirth occurs in an institutional setting, such as a maternity hospital or birth centre. As this model accounts for the majority of births in both the UK and Brazil, this research focuses exclusively on them (Walker 2017, 79; Cursino and Benincasa 2020, 1433). However, future research could explore if and to what extent OV occurs in Planned Home Births (PHB), since they are also assisted by health practitioners (Walker 2017, 79).

international recognition (O'Brien and Rich 2022, 2183). In this sense, the largely disregarded history of violent birth practices suggests how different forms of social and political relations, oppression, and ostracism were exacerbated in childbirth in previous centuries (Pickles 2024, 1; O'Brien and Rich 2022, 2183).

One example of this historical abuse of marginalised groups can be seen in the colonial rule of the Americas, where the particular social and economic conditions and subsequent official slavery and theological mandates elucidate how OV was historically enabled, largely by men in power (O'Brien and Rich 2022, 2183). To put it into context, some historical evidence points out that some women were forced to undergo caesarean sections by priests during the occupation of the Spanish Empire in the Americas in the late 18th century (O'Brien and Rich 2022, 2183). Accordingly, crown officials made these operations mandatory, stressing that their primary objective was to save the foetuses' souls, not their mothers' lives (O'Brien and Rich 2022, 2183).

A further example can be found in the evolution of modern gynaecology and how historically impoverished and racially marginalised groups have been exploited in order for medical treatments and technologies to be developed (Axelsen 1985, 10; O'Brien and Rich 2022, 2183; Warren et al. 2020, 233). Dr. J. Marion Sims (1813-1884), widely regarded as the "Father of Gynaecology", conducted gynaecological surgery experiments on enslaved African-American women in Montgomery, Alabama, between 1845 and 1849 (Axelsen 1985, 10; Ojanuga 1993, 28). It is essential to emphasise that his motivation, according to Lokugamage et al. (2020, 266), was "to repair fistulae in black women slaves, so they could *return to the workforce* rather than to heal them — representing the 18th century enlightenment's aspect of dehumanisation" (italics supplied).

Considering this example in the past as a link to today's "marginalised groups [who] have poorer healthcare outcomes than patients at the top of the postcolonial hierarchy", it becomes even more pertinent to raise questions regarding current medical syllabi and the extent to which they include recognition of the role of racism in clinical practice and how these encounters can not only enable but also deepen the effects of colonial legacies (Lokugamage et al. 2020, 265). This shall be further explored in section *3.2*.

In this regard, these concise but significant historical accounts offer an essential foundation for discussing OV as a form of gender-based violence inherent to the

masculinist practice of obstetrics and gynaecology, and which disproportionately affects racially marginalised society groups.

Conceptual Emergence and Multiplicity

In the 1980s, the first debates around violent practices, over-medicalisation, and unnecessary interventions performed during institutional childbirth emerged amongst feminist activists and scholars in Latin America (Sen et al. 2018, 7). In 1993, Brazil pioneered the debates on the humanisation of birth in the founding charter of the international conference Network for the Humanization of Childbirth and Birth (ReHuNa), favouring positive and respectful experiences, while actively avoiding terms that explicitly focused on violence around the topic due to belligerent reactions from medical professionals (Diniz et al. 2015, 379; Sadler et al. 2016, 49-50). As a result of this event, the conditions that otherwise contradicted respectful and dignified maternity care experiences were officially recognised for the first time (Sadler et al. 2016, 49-50).

As a result of the increasing debates and activism against OV in Latin America, in 2007 Venezuela became the first country to codify Obstetric Violence as a form of gender-based violence with the *Organic Law on the Right of Women to a Life Free of Violence* (Lokugamage and Pathberiya 2017, 2; O'Brien and Rich 2022, 2185; Sadler et al. 2016, 50). In article 15, paragraph 13, OV is understood as (Ley Orgánica sobre el Derecho de las Mujeres a una vida libre de violencia 2015):

> [...] the appropriation of the body and reproductive rights of women by health personnel, which is expressed in dehumanising treatment, in abuse of medicalisation and pathologisation of natural processes, bringing with them loss of autonomy and ability to freely decide about their bodies and sexuality, negatively impacting in the quality of life of women.
> Author's Translation (AT)

Following that, Argentina (2009), Chile (2015), Colombia (2017), Ecuador and Uruguay (2018) have enacted statutes defining and outlining penalties against OV, also categorising it as a form of gender-based violence (O'Brien and Rich 2022, 2185).

This emerging movement originating in Latin America served as a catalyst for the rest of the world to follow the debates on this human rights violation issue while offering a solid starting point with rich transformative potential (Pickles 2024, 2, 8). Since then, international organisations such as the United Nations (UN), World Health Organisation (WHO), White Ribbon Alliance (WRA), and the European Commission (EC) have adopted the discourse on OV, disrespect, and abuse (UN

2019; WHO 2015; WRA 2024; EC 2024). This underscores the importance of scrutinising geographical biases regarding the production of scientific knowledge in the 'Global South' as it tends to be underrepresented as an accepted body of knowledge in comparison to the 'Global North' (Lokugamage et al. 2020, 269).

Yet, despite the augmented public perception of this issue — evident through its incorporation into academic discourse and its adoption by activists and policymakers seeking reproductive justice — there remains an underlying danger of over-generalisation or ambiguity (Pickles 2024, 1, 15; Dixon 2022, 268):

> Everything is obstetric violence now: if the patient cannot eat, is left in bed, gets an episiotomy, has a uterine cavity revision without anaesthesia, if we leave them there too long, if we give them Pitocin, if we ask them about birth control too much … it is all considered obstetric violence.

Particularly vulnerable to this risk is the way OV can be represented in the media, as it can provide much more scope for sensational narratives than coherent analysis, which can consequently further hamper efforts to garner support in mutual understanding from all concerned.

The literature on the topic, especially in healthcare and legal matters, reveals a significant resistance to reaching a consensus on the terminology and has outlined several other terms and concepts to determine when women and OBI experience, whether intentionally or not, physical and psychological harm during pregnancy, childbirth, and postpartum. Apart from OV, the collection of terms and concepts include: "disrespect and abuse", "dehumanised care/assistance", "mistreatment", "gender-based violence in childbirth and abortion", "violence in childbirth", "cruelty in childbirth", and "human rights violations of women in childbirth" (Bohren et al. 2015, 8; Diniz et al. 2015, 379; Sen et al. 2018, 6).

Other key themes in reproductive healthcare, including "maternity experiences" and "quality and safety of maternity care", seek to draw attention to issues related to maternal mortality and ethnic inequalities, but ultimately conceal rather complex structures that not only deteriorate the acknowledgement of violent maternity experiences, but also lack the more encompassing and structural dimension of the problem, both at micro and macro levels, deeply rooted in gender, race, and class (Brader 2024, 2; Sadler et al. 2016, 52). Ultimately, additional fundamental concepts, exemplified by "humanised childbirth" and "respectful maternity care", are centred on the overarching objective of delivering humanised and respectful experiences, a necessary approach which unquestionably symbolises the desired and progressive

outcome, but that still fails to distinctively ascertain the fundamental issues of intersectional violence at the heart of OV in society (Sen et al. 2018, 6).

The multiplicity of terms proves useful, nonetheless, when women and OBI are unable to recognise OV as such or grapple with understanding the nature of their experience, often symbolising a result of internalised and normalised patriarchal beliefs and pervasive shame to which they are subjected (Pickles 2023, 639; Freedman et al. 2018, 107; Castro and Savage 2019, 125; Cohen Shabot 2021, 443). In this sense, a wider offer of terms should also have an active space and role in the available conceptual landscape due to its adaptability to accommodate diverse cultural, social, political, and ethnic contexts, as Pickles suggests (Pickles 2023, 639):

> When different women and [other] birthing people are unable to accurately name their experience because of limited communicative tools, they are forced to engage in what Suzanne McKenzie-Mohr and Michelle Lafrance describe as "tightrope talk" (McKenzie-Mohr and Lafrance 2011). This is the process of precarious reliance on existing names that do not fully articulate their experiences and it forces them to tell their stories without adequate communicative resources. "Tightrope talk" is a matter of epistemic injustice (Fricker 2007; Cohen Shabot 2021), which undermines comprehensive recognition and response."

Overall, definition debates driven by key players in academia, civil societies, and governments should not intend to treat the problem on a superficial level based on allocating blame or targeting offensive accusations at the individual level. Rather, they should challenge power dynamics in clinical encounters, such as unconscious racial bias. Moreover, definition debates offer the language for people to identify and describe the problem while also offering tools to distinguish between *intent* and *impact* in critical decision-making processes (WRA 2023). For example, understaffed medical institutions and overworked healthcare professionals may be key factors that enable substandard care practices. In order to train professionals who can be better equipped to meet the complex needs of diverse populations, further investigations should explore how medical education and the incorporation of cultural safety mechanisms, as well as decolonial perspectives on medical syllabi, can be instrumental ways to address inequality and human rights issues in healthcare (Lokugamage 2020, 265; Lokugamage 2023, 244).

The reluctance and often downright rejection by global health researchers to name it OV, however, is continuously being faced. This comes largely due to defensiveness on the part of practitioners as well as a lack of acknowledgement of structural and intersectional power imbalances (Pickles 2023, 629; Sen et al. 2018, 7). In this regard, it is essential to highlight the importance the word "violence" carries. In the arguments thus far presented, it is possible to see a continuum of violence in time

that has not ceased, as well as an overlap with other forms of gender and reproductive violence, such as domestic violence (Pickles 2024, 1).

Thus, in order to meaningfully comprehend OV as a concept, it is imperative that deep theoretical engagement be undertaken. This is emphasised since its absence can lead to the depoliticisation of the matter, thereby delegitimising women's and OBI's authority over their bodies and, ultimately, their access to legal justice (Ramírez et al. 2016, 570; Pickles 2024, 3). As opposed to what Ayres-de-Campos et al. (2024) defended, the term OV *is* appropriate and should be used because, even though not every form of OV may be intentional, it carries historical roots that align with intersectional intricacies and gender-based violence, thus not configuring an exception, but rather close to the norm (207; cf. Pickles 2023, 639).

While understanding the value of integrating perspectives from various fields to contribute to debates, it is important that the motivation to develop the dominant discourse of OV is exogenous (primarily by victims and survivors, as well as activists), and not formulated by the healthcare sector given their leading role in perpetrating abuse and violence in institutional childbirth (Pickles 2023, 628).

Measuring Obstetric Violence

In light of the numerous strengths and weaknesses inherent to the incorporation of a varied lexicon into the issue across social, medical, legal, and academic spheres, this lack of clarity to effectively communicate OV can also hinder evaluation and measurement methods. Due to the topic's high complexity, the debate on the best methods to collect, measure, and assess evidence cross-nationally is continually being held. Additionally, given its long-lasting effect and devastating impact on victims, it can be a challenge to find reliable methods to measure its occurrence and, therefore, standardise data collection.

However, evidence gathered through both qualitative and quantitative research — e.g. in birth experience reports, induced labour rates, unnecessary or excessive interventions, maternal mortality and morbidity levels, the disparity between Black, Asian, Indigenous and other historically disadvantaged groups suffering disproportionate lethal consequences in comparison to historically advantaged ones, as well as pregnancy treatment and outcomes of incarcerated women and OBI, and intergenerational trauma as a result of the latter — can serve as some indicators to gauge the magnitude and gravity of OV (Alirezaei and Roudsari 2022, 14;

Lokugamage et al. 2020, 268; Sapkota et al. 2022, 2). Additionally, such evidence can further reiterate how OV reflects and perpetuates intersectional nuances.

Research Position

As a result of the elements discussed, the lack of respect, quality, and safety in maternity care that women and OBI can experience during pregnancy, childbirth, and abortion is a contentious subject of debate involving a variety of interest groups and perspectives (Brader 2024, 2). From academics (a great portion of which driven by female-written literature) to healthcare professionals to patients themselves: little agreement exists about how to validate an epistemological concept that does not conceal, oversimplify, nor depoliticise the crux of the matter (Sen et al. 2018, 6).

Given the interdisciplinary and cross-national nature of the present work, it is imperative to call for the definition of the term OV as a shift from all of the terms that have been used so far to one that encompasses all forms of abuse, disrespect, and mistreatment and does not diminish the social impacts of this phenomenon.

By universally acknowledging this term, gender is placed as a central component of its conceptualisation comparable with other naturalised forms of gender-based violence and misogyny of the technique (Diniz et al. 2018, 2021; Sadler et al. 2016, 49-52). Additionally, when a problem is characterised as violent, there is less scope for minimising and obfuscating experiences and more scope for promoting citizen, national, and international awareness, as well as for allowing further intersectional analyses that permeate fields beyond public health (Chadwick 2023, 1902).

Finally, it provides a necessary basis for discussing Obstetric Racism (OR), a phenomenon arising from the convergence of OV and medical racism, and central to the countries subject to this study (Davis 2018, 560; Davis et al. 2021; van der Waal et al. 2023, 109).

Ultimately, it is equally important to highlight that this definition does not aim to target healthcare professionals personally but to legitimise a historical and socio-political struggle that calls for urgent attention (Chadwick 2023, 1905). By negotiating new perspectives, it becomes imperative to understand the drivers and the historical context as well as advocate for conceptual coherence, thus providing a solid foundation for creating strategies towards mutual understanding; institutional commitment to review structural knowledge, biases and assumptions; staff and structural self-reflexivity as an inherent feature of cultural safety for women and OBI

to have a dignified birthing experience; and, finally, multilateral social and legal reform efforts (Lokugamage 2023, 246; Pickles 2024, 29).

3.
Comparative Analysis

3.1
Historical Background

a. Method

In order to understand OV as a human rights violation today, it is necessary to undertake a deeper investigation of its historical roots in gender, racial, class, and ethnic power imbalances (Lokugamage et al. 2022, 1). Historical investigations of this kind can offer a robust framework for analysing OV from two different perspectives: (1) from the people who *experience it* and the oppressive structures that impose control over women and OBI's bodies, and (2) from the people who *enable it* and the power imbalances that are reflected in healthcare staff hierarchies and how these contribute to the perpetuation of substandard care today (Lokugamage et al. 2022, 1).

In this sense, when scrutinising the institutionalisation of medicine through the eye of history, i.e., especially from Western and androcentric perspectives through which medicine has evolved, colonial powers and legacies must be considered (Lokugamage et al. 2022, 1).

Thus, one of the main goals of this section is to analyse structural inequities, oppressions, and biases in the maternity care systems in the UK and Brazil through a decolonial lens (Lokugamage et al. 2022, 2). The vital role of decolonisation is to acknowledge the lingering impacts of colonial power on social (in)justices in the present and to fundamentally restructure the systems that continue to produce and perpetuate such injustices (Lokugamage et al. 2022, 4). In the context of the provision of person-centred and humanised care, the legacy of systemic and unconscious biases is manifested especially through interactions between healthcare providers and patients, between healthcare providers themselves, and in research outputs and how the production of scientific knowledge from the 'Global North' and 'Global South' is perceived (Lokugamage et al. 2022, 5, 10). With historical contextualisation, it becomes possible to understand crucial aspects of OV that are deeply grounded in the damaging legacies of colonialism (Lokugamage et al. 2023, 245; Lokugamage et al. 2020, 265).

Therefore, the methodology employed in this section provides a historical overview of childbirth practices through historical archives as primary sources, providing evidence into parturients'[4] and midwives' experiences, as well as medical perspectives from colonial rule. Secondary sources, including literature on intersectional theories, medical history, ethics, and anthropology, are drawn upon to interpret and analyse these primary documents and to understand how subjugations of patients *and* medical staff, as well as exploitations and violations, are not isolated incidents but are tied to more profound systemic injustices sustained over time, and that continue to shape the present.

It is worth noting that, even though this research prioritises heterogenous birthing groups of people through the inclusivity of language of "women and Other Birthing Individuals" (OBI), the terms women and female shall be used when discussing androcentric biases in historical contexts (Lokugamage et al. 2022, 4).

b. UK

Midwifery in England from 1500 to 1902

Historically, midwives have been the primary providers assisting women in childbirth in the UK and other cultures worldwide (Fox and Brazier 2020, 336). As a philosophy that dates back much further than the profession of obstetrics, midwifery has supported women throughout childbirth processes, which, for a long time, was practised in the domestic setting in a network of mutual support based on care provided from *woman to woman* (Lokugamage et al. 2022, 12; Ehrenreich and English 2010, 25).

In sixteenth-century England, the ritual of birth was held as a social event and was widely practised by married, neighbouring women who had previously given birth (Fox and Brazier 2020, 314; Wilson 2016, 218-219). During this period, midwifery was overseen by the Church of England and was, overall, largely influenced by the ecclesiastical sphere (Fox and Brazier 2020, 309). This influence was reflected and emphasised in midwives' roles in baptism and overall liturgical correctness (Fox and Brazier 2020, 309).

[4] "Parturient" is a widely used term in academic research, particularly in the Brazilian context, to describe someone who is about to give birth or who is in labour (Oxford University Press 2024; Lansky et al. 2019, 2811).

From around 1500 to the eighteenth century, diocesan bishops issued midwives with an episcopal[5] license to practise (Fox and Brazier 2020, 309; Guy 1982, 537). The requirements for admission were their marital status and reputation based on skill and character, with testimonials obtained from local officials, namely churchwardens and curates, as well as previous parturients (Muir 2020, 399). One of the motivations for formalising midwifery practices arose from the desire to maintain the religious integrity of communities, resulting from the Church's suspicion of female knowledge of and experience in childbirth and healing processes that were demonised through accusations of witchcraft (Lokugamage et al. 2022, 13; Fox and Brazier 2020, 309).

Although the Church's validation of the occupation did confer midwives a skilled and expert status, this could only be achieved by the approval of males (i.e. Church representatives and husbands).

The validation of the occupation by the Church and subsequent statutory regulation introduced by Parliament through the Midwives Act 1902 was a step ahead towards a greater level of respect and recognition for the profession (Fox and Brazier 2020, 308-9; Dale and Fisher 2009, 427; Midwives Act 1902). However, these women still struggled to gain respect from doctors, particularly due to the shift towards medicalised delivery techniques employed by obstetricians (Lokugamage et al. 2022, 13). Even though the Midwives Act restored the credibility of midwives as acknowledged healthcare professionals, they still occupied a subordinate role (Fox and Brazier 2020, 337).

Although women in healthcare have historically been autonomous healers, the regulation of midwifery as a profession first through the ecclesiastical institution and then through statutory regulation serves as evidence of a recognition system subjugated to dominant male professions (Ehrenreich and English 2010, 27). These historical power imbalances, which will continue to be discussed in the following sections, are vital for understanding chains of oppression between healthcare providers and the transferability of these factors to the way healthcare providers treat women and OBI undergoing pregnancy.

[5] "Episcopal" means "of or pertaining to a bishop or bishops" (Oxford University Press 2024).

Windrush Generation Midwives

Moving forward to the post-World War II era, when Britain was undergoing significant efforts to rebuild the country, the arrival of immigrants from the Commonwealth was the backbone for the NHS's inception in 1948 and its subsequent development (Grainger et al. 2018, 318; NHS 2023).

Staff recruited from the Caribbean, known as the 'Windrush Generation', played a crucial role in establishing the universal health system in Britain (NHS 2023; Mead 2009, 137). In the context of the NHS' midwifery care workforce, when taking into account midwives coming from the West Indies, Western NHS users imposed significant colonial oppression on immigrant midwives (Lokugamage et al. 2022, 13; "The 'Windrush' midwives" 2016). Apart from being denied British citizenship, they were often treated in dehumanising ways, as observed in a personal account from a former midwife, Jannett Creese ("The 'Windrush' midwives" 2016):

> I was in my second year and this patient said, when I was going to wash her: "take your black hands off me!". She said it with so much venom that I just rushed to the toilet and cried. That was so hurtful. I found it extremely upsetting.

What is striking about such neglected accounts is that they reveal two dimensions of oppression largely unexplored by scholarly inquiry to date: (1) the oppression suffered *by* (BAME)[6] providers *from* (white) parturients in obstetric care, and (2) the absence of academic literature on the crucial role Windrush midwives have played in the NHS' maternity care workforce (Lokugamage et al. 2022, 13).

Although a detailed analysis of Windrush midwives would necessarily warrant a separate study, it can be said that this account serves as evidence to highlight the fact that women are and have been, as both healthcare providers and consumers of care, oppressed *and* oppressors as they have been subordinate to the ruling classes of Western supremacy (Ehrenreich and English 2010, 8; Lokugamage et al. 2022, 13).

Parturients' Experiences Through Their Voices

Now shifting from the historical perspective of midwives to that of parturients, in the course of conducting research on traumatic birth experiences in Britain, social anthropologist and natural childbirth activist Sheila Kitzinger revealed ground-

[6] Black, Asian and Minority Ethnic.

breaking findings since the 1960s that facilitate the understanding of OV in the past and today.

When scrutinising traumatic birth experiences due to substandard treatment, Kitzinger pointed out that women often do not believe that their emotional reactions can be validated and that they do not feel entitled to the negative emotions they are experiencing, often leaving them feeling as though they were "making a fuss about nothing" (Kitzinger 1992, 67). This has historically not only rendered women silent, but also stimulated healthcare professionals to claim that some patients "exaggerate" their negative experiences of childbirth (Kitzinger 1992, 67).

This leads to some patients sometimes trying to "act the part of a happy mother with her new baby, and say how wonderful her doctor is", which reflects one reason behind positive feedback in questionnaires in the immediate postpartum period (Kitzinger 1992, 74). Although patients may express high satisfaction levels regarding the care they receive then, over time, they may express significantly different emotions and often blame themselves for what has occurred (Kitzinger 1992, 74).

Several of these feelings and attitudes can be evidenced through personal letters from women to a trustee of the National Childbirth Trust (NCT) in 1959, recalling their experiences of poor treatment in hospital maternity care in England (Wellcome Collection 1959; Appendix A, Letters 1 to 6). As such, the following excerpts are categorised into four instances: (1) violent practices and abusive language, (2) abandonment and the need for freedom of choice for the birth companion, (3) euphemised language, and (4) the lingering issue of shortage of staff.

Instances of violent practices and abusive language:

> During the second stage of labour the gas and air was forced over my face with the instructions: "take two deep breaths and push" - virtually impossible. This was only discontinued after a near 'free fight'. (Harriet Baker 1959, Letter 1)
>
> The pumeling *[sic]* on my stomach to help release the placenta was most painful and unnecessary. (Harriet Baker 1959, Letter 1)
>
> The Sister came and asked what the fuss was about, said it was only 1 am. and I'd have to wait. This I appreciated, and apologised for bothering her. I rather felt I was being a nuisance when I was trying to put up with as much as I could. (Beverly Cooper 1959, Letter 3b)
>
> By this time, I did feel I've got to be on my best behaviour and not make any noise. This was my first baby & naturally I was apprehensive but I don't think I was making a fuss. (Beverly Cooper 1959, Letter 3b)

Instances of abandonment and the need for freedom of choice for the birth companion:

> I would like to extend my thanks, however, for my husband being allowed to be present. It was a great comfort and was extremely useful in helping me to keep control of myself during the breathing. (Harriet Baker 1959, Letter 1)

> I was taken to the labour ward at 8.30 ish and left alone as previously, with instructions to ring if necessary. This I did at 8.45, was told to inhale gas and air which I found useless and was left alone immediately. By 9 am, I got into a panic instead of being calm as before, as I knew it was essential I had attention. (Briony Jones 1959, Letter 2)

> The illusions that had been built up at the antenatal classes about cooperation between midwife and patient in being told when to stop pushing and when to pant etc were bitterly shattered as no one was with me when I first needed this guidance and I cannot help feeling that this was why stitches were necessary. (Briony Jones 1959, Letter 2)

> To sum up I felt that if I hadn't had some understanding of what to expect at each stage in childbirth, particularly as this was my first child, I would have been petrified & screaming my head out, because I had to be left so long. (Beverly Cooper 1959, Letter 3b)

> I feel that, had my husband and/or Mrs. Lloyd been with me all the time, I would have called on her less. Being left on one's own, even with a bell at hand, is not satisfactory. (Diane Clark 1959, Letter 4b)

Instances of euphemised language, especially expressing feelings of "This is not a complaint, but…":

> I am not intending this to be in any way a complaint against the staff of Rodney House as I found all extremely kind and efficient, but know you would like me to mention some of the events which occurred in my case. (Briony Jones 1959, Letter 2)

> I may have been unfortunate that my baby was born at a busy time but even so, I feel that where the lives of mother and baby may be at stake, this sort of thing should be avoided. (Beverly Cooper 1959, Letter 3b)

> Firstly, I would like to make it quite clear that, apart from the actual delivery, I have nothing but right praise for the kind, efficient attitude of all the staff, and for the happy atmosphere which one finds there. I would still recommend anyone to go there. (Beverly Cooper 1959, Letter 3b)

> You can see from this that my first day at Rodney House was rather unfortunate and not what I expected. However, once the baby was born my mind was quickly put at rest and I personally feel that once Rodney House accepts and can cooperate with the N.C.B Trust it will be better for expectant mothers. (Helen Wright 1959, Letter 5)

> I've tried to be as brief and to the point as possible but this nevertheless has developed into rather a screed. Please don't use it as a list of grumbles from me but merely as an indication of what improvements could be made. (Anne Carter 1959, Letter 6)

An instance of the lingering issue of shortage of staff:

> Shortage of staff seemed to be the cause of these difficulties; lack of appreciation that trained mothers are likely to be "getting on with the job" more quickly than the nurses think was another. (Briony Jones 1959, Letter 2)

What is striking to observe in these letters is that even though they might not be representative of a wider scope of OV at the time in the UK, they do emphasise the *experience* of these women through *their* voices, particularly when it comes to: (1) more than one introduced her feedback in an apologetic manner, stating that it was not by any chance any sort of criticism; (2) more than one mentions that she was left

alone for a long time (which points to potential staff deficiency and no regulations on the presence of a companion); and (3) it points to the failure of professionals in acting with kindness, compassion, and patience towards women in labour, symbolised by terms such as "making a fuss about something".

Several of the issues revealed in these rare materials from 1959 are still prevalent within the NHS today, as will be further explored throughout this study.

c. Brazil

Traditional Midwives (*Parteiras Tradicionais*)

In order to gain a comprehensive understanding of contemporary obstetric practices in Brazil, an examination of colonial influences from the Portuguese-Brazilian Empire (1500-1822) vis-à-vis birth practices is essential.

Until approximately 1870, childbirth, which happened predominantly in the home environment, was exclusively a female domain (Telles and Pimenta 2024, 3). Notably, women who were still or previously subjected to colonial rule — i.e. enslaved and freed women of all ages — were widely known in their communities for assisting the births of other women (Telles and Pimenta 2024, 2-3). Given the range of urban specialities and obligations they needed to fulfil (see, for instance, the following subsection on wet nursing), performing as midwives (*parteiras*) constituted a crucial aspect of their lives.

Although studies on the details of procedures, rituals, and experiences have been scarce and only recently conducted, it is known that their actions involved (Barreto 2016, 389; Telles and Pimenta 2024, 11):

> [...] manoeuvres in difficult births, through rituals related to the protection of the mother and baby, using amulets, herbs, prayers, enchantments, and magical-religious resources that aided childbirth, warding off spells and preventing adverse outcomes. (AT)

These traditional midwives supported women across all social and ethnic groups: women of African descent, Indigenous women, the Portuguese elites, and impoverished white descendants (Telles and Pimenta 2024, 2-3). Their practical knowledge to assist not only mothers and their new-borns during birth, but also uterine diseases and puerperium periods, was based on traditional practices that had been shared and transmitted orally through generations (Palharini and Figueirôa 2018, 1040; Telles and Pimenta 2024, 1-3).

Considering the oral foundation of midwifery practice among African-descendant women and the omission of their perspectives, voices, and experiences from historical archives in the Brazilian context, explorations of other places in the Americas with comparable colonial-based midwifery developments suggest that these women had a central role in their communities in building bonds of solidarity among other enslaved women (Fett 2006, 66; Telles and Pimenta 2024, 7). This can be seen by the adoption of the popular term *comadre* (equivalent to "godmother") in reference to the ritual kinship celebrated in the sacrament of baptism, but affectionately assigned to the *parteiras* as an expression of female camaraderie, trust, and sociability (Telles and Pimenta 2024, 3).

Adding to the importance of the study and existence of traditional birth practices is the role of p*arteiras tradicionais indígenas* (traditional Indigenous midwives) in the same period. These midwives, fundamental preservers of Indigenous wisdom, employing traditional Indigenous techniques and rituals to facilitate childbirth within their communities, have existed long before Brazil existed as a country (Araújo 2019, 30).

However, despite their significance, historical records offer scant information about their practices and contributions during colonial rule, often overshadowed by the more dominant and dehumanising narratives of Western-centred medicine, as evidenced by excerpts of a newspaper article from February 1869, written by Dr. Costa Ferraz (Telles and Pimenta 2024, 6; Annaes Brasilienses de Medicina 1869, 321; Appendix B):

> And an old black woman as ignorant as stones, or a speculator and a *mezinheira*[7] who, by way of *comadre*, ends the life of a poor innocent, and often the unfortunate one who was carrying it in her womb. (AT)
>
> Brazil is no longer in a state to allow such a difficult branch of medical science to serve as a means of living for so many women around here who are worn out and even unfit for prostitution. (AT)

The lack of historical evidence from *parteiras tradicionais* and Indigenous midwives points to a critical gap in the understanding of Indigenous midwifery in colonial Brazil and the unique social and cultural settings in which these midwives practised. Hence, further research is essential to illuminate their roles from their perspectives in the period herein described in order to better understand the impact of birthing practices changes and adaptations.

[7] *Mezinheira* is a woman who uses homemade remedies (Dicionário Online de Português 2024).

Wet Nursing in Colonial Brazil — An Early Form of Obstetric Violence?

To contextualise how systemic gender-based violence and the appropriation of the female body play a role today in the Brazilian reproductive care scenario, further examinations of colonial influences are essential. For this purpose, it becomes relevant to scrutinise how the perennial myth of women of colour being more resistant to discomfort and pain was present in the social and economic function of black domestic enslaved women during the nineteenth century in Brazil (Burns 2023, 17; Silva 2016, 298).

Beyond their roles as instruments of sexual satisfaction to slave owners (otherwise understood as victims of rape and sexual violence) and as bondswomen (also known as *mucamas*), young black lactating enslaved women were purchased or rented to become wet nurses (*amas de leite*) for their masters' children (Moura 1998, 190; Silva 2016, 302-15). This practice was imposed by the masters of affluent families largely due to racial stereotypes referring to black enslaved people's physical proportions in comparison to white women, often regarded as fragile and not suitable for breastfeeding (Silva 2016, 306). The belief that the milk of black women, a commodity readily available for purchase and sale, would provide a greater nutritional benefit for the white master's infant is one of several factors adding strength to the notion of slavery enterprise mentality and economic exploitation through dehumanising means (Roth 2018, 805; Silva 2016, 299- 302).

Through expansionist and power ideologies, slave masters acted in the name of the state to displace and dispossess non-European people of their rights, their lands, and their lives by justifying that this was part of the process of a civilising mission (Gurnah 2023). Because in colonial Brazil population growth occurred mainly through forced migration and not natural reproduction, the profit slave owners made from wet nurses had a greater importance than ensuring children reached adulthood (Roth 2018, 805).

Throughout generations, these women suffered psychological trauma and, most poignantly, from the devastating forced separation from their own children (Roth 2018, 806). Since black mothers were often stripped of their motherhood, they were in no position to provide adequate care for their own offspring, which contributed significantly to a high mortality rate among black children (Silva 2016, 302). In contrast to widespread advertisements made in newspapers from São Paulo and Rio de Janeiro at the time offering the assistance of lactating enslaved women, the

experiences and feelings of these women, as well as the precise death numbers of their children, have largely been excluded from written archives (Gil 2018, 164; Gurnah 2023; Henschel 1880; Rodrigues 2017, 189-196).

By utilising notions of unconscious racial bias and assumed superiority as central components of colonial rule legacies to guide this work, a deeper understanding can be gained of the phenomenon of wet nursing in colonial Brazil and its intersectional impacts then and now (Lokugamage 2020, 268). As such, this practice serves as a functional equivalent of integral issues within OR today: that of how enforcing Western beliefs and reinforcing racial stereotypes exacerbate damaging impacts and lingering inequalities of colonialism (Dannemann 2019, 394; Lokugamage 2023, 245).

This violation of reproductive and human rights renders visibility to oppressed motherhood experiences (Marcos 2020, 172). It provides an intertwining link between past and present by illustrating how women of colour had no agency over their bodies and were systematically subjected to abusive treatments, in addition to being ignored and invalidated for their wishes and pain (Marcos 2020, 172). The mistreatment and violence they undergo today in obstetric care, along with their alarmingly high death rates, cannot be divorced from colonial amnesia (Marcos 2020, 172).[8]

Institutionalisation of Medicine in Brazil

While Brazil was gradually undergoing the process of abolishing the slave trade — with its consummation in 1888, becoming the last country in the Western Hemisphere to legally abolish it — it was also experiencing a gradual institutionalisation of medicine and regulation of healthcare professions (Roth 2018, 804). Among the many factors that contributed to the abolition process were attempts made by physicians to curb the practice of selling the milk of bondswomen (Roth 2018, 806). This did not occur as a measure to protect bondwomen's and wet-nurses' wishes and cease the brutal practice of forcing them to feed children other than their own, but rather because physicians believed that (Roth 2018, 805):

> [...] the milk of enslaved wet nurses was both physically inadequate (e.g., it had poor nutritional quality and carried disease) and morally dangerous (e.g., it contained within its liquid form the specter of licentiousness and immorality that many physicians believed "natural" to black women). Many physicians argued that the milk of enslaved wet nurses was dangerous to white children and consistently called for white women to breastfeed their own children.

[8] See Alyne Pimentel's case in sections *3.4* and *3.5*.

As such, the nineteenth century — the second half in particular — marked a fundamental shift in gender roles regarding the provision of childbirth assistance in Brazil (Palharini and Figueirôa 2018, 1040). This shift, encouraged by the establishment of medical academic institutions in the country and the development of technological instruments, has led to today's notion of OV and excessive and invasive interventions (Telles 2022, 82; Palharini and Figueirôa 2018, 1041; Telles and Pimenta 2024, 2).

Rio de Janeiro and Salvador, two of the leading cities in establishing *Escolas de Cirurgia* in 1808 (Surgery Schools), which then became *Faculdades de Medicina* in 1832 (Faculties of Medicine), had their student corps mostly populated by white males who composed the Brazilian aristocracy and middle urban classes (Telles and Pimenta 2024, 2; Telles 2022, 83).

The employment and handling of technical instruments by male surgeons, such as the forceps, played a crucial role in the gender shift of the birth assistance scene, thereby marginalising the traditional role of *parteiras*, as seen in (Nunes and Moura, 2004, 340; Palharini and Figueirôa 2018, 1041-42):

> The use of these technical instruments, which ensured greater ‘success’ in difficult births, contributed to the perception of the surgeon as having greater control over childbirth, a perception reinforced by midwives' resistance to the use of the instrument. (AT)

In their quest for credibility and clientele, medical professionals began expressing prejudiced, racist, and slanderous rhetoric towards midwives, which gave a basis for the establishment and indoctrination of scientific racism (Telles 2022, 100; Telles and Pimenta 2024, 6). The emergence of medical periodicals, along with medical theses and local newspapers, questioned in offensive manners the legitimacy of midwives’ practices and commonly described these women from oppressed classes as “superstitious, infanticidal, and abortionists” (Telles and Pimenta 2024, 6; Annaes Brasilienses de Medicina 1869, 321; Appendix B).

To the detriment of preserving Brazilian traditional midwifery as an intangible heritage, doctors and academics promoted the stereotypes of the "charlatan" and the "ignorant midwife", many of whom were Indigenous, African, or their descendants, who began to be ostracised (Mott 1999, 26; Telles and Pimenta 2024, 6; Palharini and Figueirôa 2018, 1058).

As a consequence, black women started giving birth in hospitals in order to provide training opportunities for medical students, which still happens today (Telles

2022, 81; Diniz 2016, 253).[9] This often meant they gave birth in precarious conditions, isolated from their families, and without the support of other women, while concurrently undergoing invasive and painful examinations conducted by inexperienced white students (Telles 2022, 101).

In this regard, the rigid colonial structure of the time allowed no space for dialogues or exchanges between doctors and traditional midwives. Consequently, this environment was not conducive to collaborative and respectful learning, but rather one that promoted invasive interventions.

d. Discussion

The exploration of historical and colonial legacies in this chapter provided a robust framework for interpreting OV as a human rights violation then and now. As Lokugamage puts it (2022, 2):

> As there are significant differences in the colonial histories of various European colonial powers across different geographic regions, and populations, it is important to decolonise with respect to these unique histories, territories and challenges, though there are areas of commonality and shared experience to draw from.

By accounting for such colonial histories, it becomes possible to understand how previous structures continue to shape contemporary childbirth practices in profound ways, thereby separating OV from the superficial lens of intentionality, but with that of gender-based and intersectional violence.

Similarly, it was possible to observe how midwives in both the UK and Brazil were systematically subjugated to male acceptance, either by initial regulation of the profession based on marital status and 'morality', as defined by the clergy and patriarchal power structures, or through the intensification of obstetric care by male doctors.

As such, colonial childbirth practices often imposed oppressive structures on Indigenous populations, including the medicalisation and control of women's bodies. This history of subjugation and exploitation created a foundation for contemporary forms of OV, where medical interventions during childbirth can perpetuate power imbalances, disrespect, and a lack of autonomy for women and OBI. By interpreting OV through the lens of colonialism, it becomes possible to understand how these violations are not isolated incidents but are connected to broader systemic injustices that have persisted over time. This perspective highlights the importance of

[9] See the "Vagina School" seminar in section *3.2*.

addressing OV not only as a medical issue but as a critical aspect of social justice and human rights.

Ultimately, this historical account on both the UK and Brazil on OV are paramount to avoid the one-sided and defensive denial of enduring structural biases within medical professional bodies (Lokugamage et al. 2022, 25).

3.2
Healthcare Systems

a. Method

The primary objective of this section is to understand how the structure of each healthcare system in the countries analysed, i.e. the National Health Service (NHS) of the UK and the Unified Health System (SUS) of Brazil, works in maternal health services and how the current state of each might contribute to OV. Therefore, this analysis will rely extensively on studies from the fields of public health, midwifery studies, government policies, medical research reports, medical ethics and history, as well as studies from the field of social science and medicine.

b. National Health Service (NHS)

During the 1950s, the UK witnessed a progressive shift from childbirth taking place predominantly in the domestic setting, assisted by women, to becoming a medicalised event by medical men (Einion 2017, 169). Even though, as seen in the previous section, midwifery as a profession was performed by women, childbirth practices became gradually associated with the rise of a scientific culture dominated by men (Squire 2017, 17; Johanson et al. 2002, 892).

As seen in the previous section, the regulation of the profession through the Midwives Act of 1902 did not have exclusively the objective of guaranteeing midwives their rights as healthcare workers, but mainly as a means to ensure medical and social control over them (Kirkham 1999, 732; Heagarty 1996).

Gradually, the number of midwives employed in hospitals grew, especially with the foundation of the NHS in 1948 (Kirkham 1999, 732). With the 1974 National Health Service (Re-organisation) Act, community midwifery and hospital services were merged, and the relatively autonomous community midwives were moved into the hierarchical structures of hospitals, where mostly men were responsible for statutory supervision and hierarchical management of the profession (Kirkham 1999, 733).

As Kirkham observed back in 1999, the gendering of institutions was present then and remains so today: the centralisation of medical technology and expertise for

maximum efficiency (analogous to that of a factory) continues to "reflect the male-cultured values and create 'hierarchy of institutional expertise'" (Kirkham 1999, 733; Freidson 1970, 127). In this sense, in many circumstances, midwives are still low in the hierarchy, and their position is often taken as a "subcontractor" type (Kirkham 1999, 733; Schwartz 1990, 58). This is still a common feature of contemporary perceptions of midwives by doctors, and can also be seen in the substantial discrepancy in pay levels: in 2016, the yearly average basic pay of a registered nurse, the typical position held by midwives, was £25,298, in contrast to the basic salary of a first-year senior doctor of £76,001 (Castro-Pires et al. 2023, 8; NHS Employers 2016).

In this regard, if theories of oppressed groups are taken into account, it is worth mentioning the Brazilian educator Paulo Freire's considerations on internalising paternal and patriarchal authority: when the repressive structures of the regulating bodies are internalised, there is a tendency for professionals (in this context, midwives) "to repeat the rigid patterns in which they were miseducated." (Freire 2005, 155). These aspects can be observed below in Figures 1 and 2 with instances of oppression regarding working conditions and rights, of which midwives are often deprived, but expected to perform without failure.

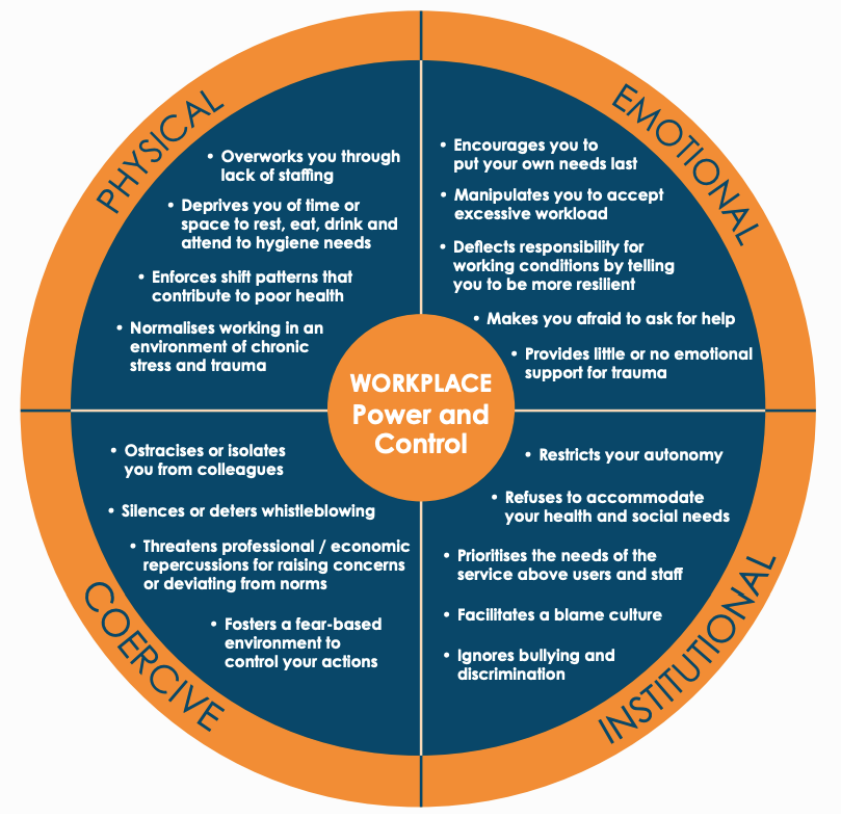

Figure 1: "Workplace Power and Control Wheel" (WRA 2023, 28).

Figure 2: 'March With Midwives' campaign across the UK in 2021 (Woman's Place UK 2021).

Taking these aspects into consideration, it is possible to suggest that, while OV is generally enabled by a high-interventionist birth culture, there is *also* a decreased focus on dimensions of oppression against healthcare workers, especially midwives. Thus, it can be argued that these power imbalances generate a chain of oppression in which: the oppressed healthcare workers (midwives), oppressed by higher or more senior professionals (obstetricians or senior midwives), can also sometimes oppress patients (women and OBI), thus creating a continuous cycle of oppression where OV has the potential to persist.

Education and Training of Maternal Healthcare Professionals

In the UK, the primary professionals assisting in childbirth are the midwife and the obstetrician (NHS 2023).[10] Midwives assist in birth centres characterised as "Midwifery Units" (MU), which can be either Alongside (AMU) or Freestanding (FMU) in straightforward and normal pregnancies and births, as well as in home births (Walsh et al. 2018, 10; NHS 2023). Obstetricians manage high-risk pregnancies and births, as well as surgical interventions, in maternal hospitals, specifically in Obstetric Units (OU) (Walsh et al. 2018, 10; NHS 2023).

Until the 1990s, midwifery training was undertaken in the NHS (Marshall and Furber 2017, 277). After education reformations, the profession was transferred to higher education institutions, i.e. universities, leading to more significant opportunities for professional development and elevating its social standing (Marshall and Furber 2017, 277).

Since then, these maternity care professionals rely on leading bodies of scientific evidence, such as guidelines focusing on the overall experience of birth and better communication with patients from the National Institute for Health and Care Excellence (NICE), the Royal College of Midwives (RCM), and the Royal College of Obstetricians and Gynaecologists (RCOG) (von Benzon et al. 2024, 1; Mobbs et al. 2018). However, there is growing concern about how these guidelines are being translated and incorporated into practice. An example of this is how paternalistic and misogynistic language towards women and OBI can be, as research integrated with the perspective of users has demonstrated (von Benzon et al. 2024, 8). In obstetric care in the UK, it is not uncommon for language by midwives and obstetricians to be disempowering, ridiculing, belittling, or even infantilising women and OBI, such as the following examples (von Benzon et al. 2024, 7):

> "My doctor just called me a good girl and I died a bit inside."
>
> "I remember the anaesthetist asked if this 'was the silly girl' he'd heard about and that I needed to control myself."
>
> "My baby was in a crib by the bed, and I had to press a buzzer when he cried for a feed, and a nurse would come along and hand him to me so I could breastfeed. It was non-stop, and I hadn't slept at all the night before. Eventually I just held him on my chest and let him feed on and off. I was actually told off for that like a naughty child, because I was supposed to press the buzzer every time he fed so that they could record it …. There was more telling off the next day because I fell asleep with my baby on my chest (my husband was there watching us)."

[10] Other professionals involved in antenatal support are: heads of midwifery, anaesthetists, paediatricians, neonatal nurses, sonographers, obstetric physiotherapists, health visitors, and dietitians (NHS 2023).

Stories such as these raise questions about the imbalance between emphasis on clinical outcomes versus providing a safe birth experience for all. This reflection also points to the fact that evidence-based practices must be in tandem with sound communication practices. In this regard, Tables 1 and 2 offer some examples of how poor language choice (either because it is too technical, impersonal, or disrespectful) can be adapted and substituted for more respectful and inclusive language (Mobbs et al. 2018). By adopting such attitudes, the woman or OBI is no longer a passive recipient of procedures performed on them, but an active participant and owner of their own experience.

	Example of poor language	**Suggested alternative language**
Avoiding phrases that are anxiety-provoking, over-dramatic, or violent.	"Fetal distress"	"Changes in the baby's heart rate pattern"
	"Trial of forceps"	"To see if we can help the baby out using forceps"
	"Labour ward"	"Birthing suite"
	"Rupture the membranes"	"Release the waters"
	"Bloody show"	"A show with some blood in it"
	"Big baby"	"healthy baby"
Respecting women as autonomous adults	"My woman" (for the woman giving birth)	Use her name, or say "the woman I am caring for"
	"Girls" (For staff, midwives)	"Midwives"
	"Good girl" (during labour)	"You're doing really well".
Respecting women as individuals (rather than simply a container and mechanism for producing a baby)	"Delivered"	"Gave birth"
	"The primigravida in room 12"	Use her name (best) or say: "The woman in room 12"
	"I'll go and consent her"	"I'll go and ask if she's happy with that and ask her to sign a consent form" / "discuss informed consent"
	"She" (when present in the room)	Use her name and be careful of speaking about her rather than to her
	"she's 7cm"	"[Woman's name's] cervix is 7cm dilated"
Respecting the woman's autonomy as a decision-maker	"You must have/need/require a caesarean section" (or any other action)" [or "you're not allowed to..."]	"I would recommend / suggest / advise caesarean birth because..." (give benefits, risks and alternatives for any recommendation, of course)
	"Patient refused"	"She declined"

Table 1: "Good practice in birth communication" (Mobbs et al. 2018).

Replacing exclusive or codified language with plain language that she can understand	"SROM"	"Your waters have broken"
	"PPH"	"extra bleeding after childbirth"
	"APH"	"Bleeding during pregnancy"
	"VBAC"	"Vaginal birth after caesarean birth"
Avoid discouraging or insensitive language	"failed VBAC / induction"	"unsuccessful VBAC / induction"
	"Poor maternal effort"	"not finding it easy..."
	"Failure to progress"	"slow labour"
	"terminate pregnancy" (when there is a terminal diagnosis)	"compassionate induction"
	"poor obstetric history" / "high risk"	"medically complex"
	"painful contractions"	"strong contractions"

Table 2: "Good practice in birth communication" (Mobbs et al. 2018).

Obstetric Racism in the NHS

In addition to good practice in birth communication, there is a pressing need to address a decolonial lens and cultural safety in medical and midwifery education syllabi (Lokugamage et al. 2023, 249). The higher mortality rates among BAME women and OBI, further explored in section *3.3*, serve as evidence of stereotyping and racism from health service staff in the NHS and how these severely impact the lives of healthcare service users (Bulman and McCourt 2002, 365). This is also seen in the inadequate provision of interpreting services for non-UK-born NHS users (Bulman and McCourt 2002, 365).

Notably, the colonial legacy within higher education institutions continues to reflect colonial oppression in global research outputs, as pointed out by Lokugamage et al. (2022, 7):

> Prompted by ground-up, member-led movements, some institutions have reflected on their relationship to benefactors with links to slavery and colonialism, some of who have been commemorated by statues and designated spaces within the grounds of these institutions. The Royal Colleges of the various medical and surgical specialities within the UK, including the Royal College of Obstetricians and Gynaecologists (RCOG), have yet to lead in decolonial evaluations of their institutional histories.

In the context of medicine and, specifically, obstetric and midwifery care, decolonial approaches to healthcare are paramount, especially when it comes to the acquisition of knowledge in higher education institutions. Lokugamage et al. (2022, 7) point out that without reflections on colonial histories, "institutions run the risk of unintentionally perpetuating persistent academic inequities and tacit acceptance of medical knowledge based on eugenics or colonial exploitation."

Brexit's Impacts on Midwifery Staffing Levels

As one of the largest employers in the world, the English NHS is staffed by around 1.3 million workers and runs more than 1.000 hospitals grouped into 219 organisations named "Trusts" (Castro-Pires et al. 2023, 7; NHS Digital 2024). The core of the hospital workforce is represented by doctors and nursing and midwifery staff, with nurses accounting for over a third of the total number of English NHS employees (Castro-Pires et al. 2023, 7).

While the NHS has been suffering from a long-lasting workforce shortage since well before the 2016 Brexit Referendum, the immigration outcomes since then have impacted a critical disruption on sectors that rely extensively on immigration-related labour supply, such as healthcare (Castro-Pires et al. 2023, 2, 31). In this context, the fall in NHS nursing and midwifery staffing levels did not occur due to pre-existing EU nurses and midwives employed by NHS hospitals leaving the UK, but rather due to a substantial decline in recruits from Europe in the early stages of their careers (Castro-Pires et al. 2023, 2). Notably, thanks to the 2018 reformation on visa policies for non-EU work migrants, the reduction in EU nurses and midwives coming to work in the NHS was relatively compensated by increased NHS joiners from non-EU countries, but still not enough to support the demands of the system (Castro-Pires et al. 2023, 2; Portes 2022, 82).

This, in turn, has its effects on the overall quality of healthcare services provided. While this brief subsection focuses on qualitative reviews of the results of Brexit on NHS staffing levels (rather than exploring the statistics in detail), it is essential to mention the impacts of such staffing reductions on healthcare quality, particularly regarding maternity care.

Although a direct correlation between OV and staffing shortage cannot be yet proven through empirical data, there is evidence to support that women and OBI's experiences of a positive birth, kindness, and respect may be supported by higher staffing levels (Turner et al. 2022, 1). In this regard, it has been reported that negative experiences in postnatal wards tend to be more prevalent in trusts with insufficient numbers of midwives (Turner et al. 2022, 1). This, however, is not an exclusive problem in the UK: to provide safe care and positive birth experiences, 900.000 midwives are needed worldwide, according to the State of the World's Midwifery Report (Turner et al. 2022, 1; UNFPA 2021).

c. Unified Health System (*Sistema Único de Saúde*, SUS)

Over the twentieth century, Brazilian society underwent notable transformations in birth assistance. While home births remained widely practised, a notable shift towards hospital births began in the 1940s, heralding a new era in maternity care (Moura et al. 2007, 452).

This shift to the hospital as a primary care unit emphasised a model in which the woman and OBI was no longer the protagonist of their own experience of birth (Moura et al. 2007, 452; Osava 1997, 17). Practices which excessively medicalise and pathologise the birth ritual, prioritising technology and medical interventions in the name of the comfort of the parturient, are often closely connected to the doctor's convenience or correctional perspectives over the female body (Rede Parto do Princípio 2012, 85; Diniz 2022). This model of birth, presented and extensively researched by anthropologist Robbie Davis-Floyd, has been internationally recognised as the technocratic model of birth, and it will be further developed in this section in the context of the Brazilian health system (Davis-Floyd 1993, 297).

The implementation of the SUS in 1988 was a significant and positive change in the provision of healthcare in the country, especially in terms of reproductive, maternal, neonatal, and child health (Leal et al. 2018, 1916). In regards to antenatal, labour, and delivery care, as well as maternal and infant health, the universalisation of public health was characterised by significant progress and fundamentally impacted access to health, thereby decreasing maternal and infant mortality, as well as access to healthcare (Leal et al. 2018, 1915, 1925). However, this process was also characterised by challenges and setbacks (Leal et al. 2018, 1925). In the case of this research, one of the challenges refers to the training and formal education of healthcare professionals who are certified to assist in childbirth in Brazil and how some aspects of their professional training have significant implications for the prevalence of OV.

Training of Maternity Care Professionals

In Brazil, maternity care and childbirth are mainly assisted by obstetricians (*obstetras*), midwives (*obstetrizes*), and obstetric nurses (*enfermeiras obstetras*) (Aquino et al. 2023, 2; Dotto and Mamede 2008, 336; Norman and Tesser 2015, 2;

Cruz 2023, 27).[11] Obstetricians, medical doctors specialised in obstetrics and gynaecology, assist with pregnancies, deliveries, and medical or surgical interventions (Diniz 2005, 634). They are often involved in high-risk pregnancies or complications during childbirth, and in Brazil, in many cases, they assume the primary responsibility for assisting with birth (Rede Parto do Princípio 2012, 15; Diniz 2005, 634). Midwives, who have specialised training in midwifery, focus on providing care during pregnancy and childbirth, often emphasising natural birth and working in both hospital and non-hospital settings such as birthing centres and homes (Cruz 2023, 25; Diniz 2005, 634). Obstetric nurses, who are registered nurses with additional training and certification in obstetrics, provide comprehensive care throughout pregnancy, labour, and the postpartum period, including conducting deliveries, particularly in low-risk pregnancies (Moura et al. 2007, 454; Diniz 2005, 634).

Because these professionals' responsibility is primarily providing *care*, the fact that these assistance models can be conducive to violent practices is often not accepted by many professionals since they are working to the best of their ability to deliver positive experiences and outcomes, as described by Diniz et al. (2016, 253; Tesser et al. 2014, 5):

> As health professionals, we are socialised to believe that our care is always a help to women, and we are shocked, sometimes hostile, when we hear from parturients who perceive our assistance as abuse, disrespect and a form of indignity.

However, the education model of these professionals is compatible with the technocratic model of birth, whereby the excessive and often unnecessary reliability of technology and interventions such as episiotomies, forceps, and acceleration of labour techniques make childbirth more "convenient" (for professionals) and which limits the scope for the process to happen naturally (Davis-Floyd 1993, 297). This is one factor that explains why in countries where birth is assisted mainly by obstetricians (instead of midwives, obstetric nurses, or physicians), caesarean rates and other forms of interventions are particularly high (Rede Parto do Princípio 2012, 160; Norman and Tesser 2015, 2; Diniz et al. 2016, 254).

The role of professionalising institutions in providing updated evidence-based practices and humanised care is often overshadowed by the teaching of routine

[11] In addition to these, other professionals directly involved in childbirth care include: paediatricians, neonatologists, anaesthesiologists, general practitioners, care nurses, and nursing technicians (Ministério da Saúde 2017, 10). Those who are undergoing training and are directly involved in care include: specialising and neonatal nursing residents, obstetrics undergraduates and residents of obstetrics, neonatology and anaesthesiology (Ministério da Saúde 2017, 10).

practices that have been in place for decades, in which women and OBI are not seen as human rights recipients, but rather as instruments of doctors' actions (Diniz et al. 2016, 254; Hotimsky and Schraiber 2005, 640; Hotimsky 2007, 15). These processes which depersonalise parturients can be evidenced by the fact that, as the teaching of obstetrics in Brazil traditionally requires a certain number of procedures to be performed by those undergoing training, many of these happen unscrupulously in patients (rather than in synthetic models), who are predominantly SUS users, without their consent (Diniz et al. 2016, 255; Procuradoria Geral da República 2014; Ministério Público de São Paulo 2014). The seminar "Vagina School", held in 2015 at the University of São Paulo's School of Public Health, highlights episiotomy as a training opportunity in poor women and OBI (Diniz et al. 2016, 255):

> In the second half of 2014, during two of these hearings in São Paulo, one testimony was particularly disturbing: Mary Dias, a Black university student, reported that at a teaching hospital, she received two episiotomies during the same delivery. She recalls hearing one of the professionals give brief instructions to two students: "You cut to the right, and the other cuts to the left," supposedly so both could have the opportunity to practice cutting and stitching on her vagina. (AT).

Despite decreasing levels of occurrence, these "correctional practices of the female body", such as episiotomies and follow-up suturing techniques commonly known as the "husband's stitch", to tighten the vagina to 'preserve' male pleasure during sexual intercourse after labour, are still widely practised and taught interventions (Rede Parto do Princípio 2012, 85; Diniz et al. 2016, 255; Procuradoria Geral da República 2014).

Obstetric Racism at SUS

Even though more than half of the Brazilian population is Black — at 56% as of 2022 — the inequalities in political and institutional representation, as well as in access to health and education, configure a structural problem that, in obstetric care, is predominant and systemic (IBGE 2022; Ministério da Igualdade Racial 2022).

As seen in section *3.1*, Black and Indigenous mothers are historically more likely to die during childbirth in Brazil (Ministério da Saúde 2023; Garrafa et al. 2024, 1). In this sense, characterising OR involves everything OV does, with the additional historical consequences of the intersection between race, class, and gender, as observed in the *Pequeno Manual Antirracismo Obstétrico* (2023, 3):[12]

[12] In English, "Little Anti Obstetric Racism Manual" (AT).

> [...] any type of action directed at a person and their body during pregnancy, childbirth, postpartum, or abortion care that involves words and/or actions that characterise oppression, discrimination, and/or violence, defined by race and gender disparities. Any stigmatising justification that denies or endangers the protection of a person's human rights in the obstetric environment, such as racial slurs, obstetric violence, racism, LGBTQIAP+phobia, or that devalues the motherhood of black individuals. (AT).

OR is normalised when it is assumed that black women and OBI are more tolerant to pain, have larger hips and therefore are more suitable for birth, do not need as much anaesthesia or other medications, have thicker skin (literally and figuratively), or can better breastfeed (Curi et al. 2020, 160). These prejudices and unconscious biases are normalised, internalised, accepted, and further reproduced in many institutional settings. The *Pequeno Manual Antirracismo Obstétrico* (2023), promoted by Rio de Janeiro city councillor Thais Ferreira, is an example of awareness-raising initiatives that should be available at SUS units.

Examples of abusive language, violent treatment, lack of dignity and respect that many non-white women and OBI go through can be seen in the following statements (Rede Parto do Princípio 2012, 135-9):

> "It had to be! Look at that, poor, Black, tattooed, and a drug addict! This isn't eclampsia, it's drugs!" This statement was attributed to the anaesthesiologist who was called during the night (on-call shift) to assist in an emergency caesarean of a pregnant teenager with eclampsia, whose partner was in prison for drug trafficking. — Pró-Matre Maternity Hospital, Vitória-ES. (AT).

> "The pregnant woman was in the PPP room [Pre-labour, Labour, and Postpartum ward] in a calm and dimly lit environment during labour. When the doctor entered the room, she said: 'What nonsense! What is this here? Turn on that light! This isn't an Indian's hut! Hey! (patting her leg), wake up! Like this, you'll never give birth! Cooperate!'" — Former student of the Universidade Federal do Rio de Janeiro (UFRJ) teaching hospital. (AT).

Inequalities in race, gender, and class are particularly evidenced in times of global crisis. The COVID-19 pandemic brought further challenges to OV and, especially, OR. Black women and OBI were particularly susceptible to dehumanised treatment at SUS units, as healthcare and maternal services were being stretched to their limits and possibilities of birth companions were restricted (which opposes the Birth Companion Law, as it will be further explored in section *3.3*) (Guimarães 2022, 94; Santana et al. 2023, 230; Santana et al. 2024, 6).

Caesarean Section Normalisation

Caesarean sections, when necessary and indicated, can save lives and decrease morbidities for the mother and the new-born (Tesser et al. 2015, 5; Villar et al. 2007, 1). However, evidence shows that women and OBI undergoing unnecessary

caesarean sections may suffer increased risks of severe maternal morbidity compared with those undergoing vaginal birth, therefore outweighing the benefits commonly associated with the indiscriminate practice of caesarean sections (Villar et al. 2007, 1).

Brazil's birth culture is gravely affected by caesarean sections. It has been, for many years, one of the countries with the highest rates in the world (Norman and Tesser 2015, 2). Many parturients (usually the minority covered by private health insurance) do not even consider the possibility of a natural birth because they are perceived as a terrifying, unpleasant, and harmful event with unnecessarily invasive practices such as "shaving pubic hair, giving enemas, routine episiotomy, routine induction of labour, and preventing women having companions in labour" (d'Oliveira et al. 2002, 1681). In this regard, the request for caesarean sections for women and OBI's convenience is a significant factor driving the rise of caesarean delivery rates (Diniz 2005, 635; Gamble et al. 2007, 331). That means that caesarean sections happen unscrupulously without clear indication, for two significant reasons: (1) women and OBI who conform with the norm of a presumed "safer" birth and (2) because of the increased compensation that private care obstetricians receive when performing these surgeries (Diniz 2005, 631; Diniz et al. 2016, 253).

In turn, non-evidence-based practices have an extensive scope of application, as well as an overestimation of the benefits of childbirth interventions and an underestimation of the risks associated with these (Diniz 1996, 210-11). When such circumstances arise, there are more potential opportunities for OV to occur, since women and OBI are restricted in their right to an informed choice primarily due to doctors' financial interests and work schedules . This leads obstetricians to claim they are acting in the best interests of their patients since such births can be pre-booked, are quicker and more convenient for doctors, and have fewer malpractice complaints (Diniz 2005, 635; Tesser et al. 2015, 5). In this sense, it becomes possible to understand what drives women and OBI to tend to prefer caesarean sections (Diniz 2005, 631; ReHuNa 1993):

> It is considered that, in vaginal delivery, the violence of imposed routines, the birthing position, and unnecessary obstetric interventions disturb and inhibit the natural unfolding of the physiological mechanisms of childbirth, which then becomes synonymous with pathology and medical intervention, turning into an experience of terror, helplessness, alienation, and pain. In this way, it is not surprising that women internalise the caesarean section as the better way to give birth, without fear, risk, or pain. (AT).

The Humanisation of Birth Movement

The pioneer movement for the humanisation of birth in Brazil has been carried forward by feminist scholars, healthcare providers, and women since the 1990s (Diniz 2005, 631). The primary driving forces behind it include the demand for justice in reproductive rights and maternal health, and the implementation of changes based on safety, bodily integrity, self-confidence, satisfaction, and respect for the mother, the baby, and the family (Diniz 2005, 631; ReHuNa 1993).

In its inception through the *Carta de Campinas* (1993), the organisation deliberately avoided terms such as "violence", and preferred adopting a term to encompass the wished outcome, i.e. "humanisation of birth", and for fear from healthcare professionals' hostile reactions towards perceived accusations (Diniz et al. 2016, 253).

Since its inception, it engages with governmental spheres, social movements, and scholarly debates, thereby driving significant changes in how childbirth is practised and advocated for in Brazil, evidenced by birth centres specialised in humanised births such as Hospital Sofia Feldman, in Belo Horizonte, and Casa Angela, in São Paulo (Diniz et al. 2018, 29; Casa Angela Centro de Parto Humanizado 2024). The profound impacts of this movement will continue to be explored in sections *3.4* and *3.5*.

d. Discussion

This section explored how the current structure of the NHS and SUS enables the occurrence of impersonal care towards their pregnant patients, but in rather different ways. In the UK, midwives have more autonomy in maternity care than those at SUS, but face enormous pressure and oppression from institutional hierarchy. While this is, to a certain extent, also true in Brazil, it is a much less pronounced reality since birth outcomes are mostly assisted by obstetricians who, in the private healthcare system overwhelmingly opt for caesarean sections. As a consequence, the commercialisation of caesarean sections without evidence, but for convenience, is usually sustained by the common or even popular belief that the involvement of obstetricians in birth increases the likelihood of a safe birth (rather than those assisted by midwives or obstetric nurses).

While there is evidence to support that caesarean sections are performed less in countries where birth is assisted mostly by midwives (such as the UK), this section demonstrated that impersonal care and OV can still be high with midwives.

This stems from the high pressure and oppression they face in their jobs, especially for NHS trusts being severely understaffed, for receiving considerably lower pay than doctors, and for having to do whatever it takes to maintain the care of their patients. In this sense, it can be argued that even though the intent might not be a constant factor in their actions, the impact is still evident and must be considered.

It was seen that, despite guidelines and evidence being available both at international and national standards, compliance still lacks in many areas. These problems are exacerbated by cultural norms, such as correctional perspectives of the female body, and the overall training and education of medical and midwifery professionals which are still sustained by colonial legacies, especially seen in how both countries experience OR in very similar ways. Therefore, this analysis shows the importance of decolonising healthcare and in the promotion of epistemic justice (Diniz 2022).

As seen through the influence of the humanisation of birth movement in Brazil and the growth of academic input in OV and public health, it can be said that the strength of public health in Brazil cannot be underestimated.

As such, it is worth to finalise this section with a reflection on what Paulo Freire wrote (Freire 2005, 44):

> In order for this struggle to have meaning, the oppressed must not, in seeking to regain their humanity (which is a way to create it), become in turn oppressors of the oppressors [and other oppressed], but rather restorers of the humanity of both.

3.3
Social Indicators

a. Method

As mentioned in Chapter 2, measuring and quantifying OV is a challenging task due to several factors, including the existing multiplicity of terms that make it difficult to categorise types of violence and abuse systematically. Notably, "Obstetric Violence" may sound more straightforward to comprehend in some languages than others (Diniz 2022). However, scientific consensus may be helpful in creating additional indicators for systematic reviews.

In addition to the terms introduced in Chapter 2, there are other terms that may apply, such as cruelty in childbirth, dehumanised care, human rights violations in childbirth and abortion, institutional gender violence, gender-based violence in childbirth and abortion, obstetric abuse, and mistreatment in facility-based childbirth (Diniz 2022). That being said, it is worth reiterating that several health institutions and training programmes worldwide have introduced the term "Obstetric Violence" as such in their lexicon (Diniz 2022).

Along with linguistic disparities, another crucial reason why the collection of data is a challenge in many countries concerns *silence* and feelings of *shame* permeating the accounts of those who experienced OV, as Kukura describes (Kukura 2019, 209):

> Women stay silent about mistreatment during childbirth for various reasons. Strong privacy norms that protect health information make some people reticent to discuss their medical care publicly. For some patients, it takes time to identify what happened during the delivery that made the experience painful or traumatic – especially when dealing with the demands of new-born care and postpartum healing. Others may fear their complaints will not be believed, will be trivialised, or will be too traumatic to share. Shame is also a powerful silencer; women may blame themselves for not being more assertive about their decisions or not resisting more forcefully once they experienced pressure to consent.

In this sense, apart from qualitative academic research, data collection methods from health institutions, NGOs, and governments (usually reports and population-based surveys) suggest that the prevalence of OV may be found in the following: birth experience satisfaction levels, preventable maternal mortality rates (e.g., due to limited access to quality health services or unsafe abortion methods), perineal outcomes, episiotomy, induction of labour, birth trauma, right to companionship, choice of birth position, protection from verbal abuse, fundal pressure, inaccurate

information about the baby's safety, right to choice of place of birth, right to informed choice and refusal (Diniz 2022).[13]

Key findings from some of these indicators shall be used in this analysis. In this sense, it is essential to highlight the complexity of the data in the existing reports. Individual findings may not always be indicative of a broader OV scope, but do offer an important overview. Secondary sources mainly from public health studies are used to aid in interpreting the available statistics.

Ultimately, it is crucial to emphasise that, despite current challenges, there is a significant need to create new indicators to classify forms of violence in childbirth, especially for cross-national comparisons such as those presented in this study (Diniz 2022). After all, international comparison studies can bring into visibility different issues that might still be overlooked (Diniz 2022).

Finally, this analysis notes that, following the Australian survey Birth Experience Study (BESt), country-specific adaptations of the same research are being conducted by other countries, which shall contribute to further understandings of OV, as well as illuminate national and international agendas to improve women and OBI's experiences of maternity care services (Keedle et al. 2024, 2320; King's College London 2024).

b. UK

National Maternity Survey 2014

One notable piece of evidence for assessing experiences of maternity care was the National Maternity Survey 2014, which used a sample of 10.000 women and OBI in England over a two-week period (NPEU 2014). The selection of women and OBI excluded those whose babies had not survived and mothers younger than sixteen years of age (NPEU 2014, 1).[14] With a valid response rate of 47%,[15] the national survey represented a limited amount of 0,65% of the total 695.233 births in England and Wales that year (NPEU 2014, 1; Office for National Statistics 2015).

[13] Regarding rates of episiotomy and induction of labour, it is important to consider WHO's recommendations on the *Appropriate Technology for Birth*: "The perineum should be protected wherever possible. Systematic use of episiotomy is not justified. The induction of labour should be reserved for specific medical indications. No region should have rates of induced labour higher than 10%." (WHO 1985, 437).

[14] Future research could focus on teenage pregnancy and whether incidences of OV are higher among those groups.

[15] It is not clear from the report why 53% of responses were unusable.

Even though the exclusion of the two groups above could have presented meaningful data, it was observed that, despite the overall elevated satisfaction level with maternity care (80%), postnatal care fell short (68%), revealing areas of need (See Figures 3 to 6) (NPEU 2014, 5). Several questions can be raised as a result of this finding. If applied, Kitzinger's analysis observed in the previous section referring to patient response rates soon after birth often being positive, it could be that responses would express different emotions at a later stage (Kitzinger 1992, 74).

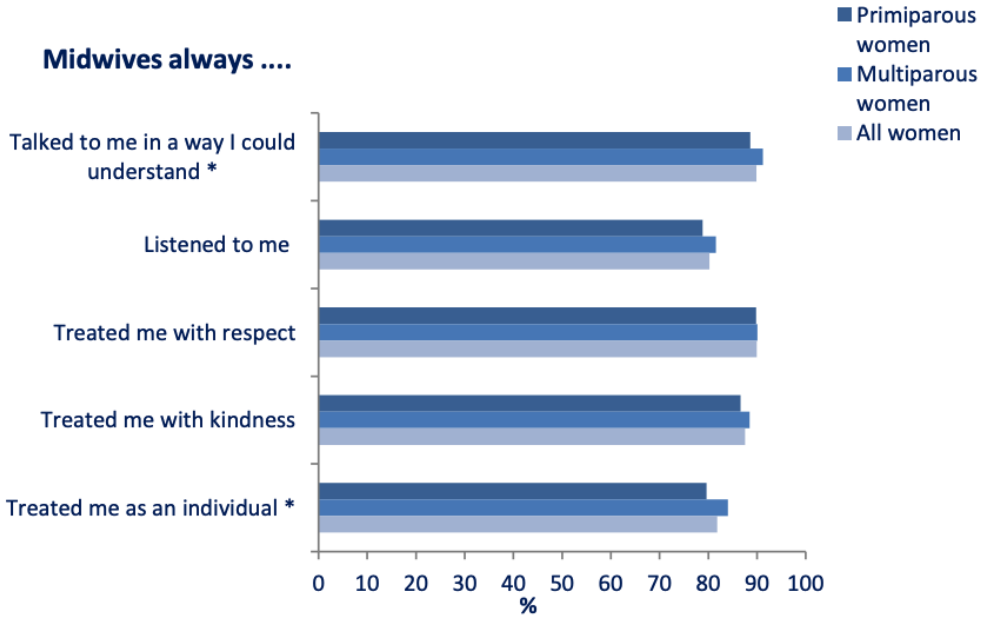

Figure 3: "Women's perceptions of midwifery care during their pregnancy" (NPEU 2014, 27).[16]

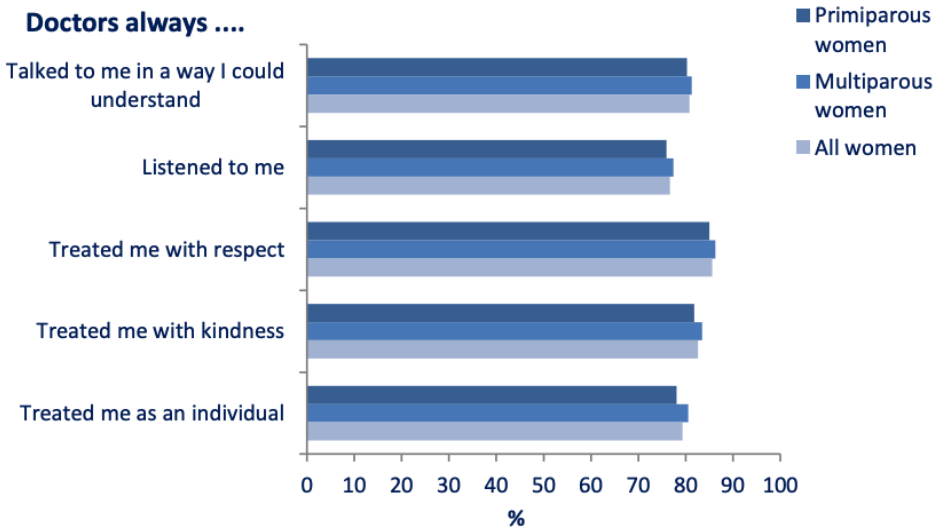

Figure 4: "Women's perceptions of medical care during their pregnancy" (NPEU 2014, 28).

[16] Primiparous women and OBI are those giving birth to a first child. Multiparous have previously given birth (NPEU 2014, 12).

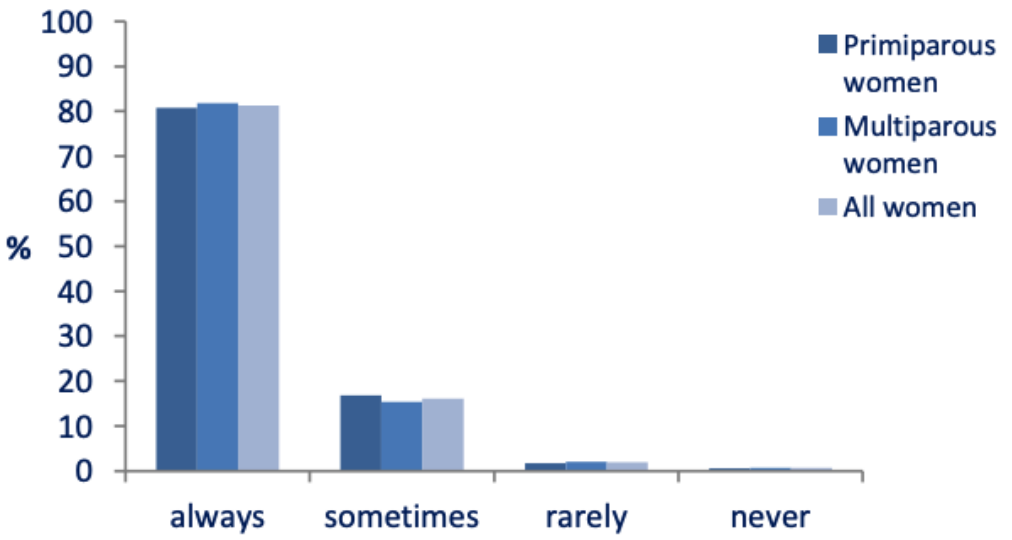

Figure 5: "Proportions of women having confidence and trust in the staff caring for them during labour and birth" (NPEU 2014, 39).

In the postnatal period, the responses changed. Especially regarding the question "Staff always listened to me", positive responses dropped from 80% in antenatal care to 68% in postnatal care, as shown in Figure 6 (NPEU 2014, 44).

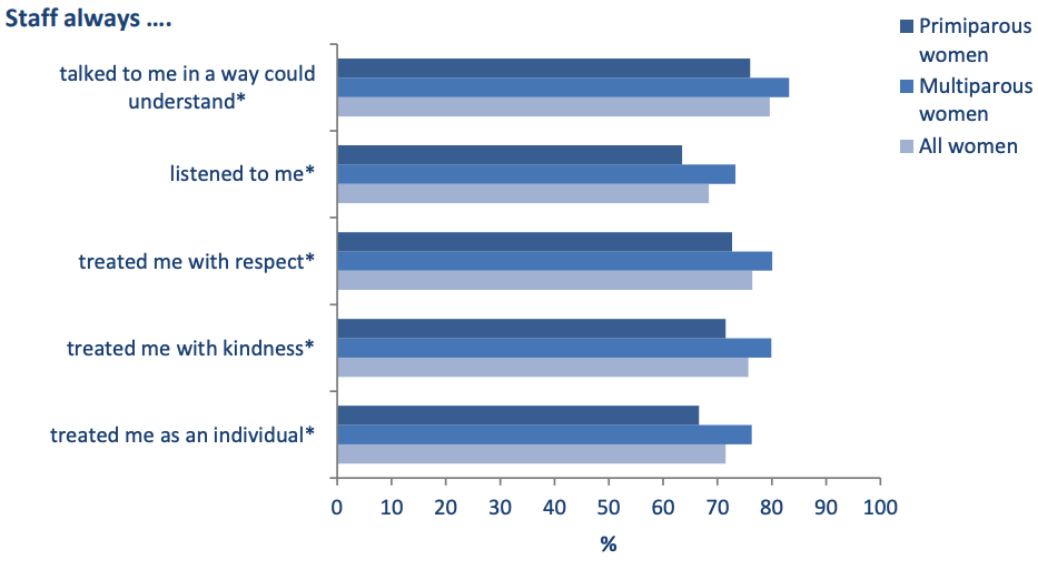

Figure 6: "Women's perceptions of maternity unit or hospital unit staff postnatal care" (NPEU 2014, 44).

National Maternity and Perinatal Audit 2022

One of the most relevant findings from the National Maternity and Perinatal Audit (NMPA) 2022 for this study was that in the 112 NHS trusts and boards in England and Wales included in the analysis, 33% of all births had an induction of labour, shown in Table 3 and Figure 7 (NMPA 2022, 6).

	England	Wales	Total
Number of trusts/boards included in analysis	106	6	112
Number of women and birthing people included in analysis	368 712	25 736	394 448
Number of women and birthing people who have induction of labour	122 956	9 035	131 991
Proportion of women and birthing people who have induction of labour	33.3%	35.2%	33.5%

6Country-level results are adjusted for case mix (unadjusted rates can be obtained using the numerators and denominators provided in the table).

Table 3: "Proportion of women and birthing people with a singleton[17] baby at term who have an induction of labour" (NMPA 2022, 6).

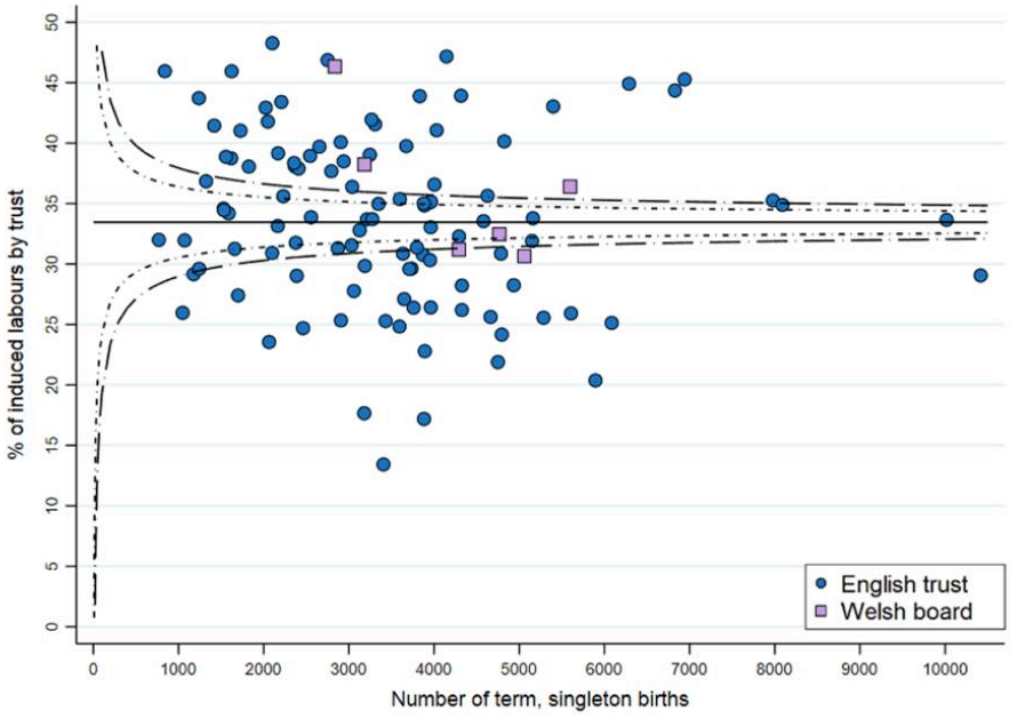

Figure 7: "Trust/board level proportions of women and birthing people who have induction of labour of a singleton pregnancy at term" (NMPA 2022, 7).

According to the report, this is a significant increase in the prevalence of labour induction compared to findings from previous reports (NMPA 2022, 6). Apart from possible reasons behind high rates of induction of labour owing to the assessment of foetal movements and improved detection of foetal growth restriction, it is not clear

[17] The birth of only one child and not twins or more (NMPA 2022, 5).

from the report what reasons could lead to such a high percentage of intervention (NMPA 2022, 7; NHS England 2016, 22).

MBRRACE-UK 2023

The 2023 "Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK" (MBRRACE) report presents the surveillance information for women and OBI who died during or after pregnancy between 2019 and 2021 (Knight et al. 2023, vi). One of the most striking findings is that, compared to white women and OBI, the statistics showed an approximately four-fold difference in maternal mortality figures amongst people from Black ethnic backgrounds and a nearly two-fold difference amongst people from Asian ethnic backgrounds, as shown in Figures 8 and 9 (Knight et al. 2023, 7; Brader 2023). According to Knight et al. (2023, vi), this is a consistent finding emphasised in MBRRACE reports.

The leading death causes during the period analysed were COVID-19, cardiac diseases, blood clots, mental health conditions, sepsis, epilepsy and stroke, other physical conditions (not specified), bleeding, pre-eclampsia, cancer, and other (not specified) (Knight et al. 2023, i).

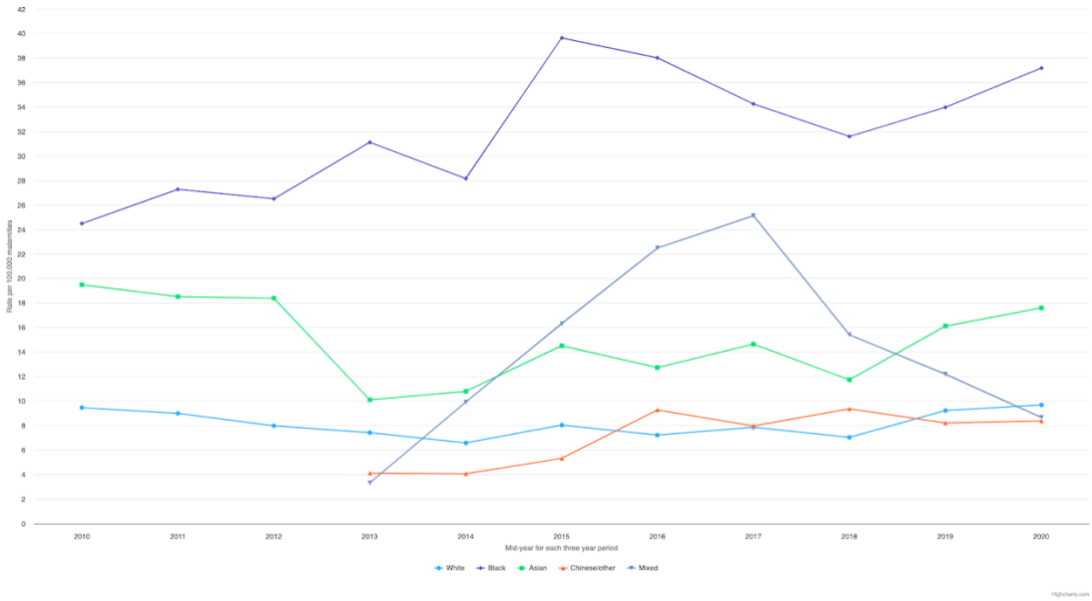

Figure 8: Inequalities of maternal mortality in the UK by ethnicity from 2019 to 2021 (MBRRACE-UK 2023).

Figure 9: Statistics of inequalities in maternal mortality in the UK based on the number of parturients from the most deprived areas between 2019 and 2021 (MBRRACE-UK 2023).

Although the deceased parturients may have suffered from pre-conditions or birth complications,[18] it is not clear from the report when or if care might have been affected by medical malpractice, such as delayed, neglected, or inefficiency of care. Taking into account the disparity in fatal outcomes where less advantaged groups are significantly more affected, it is not implausible to suggest that, according to one of the most recurring themes in the report regarding the risks of disjointed or siloed working across health and social care, this could negatively impact on the collaborative communication with patients, and, as a consequence, their lives (MBRRACE-UK 2023, 4).

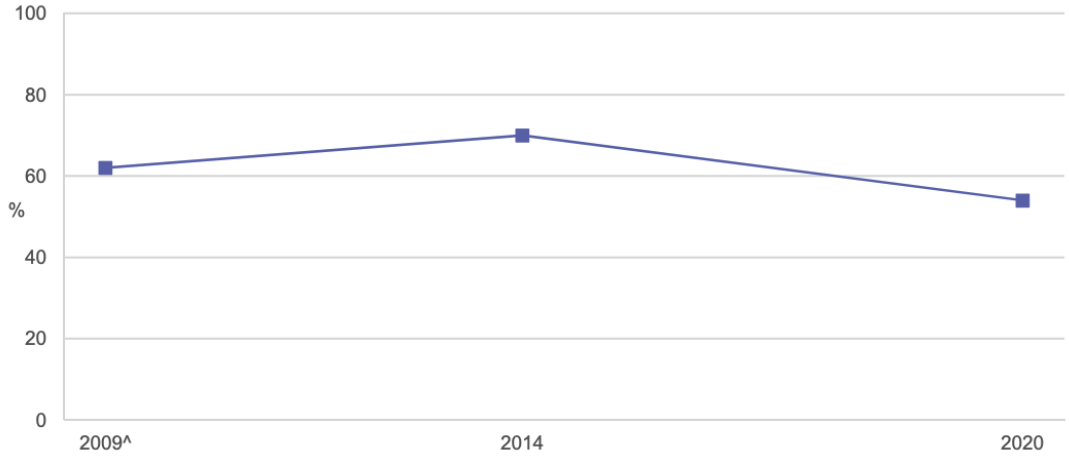

Figure 10: Proportion of women and OBI who felt they were always involved in decisions about their antenatal care across the National Maternity Survey 2020 (Harrison et al. 2021, 32).

[18] Or, as suggested in previous sections, that certain conditions may have gone unnoticed by the staff due to discrimination against Black women and OBI based on unconscious biases relating to increased resistance to pain. This often leads to fragmented, frustrating, and unclear care.

One other important finding from the National Maternity Survey 2020 — Maternity Care During COVID-19 revealed that only 54% of women and OBI always felt involved in decisions regarding their antenatal care, illustrating a drop from previous years (Harrison et al. 2021, 32).

Birth Trauma Inquiry 2024

The 2024 All-Party Parliamentary Group (APPG) Birth Trauma Inquiry, commissioned as the first national inquiry of its kind, studied the submissions of 1.300 women and OBI who had a traumatic birth experience and 100 submissions from maternity care professionals (Clarke 2024, 3, 8). The report pointed out that "in many of these cases, the trauma was caused by *mistakes* and *failures* made before and during labour" and, in some instances, does mention OV (Clarke 2024, 8; italics supplied). Previous research estimated that 30% women and OBI in the UK experience birth trauma (King's College London 2024).

As such, birth trauma refers to when women and OBI "experience interactions and/or events directly related to childbirth that caused overwhelming distressing emotions and reactions, leading to short- and/or long-term negative impacts on a woman's [and OBI's] health and well-being." (Leinweber et al. 2022, 687; Clarke 2024, 22). This can result from several reasons, including medical emergencies such as preterm births, stillbirths, or severe complications (Clarke 2024, 8, 14-21; WRA UK 2023, 7). However, these form "part of the trauma" and a *significant* part of it accounts for how healthcare professionals dealt with women and OBI *during* and *after* complications, as observed in the evidence collected by the Birth Trauma Inquiry Report (Clarke 2024, 8, 14-21; WRA UK 2023, 7).

While birth trauma and OV indeed represent distinct phenomena, the correlation between the two cannot be dissociated, especially in cases of medical malpractice such as the following (Clarke 2024, 26):

> "I've tried, but at times I'm transported back to that darkened room where I'm held down as someone cuts me open without my consent and then belittles me for daring to show that I was in excruciating pain. Fifteen, nearly sixteen years down the line, and that feeling of being dehumanised is still as fresh in my mind as the day it happened. Mothers are frequently described as heroes, but how much of our heroics are only necessary because our pain is dismissed?"

Furthermore, the most common themes that emerged in the letters submitted were: failure to listen, lack of informed consent, poor communication, lack of pain relief, lack of kindness, and poor postnatal care (also observed in the 2014 NMS report

above), complaints and medical negligence (Clarke 2024, 14-21). Words such as "shame," "humiliation", and "embarrassment" appeared often in the submissions, with the word "broken" appearing in 328 of them (Clarke 2024, 14). The overwhelming narrative, according to the inquiry, was that of "distress at being neglected, ignored or belittled at a time when women [and OBI] were at their most vulnerable." (Clarke 2024, 14).

Ultimately, while some of the key findings from these reports suggest that OV is a frequent experience, it is important to note that more tailored reports and data standardisation of medical malpractice are needed. Indicators such as non-consented/accepted intervention with partial information, undignified care/verbal abuse, non-confidential/private care and discrimination would aid in the provision of even more specific and targeted policymaking efforts (Lansky et al. 2019, 2811).

c. Brazil

Brazilian Women and Gender in Public and Private Spaces Survey 2010 (*Pesquisa Mulheres Brasileiras e Gênero nos Espaços Público e Privado 2010)*

In 2010, an initiative by Fundação Perseu Abramo, in cooperation with SESC, presented the results of a large-scale population-based survey with over 2.000 Brazilian women across all regions of the country to shed light on gender-based violence within institutional and private settings (Venturi and Godinho 2013, 3). Representing the first of its kind to tackle violence in childbirth, the national survey showed that 25% of women and OBI suffered some form of violence during labour (See Figure 11) (Venturi and Godinho 2013, 173).

Interview results revealed the following: 10% said that vaginal examinations were performed in a painful way, 10% said they were denied or not offered any kind of pain relief, 9% said they were shouted at, 9% said they were not informed about the procedure that was being done to them, 8% said they were refused care, 7% said they were cursed at or humiliated, and less frequently, but crucial to be mentioned, 1% were either pushed, hurt, hit, or sexually harassed, as seen in Figure 11 (Venturi and Godinho 2013, 173).

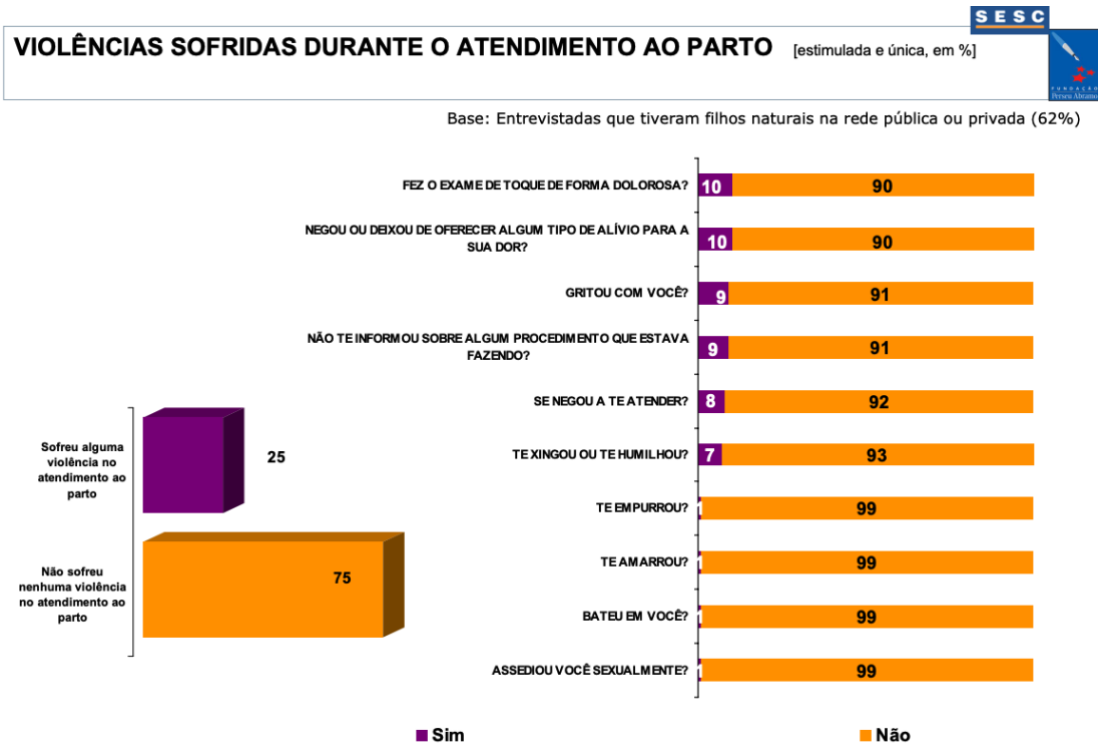

Figure 11: Violence suffered during childbirth care (Venturi and Godinho 2013, 173).

When observing the percentage of violence in childbirth per region, the northeast exhibited the highest rate among macro regions, with 27% of the interviewees, followed by similar rates in the south at 26%, the southeast at 25%, and the north and midwest at 22% (See Table 4) (Venturi and Godinho 2013, 176). There was a stark difference between OV suffered in capitals (30%) and small cities (16%) (See Table 4) (Venturi and Godinho 2013, 176).

	TOTAL	MACROS REGIÕES (BRASIL)				PORTE DO MUNICÍPIO (BRASIL)						
		N/CO	NE	SUL	SE	TT RM	CAPITAIS	OUTRAS RM's	TT INTE-RIOR	PEQ.	MÉD.	GDE.
	100%	*14%*	*27%*	*15%*	*14%*	*40%*	*25%*	*84%*	*60%*	*19%*	*21%*	*20%*
Sofreu alguma violência no atendimento ao parto	25	22	27	26	25	29	30	28	23	16	23	29
Não sofreu violência no atendimento ao parto	75	78	73	74	75	71	70	72	77	84	77	71

Table 4: Violence suffered during childbirth care, by region and size (Venturi and Godinho 2013, 176).

Another relevant finding of the research revealed that interviewees confirmed they witnessed healthcare professionals talking to them in the following manners: 15%

heard “Do not cry because next year you will be here again”, 15% heard “At the time of making it, you did not cry/did not call for mummy, why are you crying now?”, 6% heard “If you shout, I will stop what I am doing and will not take care of you”, and 5% heard “If you keep shouting, you will do harm to your baby, and your baby will be born deaf” (See Figure 12) (Venturi and Godinho 2013, 177).

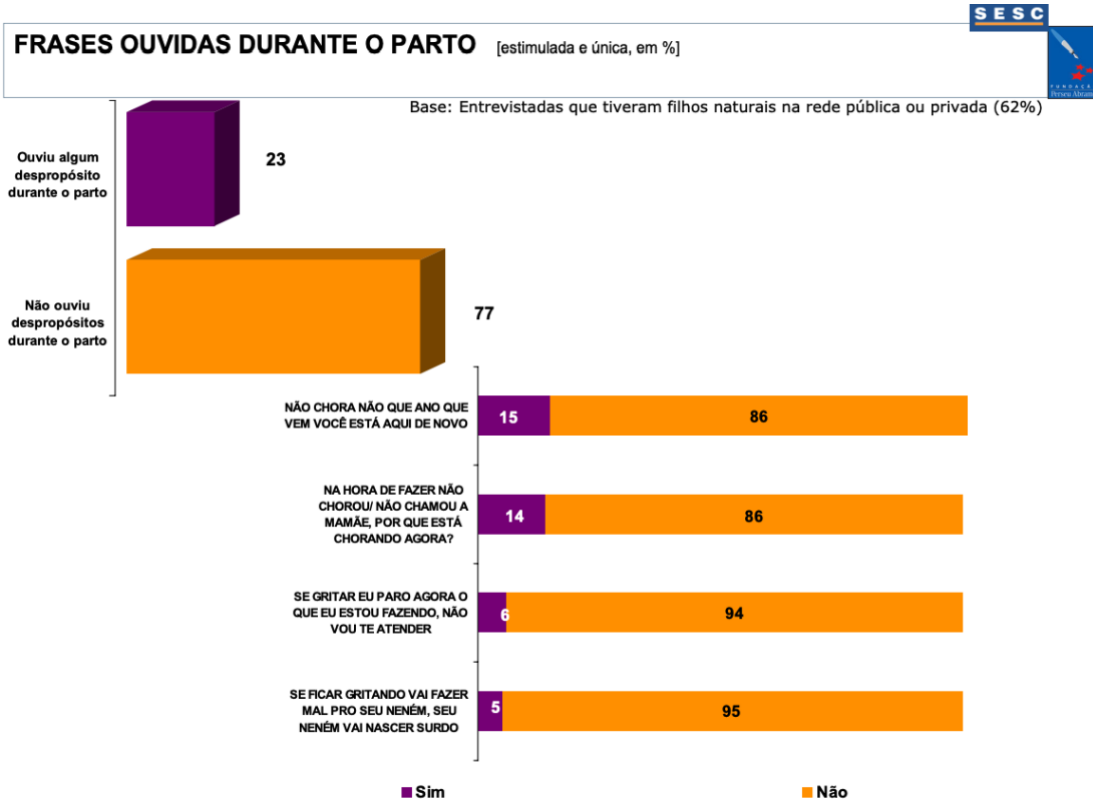

Figure 12: Phrases heard during childbirth (Venturi and Godinho 2013, 177).

Similarly to Table 4, the abusive phrases described above were more common in regions where sociodemographic and socioeconomic levels are lower, exemplified by the northeast at 29%, followed by the south at 22%, the southeast at 21%, and the north and midwest at 20% (See Table 5) (Venturi and Godinho 2013, 179).

FRASES OUVIDAS DURANTE O PARTO, por região e porte [estimulada e única, em %]

Base: Entrevistadas que tiveram filhos naturais na rede pública ou privada (62%)

	TOTAL	MACROS REGIÕES (BRASIL)				PORTE DO MUNICÍPIO (BRASIL)						
		N/CO	NE	SUL	SE	TT RM	CAPITAIS	OUTRAS RM's	TT INTE-RIOR	PEQ.	MÉD.	GDE.
	100%	*14%*	*27%*	*15%*	*14%*	*40%*	*25%*	*84%*	*60%*	*19%*	*21%*	*20%*
Ouviu algum despropósito durante o parto	23	20	29	22	21	29	29	30	19	17	17	23
Não ouviu despropósitos durante o parto	77	80	71	78	79	71	71	70	81	83	83	77

Table 5: Phrases heard during childbirth, by region and size (Venturi and Godinho 2013, 179).

Childbirth in Brazil: National Inquiry on Labour and Birth 2011 — 2012 (*Nascer no Brasil: Inquérito Nacional Sobre o Parto e Nascimento 2011 — 2012*)

A large-scale national inquiry involving multiple research institutes coordinated by Fiocruz was another noteworthy study to amplify the voices of women and OBI's experiences of birth throughout the country (Tesser et al. 2015, 5; Nascer no Brasil 2016, 2). For this survey, nearly 24.000 Brazilian women and OBI were interviewed (Tesser et al. 2015, 5). The research emphasised the excessive intervention culture in childbirth in Brazil, exemplified by 56% of all interviewees being submitted to episiotomies and 37% undergoing Kristeller manoeuvre (Tesser et al. 2015, 5). Furthermore, the survey revealed that only 18,7% had a birth companion of their choice, thus defying the Birth Companion Law, further elaborated in section *3.5* (Tesser et al. 2015, 5). Using the definitions of OV within this study, these statistics are all indicative of such medical malpractice and human rights violations.

Figures 13 and 14 show further relevant findings, respectively: (1) caesarean section rates and (2) sociodemographic disparities in access to healthcare, which accounts for black women and OBI being twice as likely to die in childbirth than white ones (Ministério da Saúde 2023).

In Figure 13, the discrepancy between caesarean section rates performed within public health services of SUS (left) and the private sector (right) is excessive, despite both being disproportionately high and contrary to WHO's recommendations on the appropriate technologies for birth in which these numbers should not exceed 10%

(WHO 1985, 436). In the private sector, caesarean sections represent 88% of births, and in SUS hospitals, they represent 46% (Nascer no Brasil 2012). Part of the reason that explains these high rates is the idea that a pre-booked birth offers reduced risks, inconveniences, and acts of violence. However, a greater number of risks can be overlooked when assuming childbirth supported by more technology and interventions is necessarily better for every birthing individual (Diniz et al. 2016, 571).

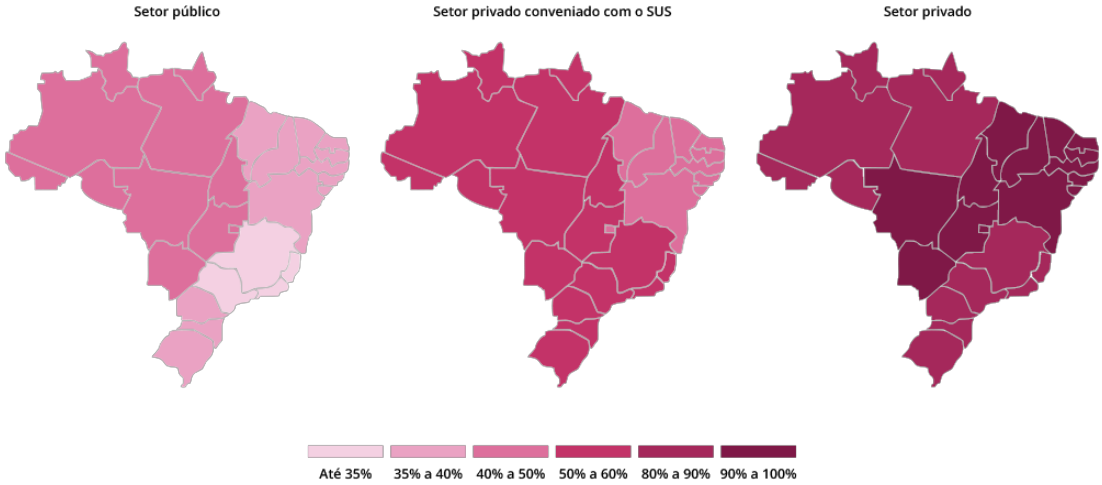

Figure 13: Caesarean section rate by region and healthcare service: public sector (left), private sector in partnership with SUS (middle), and private sector (right) (Nascer no Brasil 2012).

Meanwhile, in Figure 14, it is possible to see the stark difference between white women and OBI using private health insurances (23%) and black women and OBI (5,8%) (Nascer no Brasil 2012).

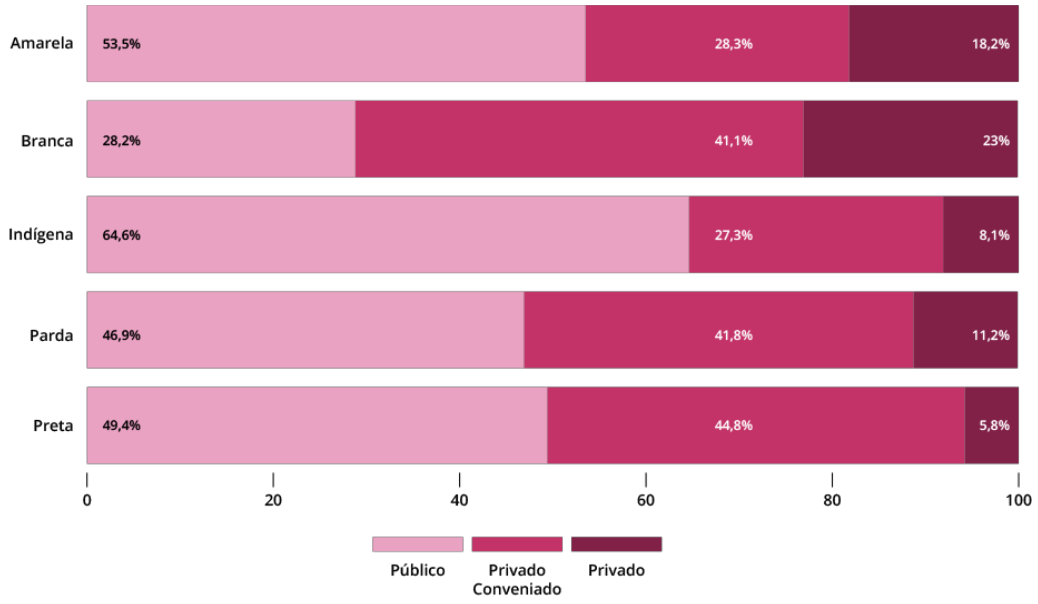

Figure 14: Use of health services according to maternal skin colour/ethnicity (top to bottom): Asian, White, Indigenous, Brown, Black (Nascer no Brasil 2012).

Senses of Birth Exhibition 2015 — 2016

(Exposição Sentidos do Nascer 2015 — 2016)

Between March 2015 and March 2016, 1.290 Brazilian women and OBI visited the exhibition *Sense of Birth* in Belo Horizonte, in the state of Minas Gerais, to gain awareness of childbirth culture in Brazil and its impacts on parturients' health through an immersive experience (Lansky et al. 2019, 2815; Ministério da Saúde 2015, 47; Santos et al. 2019, 1). Following the exhibition, women and OBI answered semi-structured questionnaires for the collection of data pertaining to: socioeconomic levels and demographics, previous and current pregnancies, and, most crucial for this study, their knowledge and perception of OV (Lansky et al. 2019, 2813). Some of the results, presented in Tables 6 and 7, highlight the disparities between skin colour, public or private care and incidence of OV (Lansky et al. 2019, 2816).

Characteristic	Obstetric Violence		p-value	Total (N=530)* n(%)
	Yes (N=70)* n(%)	No (N=460)* n(%)		
Age				
≤19	2 (2.9)	29 (6.4)	**	31 (5.9)
20-34	59 (84.3)	347 (76.3)	0.136	406 (77.3)
≥35	9 (12.9)	79 (17.4)		88 (16.8)
Skin color				
Black	44 (62.9)	230 (50.1)	0.047	274 (51.8)
Other	3 (4.3)	8 (1.7)	0.165	11 (2.1)
White	23 (32.9)	221 (48.1)		244 (46.1)
Marital status				
Single/separated	19 (27.1)	63 (13.7)	0.004	82 (15.5)
Married/stable union	51 (72.9)	397 (86.3)		448(84.5)
Schooling[3]				
Elementary /High school	12 (17.1)	106 (23.5)	0.240	118 (22.6)
Graduate school or +	58 (82.9)	346 (76.5)		404 (77.4)
Family income [1]				
< 2 MW	14 (23.0)	84 (19.4)	0.509	98 (19.8)
2 a <5 MW	25 (41.0)	136 (31.3)	0.132	161 (32.5)
5 a 10MW	17 (27.9)	112 (25.8)	0.731	129 (26.1)
≥10 MW	5 (8.2)	102 (23.5)		107 (21.6)
Health Insurance				
No	21 (30.0)	91 (19.8)	0.052	112 (21.2)
Yes	49 (70.0)	368 (80.2)		417 (78.8)
Place of birth				
Public(SUS)	32 (45.7)	160 (34.9)	0.078	192 (36.3)
Home	1 (1.4)	23 (5.0)	**	24 (4.5)
Private (SS)	37 (52.9)	276 (60.1)		313 (59.2)
Type of birth				
Cesarean	39 (55.7)	206 (44.8)	0.087	245 (46.2)
Vaginal/Forceps vacuum extractor	31 (44.3)	254 (55.2)		285 (53.8)
Satisfaction in childbirth				
Terrible/bad/indifferent	55 (78.6)	63 (13.7)	<0.001	118 (22.3)
Good/Excellent	15 (21.4)	397 (86.3)		412 (77.7)

* The category "Do not know" for obstetric violence was considered as missing for Odds Ratio calculation. Totals vary according to missing data.[1] Minimum wage in 2015: R$788,00; [2] Women that had a normal birth; [3] Full or incomplete grade (in progress).** X^2 not possible to calculate due to the low number.

Table 6: "Characteristics of pregnant women that visited the Senses of Birth Exhibition and reported obstetric violence. Brazil, 2015-2017." (Lansky et al. 2019, 2816).

Characteristics	Obstetric Violence		p-value	Total (N=530)* n(%)
	Yes (N=70)* n(%)	No (N=460)* n(%)		
Knowledge about obstetric violence before participating at SOB				
None/poor/faire	40 (58.0)	230 (50.7)	0.258	270 (51.6)
Good/Very good	29 (42.0)	224 (49.3)		253 (48.4)
Knowledge about obstetric violence after participating at SOB				
None/poor/faire	6 (8.8)	58 (12.7)	0.366	64 (12.2)
Good/Very good	62 (91.2)	400 (87.3)		462 (87.8)
Position in childbirth[1]				
Supine/lithotomic	25 (83.3)	105 (42.0)	<0.001	130 (46.4)
Non supine	5 (16.7)	145 (58.0)		150 (53.6)
Kristeller[1]				
Yes	17 (56.7)	50 (19.8)	<0.001	67 (23.7)
Don´t know	0 (0.0)	1 (0.4)	**	1 (0.4)
No	13 (43.3)	202 (79.8)		215 (76.0)
Episiotomy[1]				
Yes	17 (54.8)	69 (27.4)	0.002	86 (30.4)
Don´t know	1 (3.2)	3 (1.2)	**	4 (1.4)
No	13 (41.9)	180 (71.4)		193 (68.2)
Informed Episiotomy[1]				
No	11 (57.9)	25 (30.5)	0.025	36 (35.6)
Don´t know	1 (5.3)	4 (4.9)	**	5 (5.0)
Yes	7 (36.8)	53 (64.6)		60 (59.4)
Non-pharmacological methods for pain relief[2]				
No	10 (20.4)	55 (17.2)	0.582	65 (17.6)
Yes	39 (79.6)	265 (82.8)		304 (82.4)
Companion during childbirth				
No	17 (25.4)	59 (13.3)	0.009	76 (14.8)
Yes	50 (74.6)	386 (86.7)		436 (85.2)
Immediate skin to skin contact				
No	37 (54.4)	119 (26.3)	<0.001	156 (29.9)
Yes	31 (45.6)	334 (73.7)		365 (70.1)
Skin to skin contact in the first hour				
No	37 (55.2)	184 (40.9)	0.027	221 (42.7)
Yes	30 (44.8)	266 (59.1)		296 (57.3)

* The category "Do not know" for obstetric violence was considered as missing for Odds Ratio calculation. Totals vary according to missing data [1] Women that reported having a vaginal birth [2] Women that reported having a vaginal birth a cesarean during labor.
** X^2 calculation was not possible due to the low number.

Table 7: "Health care markers and knowledge about obstetric violence (OV) among pregnant women before and after participating at Senses of Birth Exhibit (SOB) versus report of obstetric violence during childbirth. Brazil, 2015-2017." (Lansky et al. 2019, 2817).

As observed in Table 7, women and OBI's "good" or "very good" knowledge of OV prior to visiting the exhibition was high (48.4%), with an increase to 87.8% after attending it (Lansky et al. 2019, 2815). This indicator suggesting knowledge of OV in the country will continue to be explored in section *3.4*.

d. Discussion

The social indicators in the UK explored in this section provided insight into high rates of unnecessary interventions in childbirth and sociodemographic disparities in maternal mortalities, exemplified by: 33,5% of induction of labour, black women and OBI being four times and Asians twice more likely to die than their white counterparts. The Birth Trauma Inquiry brought to attention several cases of OV.

Regarding Brazil, the alarming rates of caesarean sections, especially in private healthcare at 88% and in public services at 46%, as well as black women and OBI being twice as likely to die in childbirth than their white counterparts were highlighted.

Pertaining to their respective statistics in induction of labour and caesarean sections, both the UK and Brazil contradict WHO's 1985 *Appropriate Technology for Birth*. Additionally, through social, economic and demographic disparities, both illustrate how pervasive OR is.

As for data collection methods, both countries utilised user perspectives on research integration (though Brazil more significantly) and exemplified how, especially in this field, population-based research can evidence perceptions of care that might often be overlooked.

It is important to recognise that examining social indicators such as the ones presented in this analysis is a task that would warrant a separate study on its own. In terms of research limitations, it is also important to recognise that this analysis does not account for the devolved nations of Scotland, Wales, and Northern Ireland. It also did not explore if or to what extent OV might happen in private healthcare institutions in the UK (as it will be seen in sections such as *3.4*, OV does not happen exclusively in public health institutions).

3.4
Media Representation

a. Method

Based on an evaluation of various media sources in both the UK and Brazil, this section examines the extent and manner in which the systemic issue of OV is represented in both territories. This comparison aims to critically examine how media discourses — or lack thereof — can shape or influence public awareness and either reinforce or question existing power structures in public health and human rights violations of this kind. Using the operative question "Do these media representations amplify voices or stigmatise experiences?", it becomes possible to emphasise the critical role that the media plays in either perpetuating silence or amplifying marginalised voices, ultimately affecting societal and institutional responses to OV matters (Hasser 2003, 264).

Primary sources used include newspaper articles, journalistic reports, documentaries, social media outputs, and an overview of top and most popular OV search engine query results in the UK and Brazil, thereby shedding light on the discrepancies in coverage in both territories and the impacts of these in broader social contexts.

As for secondary sources, this section relies on Stuart Hall's representation theory as a methodological framework to analyse the portrayal of OV across the media and its role in shaping the OV discourse in the public sphere in the UK and Brazil (Hall 1997, 1). In this sense, representation theory refers to the representation of things through language and how language is central to the process by which meaning is produced and exchanged (Hall 1997, 1).

Further secondary sources are drawn from sociology, journalism, and communication studies. Using these materials shall help question the relevance and visibility of OV as a pressing social and humanitarian issue in the UK and Brazil.

b. UK

As discussed in Chapter 2, the absence of a shared and consistent understanding of the language employed to define and acknowledge the problem of OV is a significant barrier to developing meaningful solutions and encouraging a cultural shift in how

women and OBI's health, autonomy, and rights are respected and dignified in society.

Given that critical aspects of OV are deeply rooted in systemic issues relating to patriarchal, sexist, and cultural practices within and beyond healthcare systems, the analysis of British media coverage of this issue may benefit from concepts drawing on representation theory and the production of meaning through common language (Hall 1997, 28). The use of this approach allows for the investigation of how representation of cultural attitudes towards women and OBI, medical and authoritative practices, normalisation of abuse, stigmatisation and perpetuation of silence, along with institutional systemic issues, are also shaped by the construction of meaning through language (Hall 1997, 1). Thus, by means of this process, it becomes possible to address how OV is represented and perceived in British public discourse, an argument which remains underexplored in existing research.

Availability of Obstetric Violence-Related Content in British Media Outlets

For the purpose of obtaining a preliminary overview of the availability of OV-related content in British mass media and a first impression of how the problem is framed in public discourse, a Google search was conducted between August and September 2024 using the keywords "Obstetric Violence in the UK" and "Disrespect and Abuse in Childbirth in the UK" to assess the relevant matches emerged (complete results are provided in Appendix C, 1-2).[19]

Regarding the sources among the first entry results ("Obstetric Violence in the UK"), 40% were from British universities' news portals (King's College London 2024 and Durham University 2024), 20% from an independent, non-profit British media outlet operated by academics and researchers (The Conversation 2024), 20% from Western European media outlets (Euronews 2021 and Deutsche Welle 2019), 10% from a British literary magazine (London Review of Books 2024), and 10% from a US-American journalistic network (Global Investigative Journalism Network 2024). Only 40% of the results presented keywords from the original search term ("Obstetric Violence in the UK"), of which only 20% were UK-specific (Appendix C, 1).

[19] While this preliminary Google search applied in both the UK and Brazil analysis is useful for gathering only a general overview and access to publicly available information through key terms, this research recognises the limitations of this method, such as: sampling bias and difficulty in replicating findings.

Of the results returned from the second entry ("Disrespect and Abuse in Childbirth in the UK"), none contained keywords from the original search term, nor did any focus on UK-specific content (Appendix C, 2). Instead, some articles focused on maternity care issues in India, Bangladesh, and Nigeria. From the total results, 60% came from health-related organisations and journals (International Confederation of Midwives 2024, Frontiers 2023, FIGO.org 2021, World Health Organisation 2019, and Journal of Global Health Reports 2022), 10% from a peer-reviewed journal (The Lancet 2023), 10% from a British tabloid newspaper (The Daily Star 2024), 10% from the UK Government (2021), and 10% an independent British media outlet (once more The Conversation 2024).

While this brief search may not provide a comprehensive picture of public awareness surrounding OV in the UK, it suggests a substantial lacuna in media coverage of an issue that, as evidenced by the section *3.3* is as prevalent in Brazil as it is in the UK. Furthermore, it indicates a lack of recognition of a term that has already been adopted and acknowledged by several international organisations worldwide, as shown in Chapter 2. Notably, the results generated by the second search (with an increased focus on scholarly publications and a reduced focus on content aimed at broader audiences) align with the fact that OV is still more prevalent within academic discourse.

Following this general overview, three of the most widely circulated British newspapers were selected for a medium-specific investigation, each bearing distinct political leanings (Ponsford 2024): *The Guardian* (left), the *BBC* (centrist), and *The Times* (centre-right) (Ponsford 2024). The following key terms were used: "Obstetric Violence" (1), "Disrespect and Abuse in Childbirth" (2), and "Birth Trauma" (3) (complete results are provided in Appendix C, 5-13).

In *The Guardian*, all results from the first term featured OV-related content in both the UK and international contexts, with 70% of the articles explicitly naming it "obstetric violence" (Appendix C, 5). 10% of the results from the second term exhibited the term "disrespect and abuse in maternity care", while a total of 80% related to gender-based violence in either institutional or domestic settings (Appendix C, 6). All results from the third term generated content based on birth trauma (most of them focusing on the experience of poor treatment and substandard care) (Appendix C, 7).

In the *BBC*, 20% of the results exhibited OV-related content from Croatia (one named it as such and the other as "abuse") and the rest on other birth-related content

and gender-based violence abroad (e.g. in Sudan and India) (Appendix C, 8). No results were found for the second term (Appendix C, 9). For the third term, one article referred to a baby's death in Wales resulting from substandard practice, but no results used "birth trauma" (Appendix C, 10).

In *The Times*, 50% of the results from the first term search featured "obstetric violence" (among which two articles questioned the term "birthing people" and one had the subject of "Midwives told to stop pushing own agenda for natural births") (Appendix C, 11). No results were found for the second term (Appendix C, 12). 40% of results from the third term featured "birth trauma" (most of which refer to the 2024 Birth Trauma report, also explored in this work's previous section) (Appendix C, 13).

Although some terms might resonate better than others in some countries and their respective cultural and linguistic contexts (Diniz 2022), this overview suggests that the issue is not being covered *through the same linguistic codes*, which in turn, hinders the construction of *social knowledge* around the issue, also evidenced by the absence of results in Google Trends with the term "Obstetric Violence" in the last five years in the UK, as shown in Figure 15 (Hall 1997, 4, 42; italics supplied).

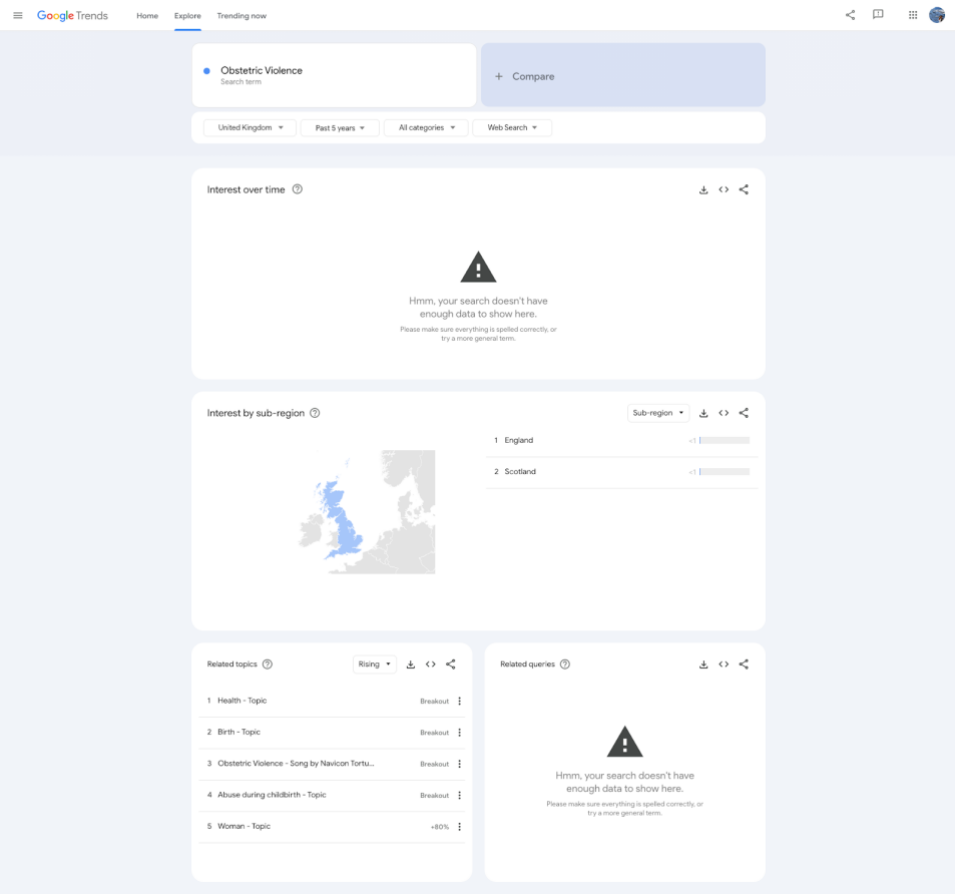

Figure 15: "Obstetric Violence" search in Google Trends in the past five years in the UK. Due to the exclusion of Northern Ireland and Wales, the data cannot fully represent the UK.

Additionally, since the UK press tends to reflect a conservative perspective of the world, it is plausible to suggest that relying on their news values to inform the production of public awareness of the problem risks undermining impartiality of media outlets (Cushion et al. 2018, 179). As such, the unsurprising difference in coverage and language used by the observed media outlets reveals how these social practices and their respective reporting practices are intimately connected to questions of power (Hall 1997, 42). The broader issue of underrepresentation of OV as a critical topic within the UK's public discourse points to a significant impact in reaching solution goals and legal representation.

With a close-reading approach of two *BBC* news reports representing OV ("Poor maternity tolerated as normal, inquiry says", from *BBC* News and "Birth trauma, Sleepwalking, Lolita Chakrabarti", from *BBC* Sounds), it is plausible to argue that even though all participants involved in the production of the meaning process (newspaper, journalist, and audience) are interpreting the issue in broadly similar ways, the lack of *common* access to the *same* linguistic codes influences how the problem can be recognised and adequately quantified, as exemplified by the following excerpts (Hall 1997, 1, 2):

> Women complained they were not listened to when they felt something was wrong, were mocked or shouted at and denied basic needs such as pain relief. (Hancock and Rhoden-Paul 2024)
>
> Women from marginalised groups, particularly ethnic minority groups, appeared to experience particularly poor care, with some reporting direct and indirect racism, the inquiry highlighted. (Hancock and Rhoden-Paul 2024)
>
> The report said that too often poor care is normalised and women are often traumatised by the lack of basic care and compassion. (Woman's Hour 2024)
>
> "There was one midwife in particular who, on her shift, just said to me: 'Why are you crying all the time? You need to pull yourself together.'" (Woman's Hour 2024)

Systematic and Strategic Silence

The insufficient reporting and appropriate representation do not indicate the problem's absence, but point to a strategic silence and complicity from ruling powers that reveal underlying injustices in British maternity care (Hasser 2003, 264-5). In this sense, strategic silence refers to the idea that birth, as a political act, is influenced by a multitude of factors, including principles of person-centred care, midwifery staffing levels and, in a broader sense, political agendas, as Rayment et al. highlights (2020, e79):

> The rise of neoliberalism and austerity in contemporary Britain has influenced the reform of maternity services, in particular the closure of midwifery units. Justifications given for closure

> silence other narratives, predominantly from service users, that attempt to present women's choice in terms of rights and a social model of care.

On the other hand, this silence prompts the production of counterhegemonic content by social activist movements and resistance fronts, usually fomented by victims of OV, which shall be further explored in the next and final part of the UK's media representation of the problem, but also by midwives who advocate for adequate staffing levels and healthier working conditions (Women's Place UK 2021).

Content Produced by Activists, Researchers, and Social Media Users

Among the first documentaries that reported on OV in the UK is "PUSH: The Truth About Obstetric Violence" (2022), produced by researchers and activists in the UK, with the active voice of victims. Despite the relatively low viewership (2,094 views on YouTube as of 24 August 2024), the language employed in the documentary is central to the representation, classification, conceptualisation, and value placed on OV in the UK (Hall 1997, 3). The following passages can exemplify this ("PUSH: The Truth About Obstetric Violence" 2022):

> "Obstetrics is the branch of medicine that looks after people that are giving birth, the birthing body, and the baby coming out. But violence is exactly what violence says. It is an act done to someone, to a body, that causes them pain, trauma and distress. Obstetric violence is where the care of the profession and the violence of the profession come together." (Mars Lord, birth activist and doula)

> "Obviously, there are times when intervention is necessary, but each of these should be done with true consent, informed consent." (Mars Lord, birth activist and doula)

> "We do not have the statistical data to establish its prevalence because we have no agreement in how to define obstetric violence." (Camilla Pickles, researcher of women's rights, childbirth and OV)

> "Obstetric Violence, as a specific wrong and harm is not recognised in law in the UK. Theoretically, there might be avenues in both criminal law and civil law, but what we find is that this not translating. Those cases that are successful generally involved damage caused to babies as a result of inadequate treatment of women and the women themselves who have been violated and experienced the obstetric violence are nearly side-lined. I do think that we need a law introduced to clarify what obstetric violence is, where the harm lies and how do we remedy it. It says a lot about the value of women in society when her harms have to be so extreme before we take notice that her rights have been violated." (Camilla Pickles)

Ultimately, despite this final observation not addressing specific statistics from the UK, it is important to take note of the role of cyberactivism by social media platform users in communicating meaning and, in a broad sense, "speaking the same language" when it comes to sharing and amplifying their experiences of OV, thereby

building communities, raising awareness, facilitating real-time advocacy, and challenging societal norms (Hall 1997, 4; Sena and Tesser 2017, 209).

c. Brazil

The Role of Social Activism in Shaping Public Discourse

In order to analyse the presence of OV-related content in the Brazilian press, it is necessary to explore the social efforts that led to increased public awareness. Since the 1980s in Brazil, an emerging movement has been advocating for women and OBI's reproductive and human rights, mainly consolidated by groups of healthcare professionals, public health researchers, and feminist social activists (Sena and Tesser 2017, 209; Tornquist 2004). The movement for the humanisation of birth, in particular, in which person-centred care is prioritised, as well as the protagonist role of the woman and OBI in the labour experience and ritual, has been the central agenda for reproductive justice (Diniz 2005, 628; Sena and Tesser 2017, 209). Notably, the leading role of ReHuNa characterised the technocratic model of birth in the Brazilian context, mainly through declaring unacceptable practices of dehumanising care with unnecessary and excessive interventions (Diniz 2005, 631; ReHuNa 1993; Sena and Tesser 2017, 210).

As ReHuNa started growing and gaining popularity in parallel with the expansion of internet use in Brazil in the late 1990s and early 2000s, the communication exchange between all actors involved in the movement and women and OBI became more substantial and widespread (Sena and Tesser 2017, 210). These interactions between female healthcare users were consolidated primarily through electronic lists, such as *Parto Natural, Amigas do Parto, Rehuna, Materna, Parto Nosso,* and *Mães Empoderadas* (Diniz 2005, 631; Tornquist 2004; Sena and Tesser 2017, 210).[20]

Notably, these lists were formed extensively by women from the middle classes (Diniz 2005, 631; Sena and Tesser 2017, 210). This factor represented a driving force with significant potential for political actions and changes, especially through the creation of various personal, institutional and public policy initiatives (Diniz 2005, 631; Sena and Tesser 2017, 210). While it is true that the immense efforts of the social movements, scholars, and healthcare professionals had an impact on the status

[20] In English, Natural Childbirth, Childbirth Friends, ReHuNa, Maternal, Our Childbirth, Empowered Mothers (AT).

quo and on media representation, there is one double-edged sword aspect from which it cannot be dissociated. The "political novelty with enormous potential for change" was significantly influenced by the power dimension of women from wealthier backgrounds who had experienced OV, thus obfuscating and underrepresenting other essential victim groups (Sena and Tesser 2017, 210; Diniz 2005, 631). This shall continue to be explored in the following subsections.

The Presence of Obstetric Violence-Related Content in Brazilian Media Outlets

In accordance with the preliminary overview of the UK case, the same criteria were applied to analyse the availability of OV-related content in Brazil between August and September 2024. In this case, the same terms were used, but in Portuguese: "Violência Obstétrica no Brasil" and "Desrespeito e Abuso no Parto no Brasil" (Appendix C, 3-4).

The first search query yielded the following results: 50% were from government entities (Portal da Câmara dos Deputados, Portal do Conselho Nacional de Justiça, Defensoria Pública do Rio de Janeiro, Câmara Legislativa do Distrito Federal, and Ministério Público Federal) and 50% were from newspapers (*Rádio Itatiaia, G1, Brasil de Fato, CNN Brasil,* and *Le Monde Diplomatique Brasil*). All the results featured the term "Violência Obstétrica" in Brazil.

The second search entry returned the following results: 20% were from health associations (Fiocruz and Abrasco) and 80% from newspapers (*O Globo, Esquerda.net, Gazeta do Povo, BBC Brasil, Politize!, Folha de S.Paulo, Portal Uai,* and *Portal Catarinas*). A striking feature of the results was that they all translated the term "Desrespeito e Abuso" to "Violência Obstétrica". 90% of the results were from Brazil, and 10% from Portugal.

Among the most widely distributed newspapers in Brazil, the following three were selected for a search related to "Violência Obstétrica", each with distinct political leanings: *Folha de S.Paulo*, *G1* and *Brasil de Fato* (Yahya 2023).[21] All newspapers' results contained "Violência Obstétrica" either in the headline or in the news article (Appendix C, 14-16).

[21] A separate study should explore the different political leanings of Brazilian newspapers and how this might affect the coverage of OV in the country. For the purpose of this analysis, *Folha de S.Paulo* and *G1* are considered neoliberal right (Ferreira 2019, 69) and *Brasil de Fato* left (Moura 2009).

While this work has shown that the term “Obstetric Violence” has been active for a long time in Latin America, this brief overview serves as a good indicator of the production of social *knowledge* constructed through the same linguistic codes (Hall 1997, 4). The representation of this human rights issue through common language — i.e. the words used to describe it, the stories told about it, the ways in which the issue is classified and conceptualised, the values placed on them — can also be exemplified by how different regions of Brazil experience OV as well as news articles with the finality of *explaining* to broader audiences what it is, how to identify and how to report it, as observed in the results generated from Google Trends in Figure 16 (Hall 1997, 3; G1 2021):

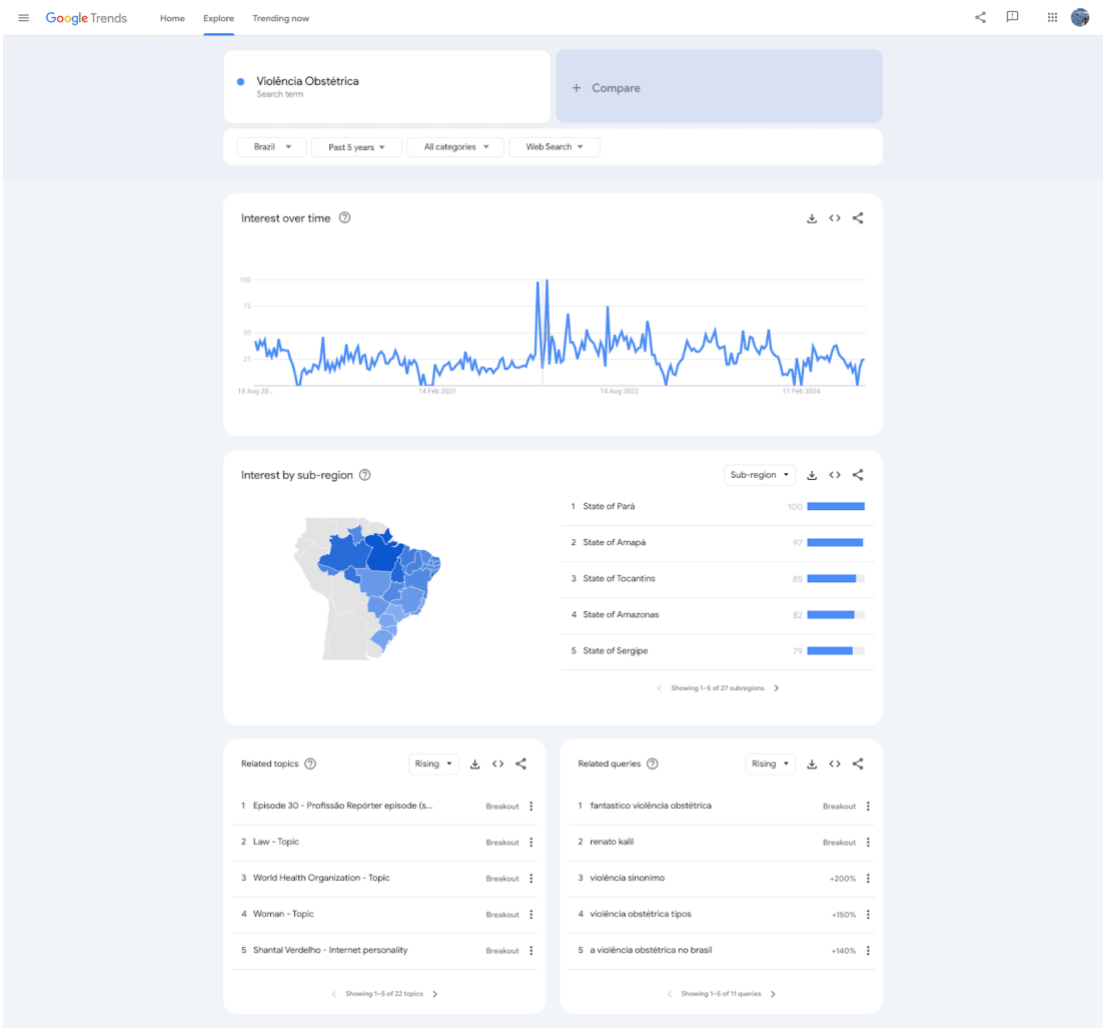

Figure 16: “Violência Obstétrica” search in Google Trends in the past five years in Brazil.

Award-Winning Obstetric Violence Reports and Notable Cases

Taking into consideration the large presence of journalistic content on OV in Brazil, evidenced by the previous sections, it is also worth highlighting the instances in which the topic was exceptionally covered by the press, illustrated by award-winning reports in video and photojournalism.

One notable example is the video report from journalist Marieta Cazarré, from *Empresa Brasil de Comunicação (*EBC), which in 2014 won an honourable mention in the National Journalism Award on Gender Violence (Régia 2014; Cazarré 2014).

The 2014 video report titled *Colo vazio – histórias de luto materno*[22] features a multidimensional perspective on the problem of OV, predominantly through the voices of women who had traumatic birth experiences (Cazarré 2014). It also explores paramount psychological elements explained by psychologists, and it questions Brazil's world record caesarean section rates prompted by financial incentives, emphasising the convenient and lucrative aspects for obstetricians (Cazarré 2014).

Also from 2014, the report *Violência Obstétrica: se você ainda não acredita, escute essas mulheres*[23] was a finalist for the "8th Délio Rocha Award for Public Interest Journalism" (Saúde Plena 2014). In this report, which also features a photojournalistic collaboration entitled "1:4: Portraits of Obstetric Violence" ("1:4" refers to the results from the Nascer no Brasil from 2014, which revealed that one in every fourth Brazilian experiences maltreatment in childbirth, both in public and private institutions), journalist Valéria Mendes explores how women's bodies are objectified in the media, in personal relationships, and in medicine (Saúde Plena 2014). She explores how women often have their reproductive and sexual rights ignored for the sake of obsolete obstetric practices which reproduce the "cultural behaviour of invasion over women's bodies" (Saúde Plena 2014).

Focusing on two specific victims, Alyne da Silva Pimentel and Shantal Buonamici Verdelho, whose stories came forward in the Brazilian press, can further highlight this culture of invasion of women's bodies. A key aspect of the media coverage of these two women's experiences of OV — in Pimentel's case, a fatal outcome — is the disparity in how and the extent to which journalistic vehicles covered each experience.

[22] In English, "Empty lap - stories of maternal grief" (AT).
[23] In English, "Obstetric Violence: if you still don't believe it, listen to these women" (AT).

Alyne Pimentel (whose case will be detailed in section *3.5* from a legal and human rights perspective) was a 28-year-old Afro-Brazilian woman who in 2002 had her pregnancy pain symptoms misdiagnosed and had emergency care neglected and denied (Center for Reproductive Rights 2021). She died after a public hospital peregrination, with her autopsy declaring digestive haemorrhage resulting from her dead foetus (Center for Reproductive Rights 2021; Catoia et al. 2020, 5). This was the first human rights case of preventable maternal mortality judged by the UN Committee on the Elimination of all Forms of Discrimination Against Women (CEDAW Committee) (Center for Reproductive Rights 2021; Catoia et al. 2020, 2). Alyne Pimentel's case is one of the most representative of intersectional violence in childbirth in research outputs in Brazil as well as a striking illustration of the fact that black women are 2,7 times more likely to die during childbirth in the country than white women (Catoia et al. 2020, 1; Oliveira and Schirmer 2012, 11; DPRJ 2018). However, when it comes to media representation in the Brazilian press, it lacks coverage by the most circulated vehicles. This serves as a bridge to the next case.

Shantal Verdelho, a Brazilian digital influencer of Italian descent, suffered OV at a private hospital in São Paulo in 2021 at 32 years old (Rodrigues 2021). Her obstetrician, Renato Kalil, communicated with her in violent ways using profanities and exposed her intimate parts in offensive and dehumanising manners to her husband and third parties, using expressions such as "Damn it, push harder. Stupid woman, she doesn't push right. Little sissy.", "Look here, all torn up. I'm going to have to put a bunch of stitches in her vagina." and "Look, where you have sex [talking to her husband], it's all fucked up." (Rodrigues 2021). These came to her attention after watching her labour video over a month after it happened (Rodrigues 2021). Since then, this case has been widely publicised by all major Brazilian newspapers.

The widespread press coverage of Shantal Verdelho's experience of OV presented a significant potential for visibility and confrontation. However, the significantly less attention Alyne Pimentel's death received over twenty years ago points to a disproportionate power dimension behind vehicles deciding *who* gets to have their story told (Hall 1997, 42). The crucial point to be made is not that Verdelho's experience warranted less attention, but that Pimentel's was gravely silenced by the press, also evidenced by the case's final decision nine years after her death (Center

for Reproductive Rights 2021).[24] Ultimately, it can be said that the reverberation of both cases, though in different manners, resulted in crucial social awareness and advocacy, which undoubtedly represents merit and a desirable outcome.

Even though the use of the internet in the early 2000s when Pimentel died is much different than Verdelho's considerable digital presence at the time of this research, these cases serve as an instance of how selective media outlets are and how disparities in access to quality healthcare are structural and intersectional.

While Verdelho's case was a powerful initiative to amplify voices and cases, the extent to which the media has publicised her case raises questions about commercial incentives behind exposing women's bodies for the generation of high viewership and click-through rates instead of as a strategy of respect towards all birthing individuals and their reproductive and human rights (Sena and Tesser 2017, 217). This poses a risk of perpetuating a cycle in which the suffering of historically disadvantaged groups is systematically silenced and ignored, while privileged voices represent a stronger potential for shaping public narratives and policy reforms that often fail to recognise and address the underlying causes of social inequality in healthcare.

Brazilian Cyberactivism

In Latin America, vast digital engagement and connectivity represent a crucial tool for strategic and immediate social action (Sena and Tesser 2017, 213). In the cyberspace, health is one of the few areas where the number of female users is predominant (Sena and Tesser 2017, 213; Soares 2004, 3). This, in combination with the output and accomplishments of social movements in Brazil, gave rise to a strong role for cyberactivism against OV in Brazil (Sena and Tesser 2017, 213).

In the context of reproductive justice and human rights, by virtue of the synergy bolstered by social activism, scholarly research, and the government, the fight against OV expressed by the ideal of "humanised birth" became accessible to the general public (Diniz et al. 2018, 25). This, in turn, contributed to the emergence of non-governmental institutions, public policies, and legal frameworks (Sena and Tesser 2017, 213).

[24] Due to time and spatial restraints, television broadcast archives could not be included in this analysis.

The use of social media — notably blogs, Facebook groups, Instagram, and Twitter — by OV victims and humanised childbirth care consumers has a significant role in rendering the issue visible and creating a community of mutual support (Diniz et al. 2018, 25).

Public engagement can be evidenced by a query on the social media platform Instagram with the hashtag "#ViolênciaObstétrica", returning over 80.000 results at the time of this research (Instagram 2024). This increased integrated system of users and content production develops and represents a meaningful capacity for collective action, directly impacting public awareness (La Rocca and Artieri 2022, 5).

One example of an active Brazilian social media user is Morganna Secco, who suffered from OV in an NHS trust in London, with over 4 million followers on Instagram, and who openly talks about her experience on a YouTube video with over 645,00 views (Secco 2024; Secco 2022).

Further examples of public engagement facilitated by cyberactivism are documentaries about OV in Brazil, such as "SUS que dá certo - Sofia Feldman" (2012), "O Renascimento do Parto" (2013), and "Violência obstétrica: A voz das brasileiras"[25] (2015) (Gomes et al. 2018, 2595; Sena and Tesser 2017, 213; Diniz et al. 2018, 25).

Reflecting on all the collective efforts analysed in this section, it can be said they were key in contributing towards mobilisations, debates, and reflections, which helped turn OV into a visible agenda in Brazil (Sena and Tesser 2017, 217).

d. Discussion

The comparison in the media representation of Brazil and the UK illustrates a significant disparity in how both countries report on the issue of OV. This does not happen because OV is not a problem in the UK, but because there is significant resistance from stakeholders to naming it as such. Meanwhile, in Brazil, even though the agenda has been pushed forward by a synergy of multiple actors, this analysis raises a concern that violation stories happening to wealthier groups tend to receive more attention than marginalised ones.

[25] In English, "SUS that works - Sofia Feldman", "The Birth Reborn", and "Obstetric violence: The voice of Brazilian women" (AT).

In Brazil, OV is a widely recognised and discussed issue, both in the media and in public discourse. The frequent coverage and representation of this issue have led to heightened awareness among the public, fostering a more significant push for accountability and systemic change. Notably, media representation, aligned with social and academic efforts, has played a pivotal role in bringing the issue to the surface, ensuring that it is not only acknowledged but also addressed within social and policy contexts.

Conversely, in the UK, the representation of OV in the media is considerably less prevalent. Despite high levels of non-governmental engagement, as evidenced by other sections, this relative silence has contributed to a lower level of public awareness which might also hinder healthcare institutions and policymakers from formally addressing the issue.

The discrepancies between the UK and Brazil regarding OV media representation point to the power of social activism and knowledge production in Latin America since the 1990s. As such, the heightened presence of OV-related content circulating public discourse in Brazil offers the possibility of systematic change in public discourse. Further, this highlights the broader movement for *cognitive and epistemic* justice between the 'Global South' and 'Global North' (Diniz 2022).

3.5
Legal Instruments

a. Method

Despite the increasing recognition of OV by health organisations worldwide and by certain legal systems in Latin America, e.g. in Venezuela, Argentina, and Mexico, the absence of scientific consensus on terminology and in international human rights laws significantly impacts how most legal systems acknowledge and address the issue (WHO 2015; EP 2024; EIPMH 2019; Ley Nº 38.668; Ley Nº 26.485; Boletín N°. 1350 2022; UN 2019, 6; Tamés 2023).

At present, there is a clear gap between medicine, law, and birthing people's rights (Pickles 2017). To bridge this gap in maternity healthcare where ethics and law meet, this section shall review legal definitions of terms such as *violence* and *abuse* within the jurisdictions analysed against international documents, as well as scrutinise principles of gender-based violence (Gangoli 2020, 29; UN 1993). As a comparative legal study, this section shall perceive law as an expression and outcome of the diverse cultures herein analysed (Dannemann 2019, 396).

In the UK case,[26] this analysis focuses on primary and secondary sources of law. Primary sources of law, such as legislation (Acts of Parliament and statutory instruments) and case law (decisions of the higher courts), shall provide insight into current legal doctrine and available instruments in the UK legal system pertaining to gender-based violence (Brennan 2019, 244; ICLR 2024). Secondary sources of law (articles and opinions of legal experts) are devoted to the current discussions on the state of the law regarding OV (ICLR 2024).

In the Brazilian legal context, this part also scrutinises primary and secondary sources of law. By virtue of their mandatory and binding nature, primary sources, in this case, refer to the Federal Constitution, normative acts, laws, and jurisprudence (Diniz 2017). In order to assist in the interpretation and application of these, secondary sources shall focus on doctrinal and jurisprudential research (written

[26] Within the context of the UK's three main jurisdictions (England and Wales, Scotland, and Northern Ireland), this analysis shall place a particular focus on the English and Welsh self-contained legal system (ICLR 2024).

works by legal scholars), as well as legal opinions (Andrighetto and Reinheimer 2023, 1; Diniz 2017).

Finally, in the context of the broader comparative law analysis, it is primarily the study of *differences* that will configure the most critical account of this comparison (Dannemann 2019, 421; italics supplied).

b. UK

In the current legal framework, the UK does not offer any dedicated legal provision to address or criminalise OV (Verity and Pickles 2022, 24). As such, this means that when a woman or OBI experiences violence amounting to dehumanising care and degrading treatment in obstetric care, legal recourse must be sought under other statutes (Pickles 2015, 13; Verity and Pickles 2022, 24).

At present, victims and survivors can technically seek damages through lawsuits under civil, criminal, and human rights law (Verity and Pickles 2022, 24). The first source of law entails torts of medical negligence and battery, i.e. actions involving force, intent, or lack of consent to treatment (Verity and Pickles 2022, 24). The second covers criminal battery, genital mutilation, and other non-fatal Offences Against the Person (Verity and Pickles 2022, 24, Female Genital Mutilation Act 2003; Offences Against the Person Act 1861).

What is essential to note about these sources of law, however, is that they have not been developed to tackle OV as a specific form of gender-based and intersectional violence (Verity and Pickles 2022, 24). One notable example of legislation that also fails to include the dimension of *violence* and, consequently, to address the gendered nature of violence against women, is the Domestic Abuse Act 2021 (Domestic Abuse Act 2021; Aldridge 2021, 1823). This may be regarded as a symptom of "a much wider tactic of resistance and refutation in patriarchal systems", which not only has a detrimental effect on female victims and survivors around the world, but also influences the potential for enacting OV legislation in the UK (Aldridge 2021, 1836).

While it is indeed true that in such cases abuse and violence also affect men, it does, however, disproportionately harm women and transgender individuals, as men are significantly more likely to be the perpetrators (Aldridge 2021, 1835). As such, these laws constitute offences which are predominantly masculinist in nature, despite

their failure to acknowledge this in their definitions (Brennan 2019, 245; Bibbings 2000, 231).

When taking into account the House of Lords' definition of Violence Against Women and Girls (VAWG), adopted by the UN in 1993, it states that (House of Lords 2023; UN 1993):

> [...] the term "violence against women" means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.

In this case, it does not only seem appropriate to include OV in this category, but also under many other significant provisions of the UN 1993 declaration, such as the following (UN 1993):

> Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs. (Article 2, Subsection C)
>
> The right not to be subjected to torture, or other cruel, inhuman or degrading treatment or punishment. (Article 3, Subsection H)
>
> Develop penal, civil, labour and administrative sanctions in domestic legislation to punish and redress the wrongs caused to women who are subjected to violence; women who are subjected to violence should be provided with access to the mechanisms of justice and, as provided for by national legislation, to just and effective remedies for the harm that they have suffered; States should also inform women of their rights in seeking redress through such mechanisms; (Article 4, Subsection D)

Finally, in addition to the primary issue of gender-based violence not being currently addressed in UK legislation altogether, it is important to mention that the need for OV legislation can also be considered through the principle of fiduciary law — referring to the duty of trust and responsibility with which healthcare providers are expected to act, thereby guaranteeing their safety, autonomy, and informed consent (Kukura 2019, 204-5). Some researchers have raised this topic, and it would be beneficial to encourage further discussion (Kukura 2019, 204-5).

Considerations on the Criminalisation of Obstetric Violence in England and Wales

Considering that current criminal law offers insufficient protection against OV in England and Wales, legal scholars in the UK have recently started to debate the necessity of enacting such offence as a specific statutory crime in England and Wales (Brennan 2019, 226-7, 243). This segment will specifically draw on these reflections, focusing primarily on traditional normative aspects of this type of harm and the individuality of each experience, therefore advocating against the trivialisation of

women and OBI's experiences of violence as the basis for criminalisation (Brennan 2019, 233). It is essential to point out that while this consideration for criminalising OV primarily focuses on the gender-based aspect of this violation and criminal law's traditional male approach to violence and harm, it must not be overlooked the fact that, as it was seen in previous chapters, a significant portion of its prevalence is also a consequence of further intersectional problems and institutional failures (e.g. involving political and economic struggles, reflected also in poor facilities resource allocations), and therefore would need additional legal arguments for discussion (Brennan 2019, 233; Verity and Pickles 2022, 24; Conaghan 1996, 431; Pickles 2017).

As previously mentioned, the gender-based factor involved in this specific violation is not adequately addressed by any of the current legal avenues (the closest relevant legislation being the Female Genital Mutilation Act 2003, however it is usually intended to criminalise cultural practices and does not originate from a healthcare standpoint), nor is the abuse or mistreatment based on patient attributes (Female Genital Mutilation Act 2003). These are some of the starting points in discussing the development of such legislation: one that focuses on the experience of victims and survivors, i.e. women *and* OBI, and that "challenges the gender norms [and intersectional structural issues] on which OV is based" (Brennan 2019, 228).

The UN Special Rapporteur on Violence Against Women issued a report on OV and mistreatment, emphasising that (Verity and Pickles 2022, 24; UN 2019, 21):

> States have an obligation to respect, protect and fulfil women's human rights, including the right to highest standard attainable of physical and mental health during reproductive services and childbirth, free from mistreatment and gender-based violence, and to adopt appropriate laws and policies to combat and prevent such violence, to prosecute perpetrators and to provide reparations and compensation to victims.

Noting that the UK is a signatory of such an international human rights treaty, it has "formally committed itself to take measures to tackle violence against women" (Verity and Pickles 2022, 24). As a grave violation, the underlying rationale for why the law has remained unresponsive is unclear (Pickles 2017).

In this sense, an explicitly defined offence would not only be following international human rights standards, but it would categorise the crime appropriately, as well as acknowledge and address the gendered power imbalance inherent to the abusive nature of harm inflicted in obstetric care (Brennan 2019, 232). This could lead to a considerable impact on prevention, as it appears to have been insufficient through "international, regional and domestic health care guidelines, policies, recommendations or protocols directed towards ensuring respectful, evidence-based and patient-centred obstetric care" and which are not binding in law (Pickles 2017).

By educating the public about their rights, it becomes possible not only to *name* the problem, but to "provide a legal mechanism to vindicate those who have been hurt" (Pickles 2015, 13).

The need for a specific OV offence is also justified by the fact that, unlike other patients who may suffer medical negligence or other forms of battery torts, women and OBI's physical limitation and vulnerability to disrespect, abuse, mistreatment, and violence do not stem from illness (Brennan 2019, 243-4). Although parturients may have previous health conditions, their condition of pregnancy does not equate to sickness.

Notably, patterns of coercive behaviour directed at parturients, particularly regarding decisions that may have a direct bearing on the life and death of the foetus or unborn baby or their general well-being, as well as attitudes linked to traditional social pressures and normative expectations of "good motherhood", can make them particularly susceptible to excessive obstetric intervention, normally imposed as routine and thus commonly non-evidence based, and substandard care (Brennan 2019, 243-4; Pickles 2015, 13).

In some cases, there may be concerns regarding the sufficiency of evidence, particularly "with prosecutors also having to consider the likelihood of conviction" and "whether prosecution is in the public interest" (Brennan 2019, 235-6, 63). It is worth mentioning that this constitutes only one component of the decision, and, once more, that the law takes an approach focused on women's and OBI's experiences of violence in this context (Brennan 2019, 228, 235-6; Birth Trauma Inquiry 2024).

This leads to why, however appealing criminalisation may be, it must not be taken lightly (Brennan 2019, 232-3). It raises questions such as "How can compliance be enforced? How can individual and state accountability take place in cases of non-compliance?" (Pickles 2017). The main rationale for criminalisation is the prevention of harm against parturients (together with other mechanisms that are non-legal, and which are explored in other sections, for example, medical syllabi reformations to include diverse forms of person-centred and culturally safe care) (Brennan 2019, 232-3). This should be done in a way that healthcare providers are not excessively afraid of exploring care options or their duty of care.

Ultimately, however beneficial reforming current laws and introducing the criminalisation of OV in the UK may be, thereby potentially preventing harm, it must be pointed out that legislation is not the ultimate solution to the problem, as it involves many societal structures to act collectively (Brennan 2019, 232-3). As such,

"law and its language can be a critical frontier for feminist change" and indeed composes a vital component in building a safer and legally secure environment for women and OBI to give birth in (Verity and Pickles 2022, 23; Palmer 2002, 115; Brennan 2019, 247).

c. Brazil

The Brazilian legal system presently lacks a federal law that expressly criminalises OV, but has several state and municipal laws that tackle OV (Silva and Alves 2023, 3). On a national level, this generally results in the application of other laws to address violent practices and provide protection for women in their experiences during pregnancy, birth, postpartum, and abortion (Silva and Alves 2023, 3).[27] These can be identified by the following three laws: Organic Health Law (Lei nº 8.080 de 19/09/1990); Birth Companion Law (Lei nº 14.737 de 27/11/2023; Lei nº 11.108 de 07/04/2005; Andrighetto and Reinheimer 2023, 6; Ribeiro-Fernandes 2019, 2); and Access to Information Law (Lei nº 12.527 de 18/11/2011).

Among the three legislative measures mentioned above, only the Birth Companion Law addresses the gendered nature of the issue during all stages of pregnancy (Lei nº 14.737 de 27/11/2023). Essentially, as well as ensuring that parturients receive the support they need from someone of their choice as a primary objective, it can be argued that this legislation may also function as a preventative measure against maltreatment and abuse by healthcare professionals, thereby potentially providing testimony in cases of rights violations. In its updated form, it guarantees a noteworthy provision (Lei nº 14.737 de 27/11/2023):

> The companion referred to in the heading of this article shall be freely chosen by the patient or, in cases where the patient is unable to express their will, by their legal representative, and shall be required to maintain the confidentiality of any health information they become aware of during the accompaniment. (§ 1, AT).

Slowly, but consistently, the discourse around violence and abuse in childbirth contexts has become increasingly visible in Brazil (Diniz et al. 2018, 31). As a result of the growing dialogue between social movements, scholars, legal experts, and the government, OV as a gender-based type of violence has become increasingly

[27] This study extensively relies on the term "women and other birthing individuals" in recognition of women, transgender, intersex, and non-binary birthing people's rights. However, this section scrutinises the Brazilian legal system, which is fundamentally a gendered body of law. Therefore, if deemed necessary, the terminology used to discuss it will be gendered. More research is needed on scenarios of childbirth which involve OBI.

acknowledged in legal contexts (Diniz et al. 2018, 31). An example is the acknowledgement of OV in a National Council of Justice document stating that (Protocolo para Julgamento com Perspectiva de Gênero 2021, 87):

> Although Brazil does not classify obstetric violence as an autonomous crime, apart from international treaties and documents, the Federal Constitution, infra-constitutional legislation and technical regulations operate for the purposes of criminal liability, including when such violations of the human rights of women and girls are practised when providing essential and emergency services to parturients, which allows violence to be catalogued as psychological, moral and physical, according to women's life and reproductive cycles. (AT)

Indeed, the 1996 Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women — also known as the 'Belém do Pará Convention' — defined violence against women as "any act or conduct based on gender that causes death, physical, sexual or psychological harm or suffering to women, whether in the public or private sphere", thus providing a legal basis also applicable for addressing OV (Convenção de Belém do Pará 1996, Article 1; Senado Federal 2024; Tribunal de Justiça do Estado de Sergipe 2024; AT).

Violence against women has been addressed explicitly by the Domestic Violence Law — also known as 'Maria da Penha Law' — which includes moral and patrimonial violence across the forms of domestic and family violence in addition to physical, sexual, and psychological violence (Lei nº 11.340, de 07/08/2006; Senado Federal 2024). As this law emphasises the gendered nature of violence in domestic and familiar contexts, it may be argued that it also establishes precedents for enacting federal legislation targeting institutional violence, as it would be in most cases of OV, thereby covering those perpetrated within healthcare facilities, both in the public and in the private spheres. After all, the UN CEDAW Committee states that "[e]ven when governments outsource health services to private institutions, they remain directly responsible for their actions and have a duty to regulate and monitor those institutions" (Center for Reproductive Rights 2021).

Obstetric Violence Laws in Local Governments

At the time of this research, at least eight pieces of state and municipal legislation specifically address OV in the Brazilian territory. One of the most comprehensive definitions of OV, elaborated by the Legislative Assembly of the State of Rio de Janeiro (2015), categorises it as follows:

> Art. 1 - Obstetric violence is characterised as the appropriation of women's bodies and reproductive processes by health professionals, through dehumanised treatment, neglect of care for women and new-borns, abuse of medicalisation and pathologisation of natural processes, which cause women to lose their

> autonomy and ability to decide freely about their bodies and sexuality, negatively impacting on their quality of life.
> For the purposes of this Law, obstetric violence is considered to be any act practised by health professionals that verbally, physically or emotionally assaults pregnant women during prenatal care, childbirth, the postnatal period or in an abortion situation. (AT)

Among the existing laws, the following states offer OV legislation: (1) Santa Catarina State Law (Lei nº 17.097 de 17/01/2017; Lei nº 18.322 de 05/01/2022; Katz et al. 2020, 624); (2) Espírito Santo State Law (Lei nº 10.694 de 07/07/2017; Lei nº 11.212 de 29/10/2020); (3) Paraná State Law (Lei nº 19.701 de 20/11/2022; Lei nº 21.102 de 21/06/2022): (4) Pernambuco State Law (Lei nº 16.499 de 06/12/2018; Lei nº 17.226 de 21/04/2021; Katz et al. 2020, 624); (5) Amazonas State Law (Lei nº 4.848 de 05/07/2019); (6) Mato Grosso State Law (Lei nº 5.568 de 16/09/2020); (7) Rio de Janeiro Municipal Law (Lei nº 7.867 de 05/12/2022); and (8) Paraíba State Law (Lei nº 11.329 de 16/05/2019).

The Pernambuco State Law provides a solid example of how violence in the obstetric context is legally defined in Brazil (Lei nº 16.499 de 06/12/2018; Lei nº 17.226 de 22/04/2021):

> Art. 2 Obstetric violence is considered to be any act practised by health professionals that involves negligence in care, discrimination or verbal, physical, psychological or sexual violence against pregnant women, women in labour, people undergoing abortion and puerperal women. (AT)

Despite being revoked and reintroduced in 2021 as law number 17.226, the Pernambuco State Law also classified OR within the scope of OV (Lei nº 17.226 de 22/04/2021):

> § 2 Obstetric racism is considered to be any act of obstetric violence referred to in the heading of this article when motivated by racial discrimination. (AT)

These laws demonstrate clear progress in acknowledging violence against women during all stages of childbirth and, in some cases, the intersectional aspect of this form of violence, addressed by typifying OR. Reformation, however, is still required, as it does not cover OBI apart from women. It can be argued that, if these state-level laws gain traction, widespread support, and have the ability to accomplish meaningful change and results, they could then be used to inform and influence national discussions and thus be applied nationwide. This would require an analysis of how the general public is aware of these laws, the effectiveness of such enactments in overcoming OV in these states, how these laws are being applied, and the consequences for noncompliance (Pickles 2017).

A Landmark Case in Discrimination, Maternal Health, and Human Rights: Alyne Pimentel v. Brazil

Representing the first documented case judged by the UN CEDAW Committee, Brazil was condemned for violating human rights against Alyne Pimentel, a 28-year-old impoverished Brazilian national of African descent, for "failing to provide timely, non-discriminatory, and appropriate maternal health services" (Center for Reproductive Rights 2021; CEDAW Committee 2011).

One of the first facts presented by the CEDAW Committee illustrates the initial discriminatory treatment based on patient attributes, as Ms. Pimentel's pain was quickly dismissed and given little consideration (CEDAW Committee 2011, 3):

> On 11 November 2002, Ms. da Silva Pimentel Teixeira went to the Casa de Saúde Nossa Senhora da Glória de Belford Roxo (the health centre) suffering from severe nausea and abdominal pain. She was in her sixth month of pregnancy at the time. The attending obstetrician-gynaecologist prescribed anti-nausea medication, vitamin B12 and a local medication for vaginal infection, scheduled routine blood and urine tests for 13 November 2002 as a precautionary measure and sent Ms. da Silva Pimentel Teixeira home. She began to take the prescribed medications immediately. (Paragraph 2.2)

Her condition worsened considerably after that. On 13 November 2002, no foetal heartbeat could be detected, and she needed to be given medication to induce the expulsion of her stillborn. After that, her condition continued to deteriorate, and she was treated with extreme negligence, seen by her waiting over eight hours on one occasion and being placed in a makeshift area in an emergency room hallway because there were no beds available on another. She also had her rights to the companionship of her mother and husband denied. On 16 November 2002, she died of digestive haemorrhage as the foetus had been dead in her womb for several days (CEDAW 2011, 3-4).

In 2011, nine years after her death, the CEDAW Committee acknowledged that (Center for Reproductive Rights 2021; CEDAW 2011, 21):

> [...] States have a human rights obligation to address and reduce maternal mortality, to ensure women's rights to safe motherhood, and to provide affordable access to adequate emergency obstetric care, meeting the specific and distinctive health needs of women, particularly women from low-socioeconomic backgrounds and historically marginalized groups.

The final decision of the CEDAW Committee emphasised that it is the obligation of the Brazilian government to incorporate the recommendations previously set to enhance "quality of maternal health care, eliminate discrimination in health care, and consequently reduce the country's maternal mortality rate" (Center for Reproductive Rights 2021; CEDAW 2011, 21). As Catoia et al. put it (2020, 9):

> The CEDAW Committee's decision is also significant in the debate on institutional violence and institutional racism, as it recognises that preventable maternal death is a violation of women's human right to sexual and reproductive health and that the gender-based violence

> against Alyne Pimentel resulted from the intersectional discrimination (of race, status, social class and gender) she suffered, which also affects black, poor and peripheral women more severely in Brazil. It therefore contributes to a deeper legal understanding of the effects of racial discrimination on gender violence and the reproductive health of black, poor and peripheral women. (AT)

As an extreme case, Alyne Pimentel's preventable death provides a glimpse into many women and OBI who have their basic maternal rights denied and suffer grave discrimination from maternal health professionals representing the State, thereby embodying the devastating impacts of intersectional issues.

Abortion Criminalisation as a Form of Obstetric Violence

While Brazil has demonstrated progress and emancipation in terms of OV state-level legislation, it still retains some of the most restricted access to abortion laws in the world (Rezende and Dittrich 2022, 249; Center for Reproductive Rights 2024).

Since the Criminal Code of 1830, abortion has been codified as a crime, under Law number 2.848/1940, against human life, punishable by imprisonment, with the exception of three instances: if it presents a life threat to the pregnant woman, in the case of rape, and should the foetus be anencephalic (Rezende and Dittrich 2022, 249; Codigo Criminal Do Imperio do Brazil, 1830; Código Penal 2017, Art.124 to 128, 50).

Although this configures a heated and extensive point of debate on its own, this research deems the criminalisation of abortion as a critical form of OV, as it prevents access to safe options, which often lead to unsafe procedures and preventable maternal mortality. When looking at the existing body of law and state definitions of OV, it is especially noteworthy to reiterate the aforementioned definition by the Legislative Assembly of the State of Rio de Janeiro (2015): "which cause women to *lose their autonomy and ability to decide freely about their bodies and sexuality, negatively impacting on their quality of life"* (italics supplied). Furthermore, it should be emphasised that (Leal et al. 2018, 1916):

> The criminalisation of abortion has been shown to reinforce inequality, as opposed to preventing the practice. While women with a higher socioeconomic status are able to afford safe abortion services, the majority are driven to use unsafe methods, such as taking misoprostol. These women then seek SUS hospital treatment at the first sign of bleeding to complete uterine evacuation and treat complications. As a result, there were 205,439 hospital admissions associated with abortion in 2015. (AT)

Bills

For a few years, Brazilian lawyers — especially those who suffered from OV themselves and are in the position of providing specialised perspectives in their areas, for example, in the case of prosecutor Maísa Melo (Lúcio 2017) — have played a notable role in the creation of legal instruments and bills to be enacted nationally (Agência Câmara de Notícias 2023; Ferigato 2014; Projeto de Lei N.º 7.867, de 2017; Projeto de Lei N.º 878, de 2019). Some of these have been discontinued, demonstrating that despite increased dialogues, significant resistance appears to exist. One reason can be attributed to the financial incentives associated with certain procedures in private healthcare (justifying, for example, the high rates of excessive caesarean sections). When considering principles of fiduciary law (in Brazil, however, these are more commonly used in property contexts than health), it is important to consider that (Kukura 2019, 210):

> [...] conflicts of interest should be disclosed to maternity care patients, including economic incentives that influence clinical decision-making, liability avoidance, internal hospital policies that dictate physician conduct without patient knowledge, and the perceived duty to treat the foetus as a separate patient.

d. Discussion

From an observer's perspective, while neither the UK nor Brazil has national laws to criminalise OV, at least eight of Brazil's twenty-six states have OV laws to protect parturients, in addition to the Birth Companion Law, and a few legal projects currently in place to criminalise it. In this regard, it is plausible to infer that, at present, Brazil has more legal mechanisms for redress. Implementation of and compliance with these laws, as it was seen, is another topic of debate and contention, with the primary point of concern being the current *existing* mechanisms for it and *legal acknowledgement* — or lack thereof — in both territories.[28]

In the case of the UK, as seen in section *3.4*, public awareness of birth and reproductive rights appears to be limited, thereby potentially affecting the likelihood

[28] Despite Brazil's advocacy for law availability, compliance systems remain insufficient. In the case of the Birth Companion Law, Ribeiro-Fernandes argues (2019, 4): "Federal Law number 11,108/2005, or the Companion Law, which guarantees women the right to be accompanied by someone of their choice in the public health network is often not complied with, leading the parturient and the baby not to enjoy the numerous benefits of monitoring throughout the period of labour. This non-compliance occurs mainly due to the mother's lack of knowledge of her rights and the authoritarianism of public institutions and their collaborators that do not allow the mother to have her right fulfilled. It is of paramount importance that the leaders of public maternity hospitals are aware of this non-compliance to change this scenario, ensuring that the mother has her right fulfilled."

that victims and survivors will be aware that they can, theoretically, seek justice and reparation through the pre-existing statues. In turn, instead of a clear targeted legal provision, this disparate framework reflects a lack of seriousness and results into less reporting and enforcement.

While it is worth considering that the federal structure of Brazil allows for state-level legislation and decentralised approaches for states enacting their laws based on local advocacy and political will, and the English legal system leaning on Parliament for any significant changes, there is a clear difference in how both governments recognise OV. In this sense, the UK is particularly ill-equipped to deal with this specific form of violence than Brazil (Verity and Pickles 2022, 24). On the other hand, Brazil is still further behind regarding safe abortion laws.

The impact of non-binding guidelines and social movement — e.g., the National Humanization Policy (PNH), introduced by the Ministry of Health in 2003, influenced mainly by the creation of the ReHuNa in 1993 — illustrates the idiosyncratic aspect of public health in Brazil and how this impacts on the development of legal framework (Política Nacional de Humanização – HumanizaSUS 2024; ReHuNa 2024).

While not necessarily every comparative law study carries the aim of legal systems learning from each other, this legal debate, which lies at the heart of human rights, maternal health, and intersectionalities, sees positive developments stemming from Brazil, where the OV expression “took shape and body at the heart of feminist movements and by the humanisation of childbirth”, and can potentially influence international legal discourses (Dannemann 2019, 421; Katz et al. 2020, 624).

4.
Synthesis

The intent to interpret the phenomenon of OV exclusively within medicine and public health domains is analogous to observing a single diseased tree in a forest without accounting for the underlying ecosystem imbalances contributing to its sickness. When viewed from a superficial perspective, it may appear to be an isolated incident. Yet, a closer examination might reveal that the state of this one tree can be symptomatic of systemic issues widespread throughout the forest. Hence, the multidimensional reflection herein demonstrates that this issue transcends individual cases to reflect more profound problems in healthcare and human rights, as well as global social accountability and justice.

In this sense, incorporating a multifaceted debate into a public and global health issue reveals that, despite the significant work-related pressures faced by health professionals specialised in providing *care*, the fundamental factors contributing to malpractice against women and OBI mainly relate to systemic injustices based on gender, race, and class.

The argument built within this body of research supports the fact that OV is strongly influenced by the technocratic systems that are prevalent in both the UK and Brazil, which extensively and systematically favour medicalised childbirth models over social ones (Kitzinger 2012, 301). This can help explain the financial incentives, time efficiency demands, or operational pressures behind the high rates of childbirth interventions that contradict WHO recommendations (Boerma et al. 2018, 1341; Minayo and Gualhano 2022, National Maternity and Perinatal Audit 2022; Rocha et al. 2023, 2; WHO 2022; WHO 1985).

Brazil's consistently high rates of caesarean sections of 56% (80% of which take place in the private sector) and England and Wales' birth induction rates of 34% (Minayo and Gualhano 2022; NMPA 2022) are representative of a culture surrounding childbirth that shapes a discourse in which natural births are undesirable or discouraged due to the pain they cause during extended periods while disregarding the adverse risks that may come with excessive interventions (Diniz 2005, 629).

As such, striking a healthy balance between natural procedures and necessary interventionist practices is commonly overlooked, often resulting in highly medicalised events, where even labours perceived as "straightforward" as possible

are subject to excessive interventions employed in high-risk births (Kitzinger 2005-2012, 303).

These practices, which are frequently implicated in pathologising childbirth, are capable of being transformed into violent and abusive conduct. Accordingly, these (mal)practices are systematically silenced, since the ultimate goal of delivering the "perfect baby" is often linked to insufficient respect for humanised practices, and personal, religious or cultural preferences given to the individual bringing the baby into the world (Davis-Floyd 1993, 302).

Despite this phenomenon applying to many industrialised and globalised societies, exploring the social aspects that lead to OV, alongside how nations acknowledge and respond to it, as well as the social impacts resulting from it, raises challenging questions permeating fields beyond public health.

This was the central argument that led this research: finding different approaches to the same challenge. The complexity of a problem such as this requires a complex solution driven and supported by collective thinking. Overall, "[t]here is no point in comparing what is identical, and little point in comparing what has nothing in common", thus a cross-national comparison of the structures that enable OV necessarily requires, albeit in varying degrees, a consideration of both commonalities and contrasts (Dannemann 2019, 392).

Ultimately, based on the belief that the UK's NHS, regarded as the benchmark for healthcare worldwide, is considered to be among the safest places for childbirth, it is not uncommon for this to configure an implicit message that the medical model of childbirth in a European country like the UK would be necessarily superior to that of a Latin American country like Brazil (Kitzinger 2012, 301).

Drawing upon the findings derived from the intersection of the historical contexts, healthcare models, statistical evidence, media representations, and legal frameworks, this chapter synthesises this study by proposing that this argument is debatable, thereby exploring what the underlying causes, common patterns emerged, and response trends can inform global discussions on maternal healthcare, pointing to potential solutions to the multifaceted nature of OV.

Exploring Key Similarities

Across the different fields analysed, significant findings were identified vis-à-vis the (1) underlying causes of OV, (2) indicators that suggest its prevalence, and (3) the similarities among first-hand accounts, in particular the *words* used by women and OBI describing their experience of birth and OV.

The disciplines of History and Public Health were instrumental in uncovering the role of social hierarchies in medical settings, particularly evidenced by differential treatment and provision of care based on gender, race, and class. In this sense, the role of intersectionalities and OR, configuring a substantial part of OV, help reveal the deeply-rooted structural injustices that reflect more profound social discrimination, racism, and neglect. This pertains not only to childbirth, but can point to how institutionalised care deals with health-related issues for patients who do not belong to historically advantaged groups. Similarly, the problem can become even more acute in times of global crises, as seen by the *profile* of maternal deaths during COVID-19, with black women being nearly four times as likely and Asian women nearly twice as likely to die than white women in the UK and Ireland (MBRRACE-UK 2022).

As such, the comparison between Brazil and the UK showed that OV can happen due to a variety of factors: power imbalances (between parturient and healthcare provider, or between senior healthcare provider/obstetrician and midwives and doulas – particularly those with less experience), working conditions, misogyny, and racism.

Even though it was seen that, at present, there is no single method by which OV can be measured, the results from the Perseu Abramo Research and the Birth Trauma Inquiry[29] point to similar levels experienced in both Brazil and the UK, with 25% and 30% yearly, respectively (Birth Trauma Inquiry 2024, 10; King's College London 2024; Venturi and Godinho 2013, 172-180; Soet et al. 2003, 26).

This leads to the *universality* of how women and OBI felt and reported on their birth experiences. Regardless of their country of nationality and how individual each of their experiences was, there were substantial patterns of commonality: feeling like their voice did not matter, that they were not informed of what was happening or what procedures were to take place, that they were left alone, that they were either

[29] As explained in section *3.3*, not all birth traumas are directly associated with OV.

given too much or too little medication, and that they did not have agency or authority over their own bodies (Birth Trauma Inquiry 2024, 10; Matos et al. 2021, 6-10). In these cases, their voices were recurrently inaudible (Mairesse 2024).

Exploring Key Differences

Numerous contrasts were revealed by this comparative analysis, ranging from the differences between healthcare models to the structural societal approaches to addressing this issue. However, the most significant ones were: (1) the differences between primary healthcare providers (along with their professional training) in maternity care and the role this plays in invasive interventions employed; (2) linguistically, problems related to language accessibility in the NHS with international users, as well as the divergent interpretations of *abuse* and *violence* within the cultural contexts analysed (and the subsequent impacts on legislation and policy formulation); and (3) the fundamental differences in acknowledging and responding to the problem.

While the primary professionals involved in childbirth in Brazil are obstetricians, obstetric nurses, and midwives, successively (Aquino et al. 2023, 2; Dotto and Mamede 2008, 336), in the UK, it is the other way around, with midwives constituting the primary professionals who assist in childbirth, and obstetricians handling high-risk pregnancies and labour outcomes (House of Commons Health and Social Care Committee 2021, 11). In both territories, the primary professionals are supported by nurses and doulas. The differences in professional training and hierarchisation among professionals who assist in childbirth in both countries might serve as an explanation as to why certain types of intervention are employed more often in one country than the other. In Brazil, for example, where obstetricians are the primary care providers, the caesarean rate of 56% (WHO suggests this should not exceed 15%) exposes a deeper problem of how attitudes towards financial incentivisation behind procedures like these negatively affect women and OBI's health and rights, especially in the private sector (Goodair and Reeves 2024, e199; Minayo and Gualhano 2022; WHO 1985). While the percentage of private healthcare in the UK is slightly lower than in Brazil (22% against 26%) and the fact that caesarean sections are not as standard as in Brazil, other forms of interventions, notably induction of labour, also have high rates, with 34% in England and Wales (Fleck 2023; NMPA 2022; Souza Júnior et al. 2021, 2534). These procedures should

be carried out “only when there is a clear medical indication for it and the expected benefits outweigh its potential harms” and “with caution since the procedure carries the risk of uterine hyperstimulation and rupture and fetal distress” (WHO 2022, 4).

Moving to the linguistic aspect, two significant differences were identified. The first is that the NHS is confronted with a number of challenges in terms of how prepared it is to receive and provide care for culturally diverse groups. Even though every user has the right to have an interpreter (Hill 2023; MacLellan 2023, 100162), this does not imply that there are interpreters available for all, thus creating a significant language barrier during an experience in which communication is essential not only for understanding what is occurring, but also for receiving words of kindness and support (Birth Trauma Inquiry 2024, 60). The second difference concerns the cultural dimensions of the terms *abuse* and *violence*, even though they are very similar in English and Portuguese (*abuso* and *violência)*. If the Domestic Violence (Brazil) and Domestic Abuse (UK) laws are taken into account and used as a legal parameter for the gender-based human rights violation in this study, it is possible to observe crucial distinctions and overlaps between them (Lei nº 11.340 de 07/08/2006; Domestic Abuse Act 2021). Consequently, a number of follow-up questions regarding violence and abuse can be raised: Does one encompass the other? How are these terms understood in each cultural context? In what ways might these nuances be reflected if national laws against OV were enacted? In this context, these questions could be explored in future research, as they also reflect how the countries respond to the issue.

Despite OV being highly prevalent in both the UK and Brazil, Brazilians have developed a distinctive way of addressing this issue, primarily through social movements and academic research, followed by legal and mediatic mechanisms. The collective efforts fostered by the interplay and cooperation of social movements, scholarly debates, policymakers, and jurisprudence have had a significant effect on public awareness, providing a precedent that other countries, such as the UK, can follow (Diniz et al. 2018, 25). Particularly noteworthy, the Birth Companion Law, which guarantees the parturient the right to any companion of their choosing, and all the state OV laws (currently in at least eight states) are strong indicators of how the country is responding to the problem and gaining momentum in conjunction with other Latin American countries, like Venezuela, Argentina and Mexico, aimed at reversing this violation of human rights (Boletín N°. 1350 2022; Lei nº 11.108 de 07/04/2005; Lei nº 17.097 de 17/01/2017; Lei nº 10.694 de 07/07/2017; Lei nº 16.499

de 06/12/2018; Lei nº 11.329 de 16/05/2019; Lei nº 4.848 de 05/07/2019; Lei nº 5.568 de 16/09/2020; Lei nº 11.212 de 29/10/2020; Lei nº 17.226 de 21/04/2021; Lei nº 18.322 de 05/01/2022; Lei nº 21.102 de 21/06/2022; Lei nº 19.701 de 20/11/2022; Lei nº 7.867 de 05/12/2022; Ley Nº 26.485; Ley Nº 38.668).

Local and Global Perspectives

Examining the local guidelines and policies and how effective they are, as well as institutions and organisations that do advocacy work in both the UK and Brazil provided insight into more different dimensions of responses to the issue of OV. In Brazil, most notably, the pioneering works of ReHuNa (Diniz et al. 2018, 19), as well as the Diretrizes Nacionais de Assistência ao Parto Normal (2017, 2022) provide comprehensive intelligence on the matter. In the UK, the National Institute for Health and Care Excellence (NICE) guidelines and advocacy work promoted by the White Ribbon Alliance are among the parameters of good medical practice (NICE 2023; WRA UK 2024).

These national policies can be aligned with most international standards. Still, some of the statistics here analysed showed how they conflict with what is practised, especially regarding caesarean sections, induction of labour, and avoidable maternal deaths, which points to a vital necessity for global debates and advocacy to better align guidelines and their impacts on society.

In this sense, examining the underlying issues that drive OV in both countries against systematic reviews and evidence-based practices provides a framework to address broader gender-based issues related to access to healthcare, power imbalances, education, and wealth distribution that are not only local or national problems, but a humanitarian concern requiring international advocacy and action (Chalmers and Altman 1995, 119; WHO 2000; WHO 2001).

The forms of gender-based violence and human rights violations in maternity care explored in this study share common roots with many other forms of systemic and patriarchal gender inequalities. Thus the need to draw comparisons between them and reflect on how social structures can exert control over women's and OBI's bodies, deprive them of their rights, and undermine their dignity and autonomy. In this light, considering the silence that permeates this human rights violation occurring in democratic countries, it becomes imperative to investigate the role of OV in societies where "[e]very aspect of female existence is controlled and

scrutinised", and gender apartheid[30] is a reality (Amnesty International 2024; Bennoune 2022, 24).

Unique Insights

As this work is intended for non-expert and non-specialised audiences, it is a striking finding that the Brazilian synergetic cooperation between different groups — i.e., the strength of social movements resulting in public actions, policies, legislation, diffusion of information and initiatives to improve medical training — has consistently promoted more (even if not sufficient) respectful, evidence-based, and humanised maternity care since the 1980s, thereby representing a pioneer agent in the development of such momentum (Diniz et al. 2018, 19, 20, 31).

While the UK has produced significant work — particular emphasis is placed on the works of Sheila Kitzinger, who articulated the voices of British women with *Some Women's Experiences of Episiotomy* and *Some Women's Experiences of Epidurals: A Descriptive Study* in the 1980s — its systematic lack of acknowledgement of OV might conceal deeper concerns within the NHS, including funding, resource allocation, and management (Kitzinger and Walters 1981; Kitzinger 1987). Notably, Brazil's SUS struggles with these issues as well, but how the country has been *addressing* the problem is noteworthy.

It is worth mentioning some of the organisations in both countries which have been leading research and discourse on respectful maternity care. In Brazil, most notably: Nascer no Brasil, ReHuNa, Fiocruz, and the Birth Experience Study - Brazil (BESt Brazil) (Diniz et al. 2018, 20; Fiocruz 2022; Lansky et al. 2014, S192; Nascer no Brasil 2019; ReHuNa 2024). In the UK: White Ribbon Alliance, MBRRACE-UK, and the Birth Experience Study - UK (BESt UK) (King's College London 2024; MBRRACE-UK 2024; White Ribbon Alliance UK 2024).

The existence of specialised centres in humanised births — i.e., which emphasise person-centred care and place the birthing individual at the centre of the childbirth experience — like *Centros de Parto Normal* (Normal Birth Centres), in particular the Casa Angela Humanised Birth Centre in São Paulo and Hospital Sofia Feldman

[30] UN (2024) experts have defined gender apartheid as "[s]tate laws, policies and practices that relegate women to conditions of extreme inequality and oppression, with the intent of effectively extinguishing their human rights". In particular in Afghanistan, where "Taliban edicts, policies and practices constitute an institutionalised system of discrimination, oppression and domination of women and girls, amounting to gender apartheid."

in Belo Horizonte are notable initiatives of SUS (Agência Câmara de Notícias 2023; Casa Angela Centro de Parto Humanizado 2024; Diniz et al. 2018, 29; Ministério da Saúde 2024; Nicaretta e Cortêz 2015, 352). These findings warrant global attention for their potential to promote alternatives to excessively medicalised birth experiences.

The Way Forward

This research points to the need to listen more to women and OBI: they are the best people to inform how care should be based and the experts on what they need. Similarly, it points to improved medical training, especially including the concept of "cultural safety", as shown in Table 8 (Lokugamage et al. 2020, 266):

*'**UNCONSCIOUS BIAS** refers to a bias that we are unaware of, and which happens outside of our control. It is a bias that happens automatically and is triggered by our brain making quick judgments and assessments of people and situations, influenced by our background, cultural environment and personal experiences.'* [72]
*'**CULTURAL COMPETENCE** education for health professionals aims to ensure all people receive equitable, effective healthcare, particularly those from culturally and linguistically diverse backgrounds.'*[73]
*'**CULTURAL HUMILITY** was used in a variety of contexts from individuals having ethnic and racial differences, to differences in sexual preference, social status, interprofessional roles, to healthcare provider/patient relationships. The attributes were openness, self-awareness, egoless, supportive interactions, and self-reflection and critique. The antecedents were diversity and power imbalance. The consequences were mutual empowerment, partnerships, respect, optimal care, and lifelong learning. Cultural humility was described as a lifelong process. With a firm understanding of the term, individuals and communities will be better equipped to understand and accomplish an inclusive environment with mutual benefit and optimal care.'*[74]

Table 8: Decolonising concepts in medical and midwifery education (Lokugamage et al. 2020,

Medical and midwifery training should be done in a way in which educators, in conjunction with other disciplines, think collectively of ways to decolonise education and prepare professionals "who can meet the complex needs of diverse populations" (Lokugamage et al. 2020, 265, 250, 246):

> In doing so, institutions should create tailored CS training depending on the syllabi or organisational structure and resources. We cannot be prescriptive about the precise educational format due to heterogeneity of target organisations. Each of the elements could work through facilitated workshops, patient public involvement and coproduction of education, health services and development of structural institutional policies.

And:

> CS, on the other hand, clearly states the rationale of increasing health equity for minority groups by urging individual professionals to examine their own position of privilege and the need to examine and address inherent power imbalances [...].

In order to continue the synergy and break the biases, the notable works developed so far, especially evidenced by Brazil's approach to OV and the strength of feminist movements, are a key way to exemplify how Latin America can offer valuable lessons. Following Lokugamage's words of "geographic biases in research outputs whereby the institutions of the *global north* dominate the evolution of global knowledge" and propositions of mitigating "these geographical biases through an active partnership with research bodies of the nations of the *global south"* could serve as a solid example of how much there is to be learned, collectively, from Latin America (Lokugamage et al. 2020, 267; Skopec 2020, 2).

Some of these efforts have already been undertaken. Collaborative development between British and Brazilian researchers commissioning health projects can be exemplified especially through: "A change laboratory for maternity care in Brazil: Pilot implementation of Mother Baby Friendly Birthing Initiative" (Diniz et al. 2021, 19), "Obstetric care models in the Southern Region of Brazil and associated factors" (Velho et al. 2019, 1), and "Technologies of birth and models of midwifery care" (McCourt 2014, 168).

Equally important is the debate of the rights of healthcare professionals, as evidenced by studies such as "Saúde sexual e reprodutiva no Brasil: como avançar na garantia de direitos com enfermeiras obstétricas e obstetrizes"[31] (UNFPA 2024).

More research is needed on OV against young girls, transgender people, incarcerated people, longitudinal studies of psychological effects (PTSD, birth trauma, depression and anxiety) and respective support systems, impacts of COVID-19 and how it exacerbated intersectionalities.

Much like the Brazilians who have fought against reproductive injustices for over three decades, there needs to be more people who take a courageous act to turn the problem of OV not any more invisible than it is. This is not a matter of assigning blame: it is turning a problem that is usually silenced and enhancing its visibility. After all, silence ought not to provide anyone protection (Mairesse 2024).

Ultimately, there are a few considerations to be made regarding the limitations of this study. The first concerns the depth of coverage of the geographical regions. In

[31] In English, "Sexual and reproductive health in Brazil: how to advance in guaranteeing rights with obstetric nurses and midwives" (AT).

the UK case, substantially more resources were found focusing on England, primarily London (which is not exclusive to this field), and therefore less on Wales, Northern Ireland, and Scotland. In the case of Brazil, considerable focus was placed on São Paulo, though less significantly than in the UK case. Similarly, the second consideration refers to inclusivity through linguistic devices. At present, the vocabulary surrounding obstetric care appears seemingly innocuous, but it often excludes transgender, nonbinary, and intersex birthing individuals. As such, this work also advocates for more research on the rights of all birthing individuals, including those in Indigenous communities and those with disabilities.

5.
Conclusion

This work investigated the issue of Obstetric Violence as a global health concern and human rights violation in the context of the UK and Brazil's healthcare systems. By restricting the autonomy of women and other birthing individuals to freely decide about their own bodies, it was observed that the appropriation of their bodies by healthcare professionals leads to the pathologisation of natural processes, dehumanised care, and correctional approaches to their bodies (Diniz 2022).

Most poignantly, it was evidenced through all disciplines explored that the issue is not only a matter of gender-based violence in reproductive care but that it is deeply rooted in systemic oppressions resulting from colonial rule, thereby revealing an issue that is not only common to the countries analysed, but point to how Western medical models depersonalise individuals and invalidate experiences. Throughout the study, this was one form of answering the first proposed research question.

Through interdisciplinary research, this study emphasised that substandard practices have profound impacts on the lives of women and other birthing individuals, particularly those from historically disadvantaged backgrounds. Even though it was seen that the issue has become more known, it is still often silenced by ruling patriarchal structures, underscoring the need for continued research. In this sense, it would be appropriate to use the words of Rwandan author Beata Umubyeyi Mairesse (2024): "What does a liberated voice do when it falls on ears that remain deaf?".

Furthermore, it was also observed that Obstetric Violence can be exacerbated by profit-based health procedures that incentivise practices such as caesarean sections, an endemic problem in Brazil. Similarly, it was seen that austerity measures of governments lead to hospitals being severely understaffed, thereby decreasing the chances of extremely overworked health personnel offering person-centred care, as seen in the UK.

In addressing the second research question, this study explored how practices of cultural safety, person-centred care, decolonised healthcare syllabi and patient treatment, cultural competence, cultural humility, and overcoming unconscious biases are key aspects to advance broader global health issues (Lokugamage et al. 2020, 266).

It was seen throughout the chapters that, despite Brazil and the UK experiencing the same problem at similar levels, Brazil has been addressing and advocating for humanised care in childbirth and Obstetric Violence for much longer. This was evidenced by the growth of the academic and socially engaged community within the field of public health, a trend that was also evident throughout Latin America (Leal et al. 2018, 1925). Even though it was shown that impacts may vary (some areas have been highlighted as positive examples, whereas others still face considerable obstacles), the dynamic and synergetic nature of the Brazilian health sector was demonstrated by an increased awareness of Obstetric Violence in comparison to the UK, as well as by initiatives to promote humanised birth, Obstetric Violence state laws, and the strength of data collection methods integrating user perspectives.

These examples serve as an important reference point to address the third research question and refute the stereotype that the 'Global South' lags behind in many aspects. In this regard, Brazil, as an example of the 'Global South', has addressed the issue of Obstetric Violence more effectively than the powerful and influential UK. For decades, Brazil has been publicly acknowledging and addressing the issue through academic research and social activism, which has, in turn, influenced public health policies and reproductive care laws. As such, this represents a call for epistemic justice in which the UK can use the Brazilian experience to enhance governmental discussions and efforts on preventing Obstetric Violence.

Due to the complexity and multidimensional nature of Obstetric Violence, the study addressed crucial discussion points but ultimately emphasised the need for further research in both territories studied, as well as globally, with concrete suggestions throughout the research. Furthermore, it highlighted the importance of active collaboration between parturients, health care providers, academics, governments, and the general public for global advancements in reproductive and maternal care and rights.

6.
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7.

Appendix A

About this work: the following letters, identified as "'Evidence of bad handling': birth experiences", are part of the National Childbirth Trust (NCT) and the Wellcome Collection, and are restricted until 1 January 2044.
Names and addresses have been changed to preserve anonymity. Aliases were selected to facilitate the reading flow by making individuals referable.
They were collected and transcribed between 17 and 24 May 2024 at the Wellcome Collection, in London.

Description: Letters from mothers to Amber Lloyd, a trustee of the NCT and local honorary secretary of the Walton & Weybridge NCT branch, recalling their experiences of childbirth, focusing on instances of poor treatment in hospital maternity care.

Publication: 1959

Location: Surrey, England

Letter 1

Harriet Baker

Mrs. Harriet Baker
18 Maple Lane
Walton-on-Thames
Surrey

31 July 1959

First Baby

There are few points of note.

1. *I would very much have appreciated it if the move to the labour ward would had been earlier in the first stage of labour, as with the contractions coming every few seconds - in my case - it was extremely difficult to manage this seemingly endless walk.*
2. *During the second stage of labour the gas and air was forced over my face with the instructions: "take two deep breaths and push" - virtually impossible. This was only discontinued after a near 'free fight'.*
3. *The pumeling [sic] on my stomach to help release the placenta was most painful and unnecessary.*
4. *I would very much have liked to have been left alone for at least half a day after the birth. Members of the staff kept coming in and altering my position and then started bringing in flowers and telegrams - very sweet of them, but I was far too tired to care.*

I would like to extend my thanks, however, for my husband being allowed to be present. It was a great comfort and was extremely useful in helping me to keep control of myself during the breathing.
On the whole the staff were extremely kind and helpful during my visit.

Harriet Baker

Letter 2

Briony Jones

Mrs. Briony Jones
27 Oak Avenue
Walton-on-Thames
Surrey
3 November 1959

Dear Mrs. Lloyd,

I am not intending this to be in any way a complaint against the staff of Rodney House as I found all extremely kind and efficient, but know you would like me to mention some of the events which occurred in my case.

I went to Rodney House at 1.30 am (26.4.59) when contractions were coming every 5 minutes. The water broke at 4 am. An enema was not given until 6 ish and having to bathe then caused unnecessary discomfort. The lack of bell in the bathroom caused considerable mental anxiety.

I was taken to the labour ward at 8.30 ish and left alone as previously, with instructions to ring if necessary. This I did at 8.45, was told to inhale gas and air which I found useless and was left alone immediately. By 9 am, I got into a panic instead of being calm as before, as I knew it was essential I had attention.

The sister came when I rang and I was by then so frightened that I did not really know what was happening. I realised why afterwards: when Dr. Windsor arrived 20 minutes after the baby was born I heard the Sister say that the head was crowning whilst she was phoning him to come.

The illusions that had been built up at the antenatal classes about cooperation between midwife and patient in being told when to stop pushing and when to pant etc were bitterly shattered as no one was with me when I first needed this guidance and I cannot help feeling that this was why stitches were necessary.

Shortage of staff seemed to be the cause of these difficulties; lack of appreciation that trained mothers are likely to be "getting on with the job" more quickly than the nurses think was another.

My one hope is that when I have my next baby whether at Rodney House or some other hospital because of my rhesus negative blood, I shall not be left unattended once labour is reaching the end of the first stage.

Yours sincerely,

Briony Jones

Letter 3a

Beverly Cooper

Mrs. Beverly Cooper
52 Pine Road
Walton-on-Thames
Surrey

3 November 1959

Dear Amber,

Herewith my epistle! All three of us, and husbands, are a little apprehensive about this, especially as we don't want to spoil it if we have to go there again. Please use your discretion. All I have written is absolutely true, I have not mentioned Sister Springs name as I feel this would be wrong. I do not mind doctors knowing - anyway the sisters can always look in their records. They deal with so many people they probably forget what they say.
I do. I wish you could get complaints from non- N.CB. people as well as it doesn't look too good if only your people grumble!
The best of luck on Friday - I must try to get hold of my other friend tomorrow & ask her experiences. My hand is tired.

Yours,
Beverly Cooper

Next time I think I'll go to Thames Ditton to train!
N.B There was a girl in with me who dusted windowsills & chairs after being induced <u>but</u> as far as I can remember she was asked if she would like to, to give her something to do and get her going, we made a joke of it - she seemed quite happy. Her baby was a spastic and died.

Letter 3b

Beverly Cooper

Mrs. Beverly Cooper
52 Pine Road
Walton-on-Thames
Surrey

3 November 1959

To whom it may concern

I have been asked to give constructive criticism of the conditions which I found at Rodney House where my son was born on April 27th 1959.
Firstly, I would like to make it quite clear that, apart from the actual delivery, I have nothing but right praise for the kind, efficient attitude of all the staff, and for the happy atmosphere which one finds there. I would still recommend anyone to go there.
I may have been unfortunate that my baby was born at a busy time but even so, I feel that where the lives of mother and baby may be at stake, this sort of thing should be avoided.
I entered the Nursing Home at 8.0 pm and at 10. pm was given sleeping pills and told nothing else could be done for me until 2.0 am my contractions were about 1 ½ mins, I am not complaining about this. I lay awake most of the time and as I became way uncomfortable and thought I'd heard the clock strike 2.0 am, I rang the bell to ask for an injection. The Sister came and asked what the fuss was about, said it was only 1 am. and I'd have to wait. This I appreciated, and apologised for bothering her. I rather felt I was being a nuisance when I was trying to put up with as much as I could.
I was given my injection before 2.0 am, together with the other patient (I believe it was a Mrs. Gray or Mrs. Cobbett), who I think were delivered the same evening. An hour or two later the woman in the other ward was moaning & the Sister came into me again and asked what all the fuss was about, I told her it wasn't me, & she went down the corridor. By this time, I did feel I've got to be on my best bahaviour and not make any noise. This was my first baby & naturally I was apprehensive but I don't think I was making a fuss.

Eventually things got going with the other woman & myself. The poor Sister was dashing from one to the other. I was alone during the transition period when I badly felt I wanted someone near. I felt I'd go mad if I didn't concentrate on counting the number of breaths to reach each climax. My discomfort was so great I felt like giving up but I knew this wasn't for long and soon I'd be in the 2nd stage.

I wanted to push, rang the bell, Sister came leaving the other patient, I think she probably examined me, I can't remember, I was told to g- [content illegible] *the gas and air as she couldn't do anything for the moment - off she went. I had gas & air because I thought if anything it would hold me up, as I knew she had to go to the other person who was ahead of me.*

When the doctor arrived, unfortunately we both had the same doctor. They tried to be one with [content illegible] *each of us. When my pushing started I had to call to the Sister to come, she arrived first in time to my great relief. Later, I did have both doctor and sister when the other patient had been delivered.*

After my baby was born, I thanked both Sister & doctor & the Sister said something to the effect, "don't thank me, I'm sorry I had to leave you so much." I do not blame her, she had had 3 deliveries that night - she was very lucky we were all straight forward. Could there not be a relief Sister in such a case?

To sum up I felt that if I hadn't had some understanding of what to expect at each stage in childbirth, particularly as this was my first child, I would have been petrified & screaming my head out, because I had to be left so long.

Secondly, one shouldn't have to feel one has to apologise all the time for attention required, I have to think twice before asking for anything. I know some patients must make a dreadful fuss, I sincerely hope I didn't, and honestly feel I kept myself under control.

Thirdly, is it really necessary for the Sister to have to fill in forms during the 2nd stage. This I believe is common practice, but it would be better to have individualised attention and not to feel she will get to you only first in time.

I do hope this would be of help to you in your enquiries & I stress again, it is only the actual delivery where there is room for improvement.

Yours faithfully,

Beverly Cooper

Letter 4a

Diane Clark

Mrs. Diane Clark
Willow Drive
Walton-on-Thames
Surrey

3 November 1959

Dear Amber,

I trust the enclosed will prove an effective weapon against the bureaucracy in Rodney House!
I hope I've stressed the right things;
If you want to change anything, or feel it doesn't help your case much, send it back with comments. I fear it has been dashed off in a moment between chores, so may be rather lazy grammatically.
Needless to say, any further help I can give is yours to demand!

Sincerely,

Diane Clark

P.S. Would M.A after my name help? It might show I am not a nitwit?

Letter 4b

Diane Clark

Mrs. Diane Clark
Willow Drive
Walton-on-Thames
Surrey

3 November 1959

Treatment in Rodney House.

On April 8th 1959 at 6pm I entered Rodney House in labour with my first baby.
Mrs. Lloyd of the Natural Childbirth Trust took me in, and stayed with me for an hour, until asked to leave by Sister Tarrant. My husband, who was also with me, had to leave then, and I was very upset at being left to 'get on with it' by myself. Mrs. Lloyd's presence was <u>most</u> encouraging, as was my husband's.
During the night, I was told I could not have a hot-water bottle, as I would get too hot. I asked the doctor if I could have one, and he said 'of course'. I was getting severe pain in my back, and asked Sister Tarrant to rub it, or put pressure on it. She refused, and said rubbing would make it sore. I repeatedly asked for my husband to be called and eventually, at 5.30 am, she did so, and my husband stayed with me until 9.30, when I was well into the second stage.
I cannot stress too much the enormous difference of my state of mind after my husband was with me. I lost all fear, and felt I could cope, although I was at the end of the 1st stage and very uncomfortable. I am sure that, had he been at hand all night (as both he and Mrs. Lloyd were prepared to be) I should have had a more bearable labour.
In fairness to Sister Tarrant, I should say that she was very kind to me, and her attitude in general was sympathetic, with none of the "what is the matter with you now?" so often found in midwives.
I feel that, had my husband and/or Mrs. Lloyd been with me all the time, I would have called on her less. Being left on one's own, even with a bell at hand, is <u>not</u> satisfactory.

Diane Clark
(Age 25)

Letter 5

Helen Wright

Mrs. Helen Wright
Willow Drive
Walton-on-Thames
Surrey
16 December 1959

Dear Mrs. Lloyd,

Following upon our conversation the other day, as requested I am pleased to point out my observations of my stay in Rodaney House.
I was inside for 10 days and in the main I would have no hesitation in recommending the place to expectant mothers. The very pleasant atmosphere that prevails amongst the nursing staff and the nice environment were better than I anticipated. But in making these comments there is one very relevant factor so far as the N.C.B is concerned.
The practice of the principles of Natural Childbirth and mothers being "trained" is not accepted.
I did practice my relaxation as soon as I arrived at Rodney House although it was suggested that walking around would bring the baby on quicker. Later I was allocated a bed and was able to relax on that (this was in the ward), and left to my own devices.
The principle of the husband being with his wife during the first stage was taboo but I was fortunate that the end of my 1st stage coincided with Sunday afternoon and the staff not realising how far on I was, allowed my husband to see me although moved me out of the ward.
When I reached the stage where I wanted to bear down I rang for the sister but again it appeared that because I was comparatively relaxed she deduced I was not yet ready and she was too busy to give me and internal ["exam" is assumed] *although she did look at me. It was perhaps unfortunate that an untrained mother was producing her baby at the same time.*
It was very significant that according to my husband, it was something more than 1 ½ hours later that the sister finally conceded that if I must push - I must push.
During this time I did try to do the panting but was told I would wear myself out before I reached the 2nd stage, and so far I did use the gas and air machine during this stage.

You can see from this that my first day at Rodney House was rather unfortunate and not what I expected. However, once the baby was born my mind was quickly put at rest and I personally feel that once Rodney House accepts and can cooperate with the N.C.B Trust it will be better for expectant mothers.

Yours sincerely,
Helen Wright

Letter 6

Anne Carter

Mrs. Anne Carter
Willow Drive
Walton-on-Thames
Surrey

16 December 1959

I've tried to be as brief and to the point as possible but this nevertheless has developed into rather a screed. Please don't use it as a list of grumbles from me but merely as an indication of what improvements could be made. I shall be interested to hear how the meeting goes. Best of luck!

Ought I to have included these details: - my age - 28
Confined to bed with toxaemia for last week of pregnancy.

Baby's weight 7.12 ons
Contractions began 15 hrs before baby was born but relaxation a special breathing made them not painful at first and easily breathable later on. Entered hospital 8 hrs before baby was born.

Anne Carter

Appendix B

ANNAES

BRASILIENSES DE MEDICINA

TOMO XX. — FEVEREIRO DE 1869. — N. 9.

REDACÇÃO DO DR. COSTA FERRAZ

O estado actual de nossa civilisação, o gráo de desenvolvimento intellectual a que temos chegado protestão contra o criminoso deleixo de consentirem-se ainda que estupidas mercenarias exerção, com visivel escandalo, na primeira cidade e capital do Imperio, a difficil e importante arte de partos.

Não ha dia, em que com dôr não tenhamos de presenciar semelhante abuso e inqualificavel attentado. E' uma preta velha ignorante como as pedras, ou especuladora e abaçanada mezinheira que á titulo de comadre dá cabo da vida de um pobre innocente, e muitas vezes da infeliz que o trazia em seu seio.

Não faltão exemplos e nem elles são desconhecidos; tambem não tem elles deixado de serem reiteradas vezes apontados em linguagem energica, porém verdadeira.

Cada um delles constitue a historia de um crime revoltante e horrendo.

A deffeza e a protecção de um ente tão fraco e inoffen-

sivo, como o innocente, que por uma lei natural se desprende do seio materno para firmar seus direitos perante a sociedade, não podem deixar de chamar a attenção e constituir uma obrigação dos executores das leis.

E' ainda um dever de humanidade bem formar o coração do povo, e diminuir-lhe os erros em que possa cahir por sua ignorancia e falta de meios.

O Brasil já não está mais no estado de permittir que um ramo tão difficil da sciencia medica, sirva de meio de vida de quanta mulher por ahi anda gasta e até mesmo imprestavel para a prostituição.

E' vergonhoso o atrazo a que estamos condemnados, maxime quando comparamos, o que se passa entre nós com aquillo que está estabelecido e firmado nos paizes verdadeiramente cultos.

Alli a sciencia progride e floresce á sombra das leis, cada operario é um guarda vigilante e severo de seus sagrados preceitos, não se tranzige com a consiencia nem com o dever. Aqui ao contrario ella definha e murcha com o calor ardente que anima o charlatanismo, que contando certo com a impunidade petulante se apresenta na praça publica aviltando a sciencia, para com trafico indigno, impingir aos papalvos, e por elevado preço, como secretas, nojentas e podres preparações pharmaceuticas.

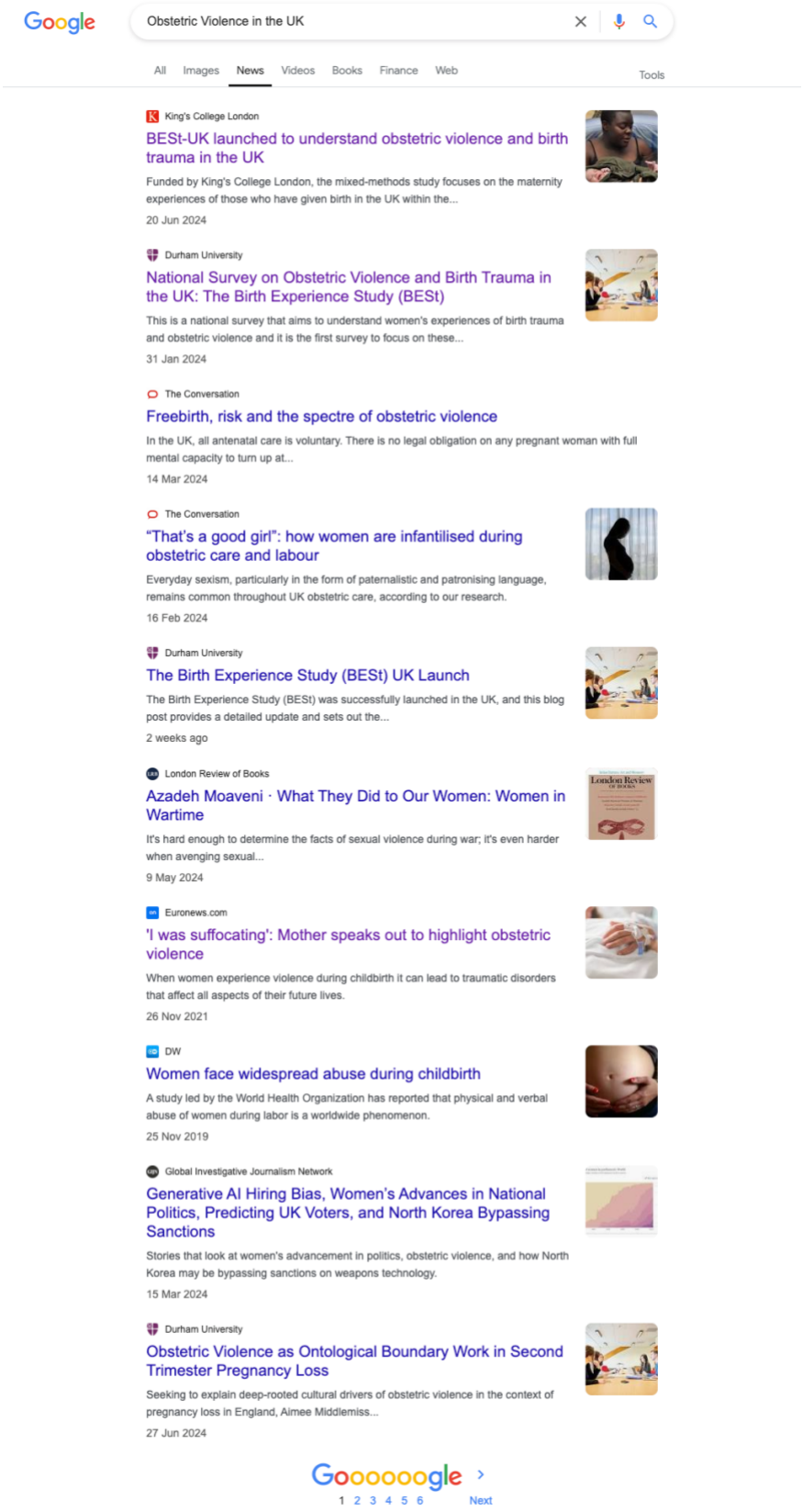
Seja muito embora um erro e merecer possa a censura e a sanha dos ganhadores o revolvermos e condemnar-mos semelhantes abusos.

Contenta-nos e satisfaz-nos a recompensa de termos cumprido com o nosso dever.

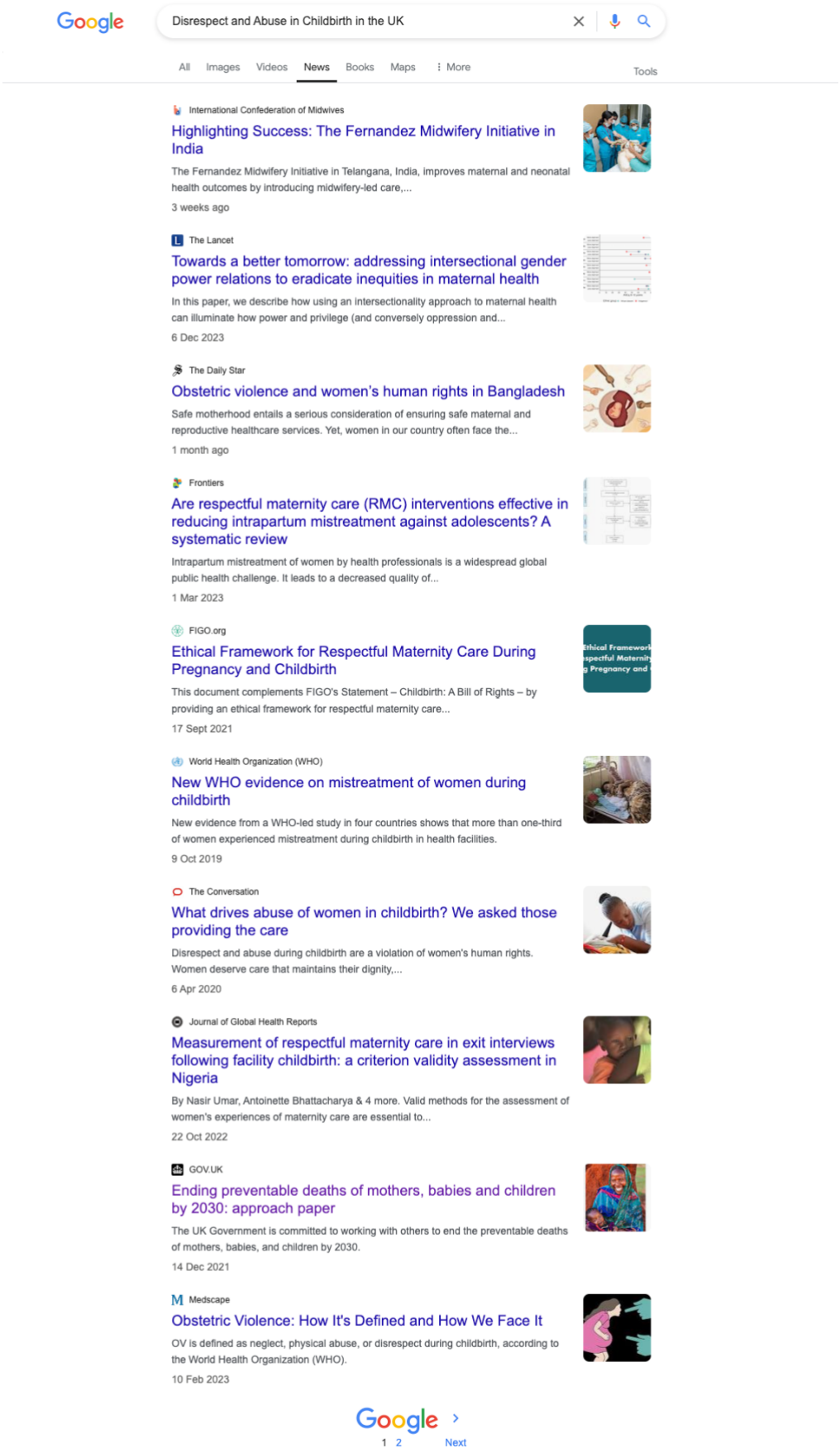
Dr. *Costa Ferraz.*

Appendix C

1. Google search results for the query "Obstetric Violence in the UK", conducted on 22 August 2024. Results may be influenced by the user's account settings, search history, and geographical location (Berlin, Germany).

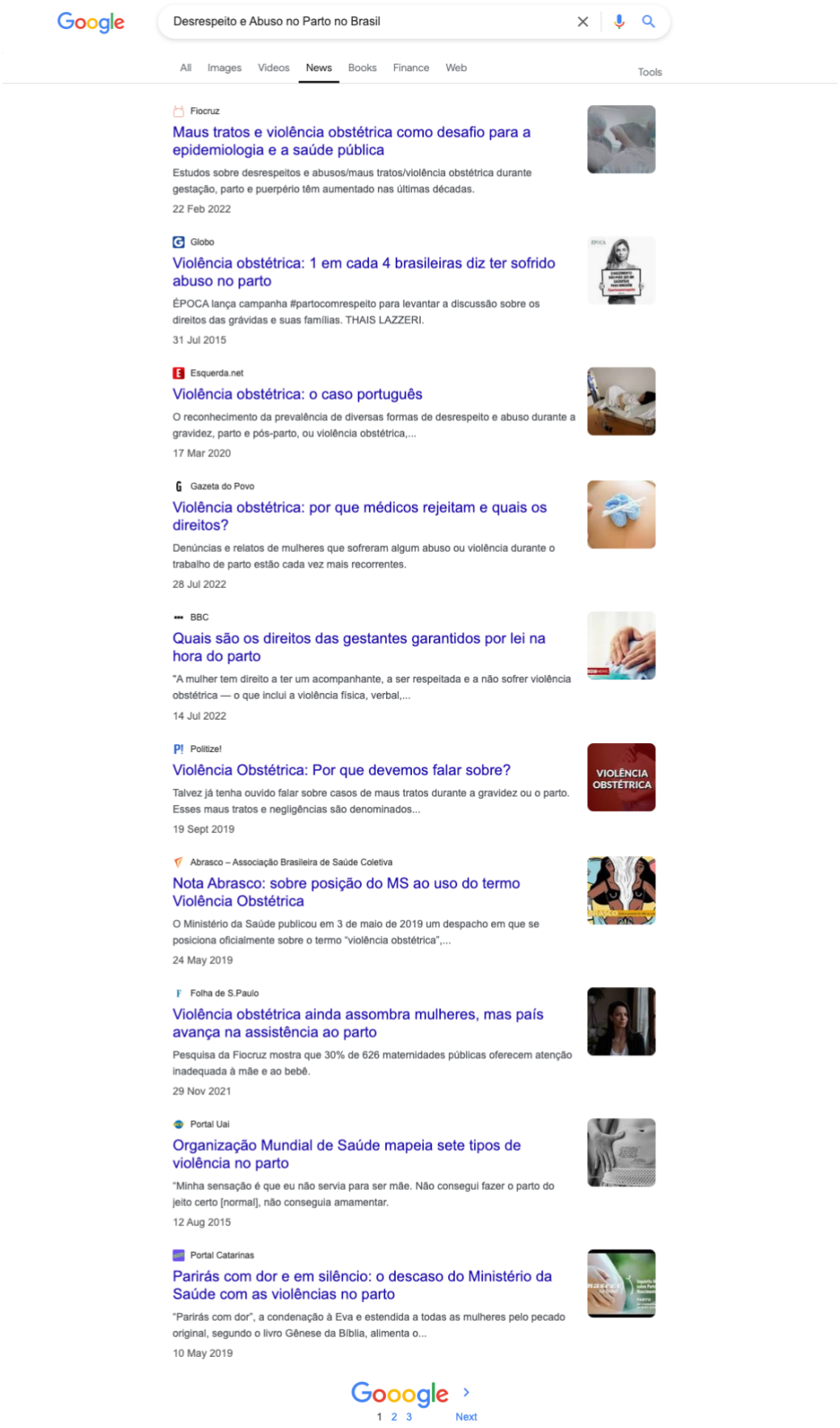


2. Google search results for the query "Disrespect and Abuse in Childbirth in the UK", conducted on 22 August 2024. Results may be influenced by the user's account settings, search history, and geographical location (Berlin, Germany).

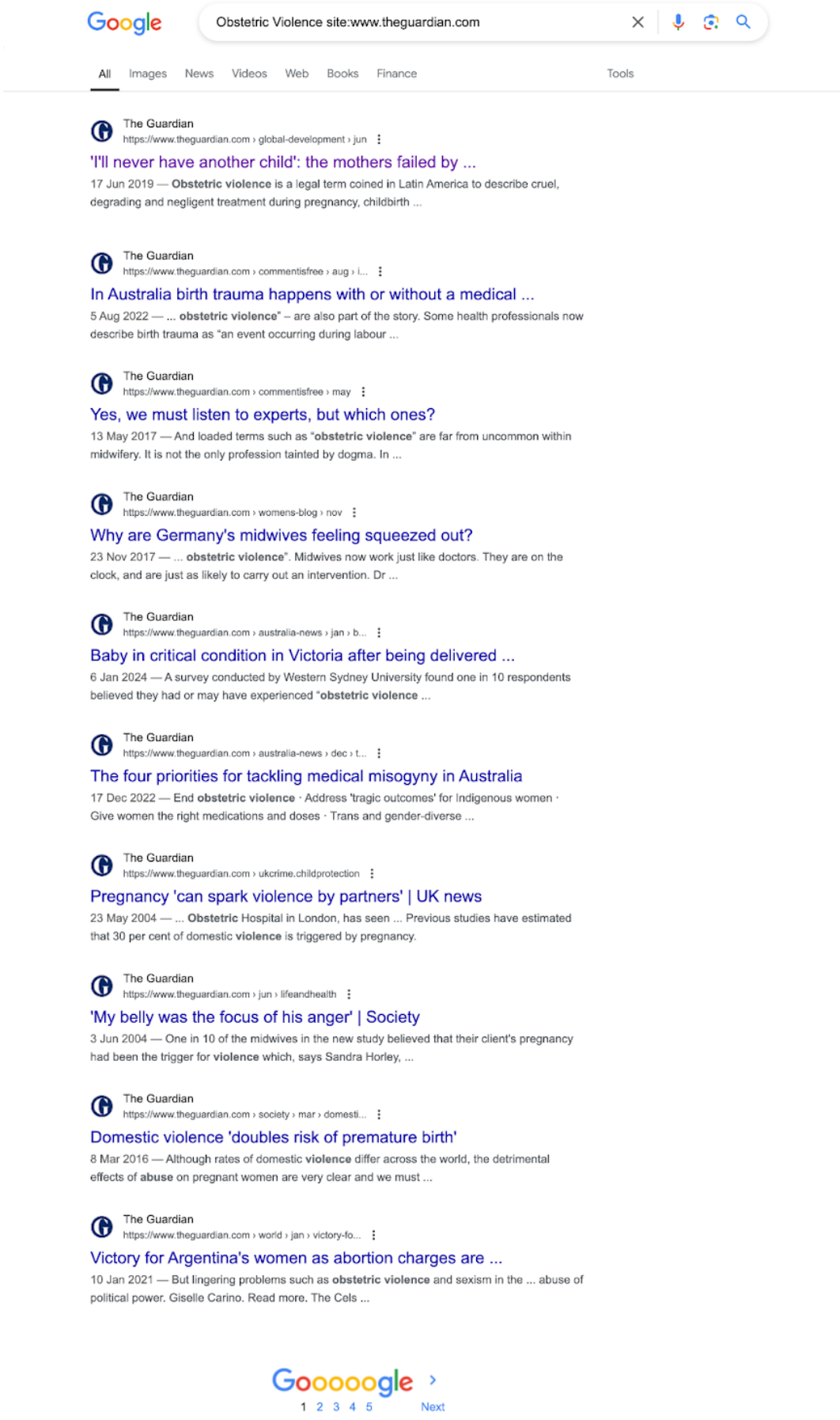


3. Google search results for the query "Violência Obstétrica no Brasil", conducted on 22 August 2024. Results may be influenced by the user's account settings, search history, and geographical location (Berlin, Germany).

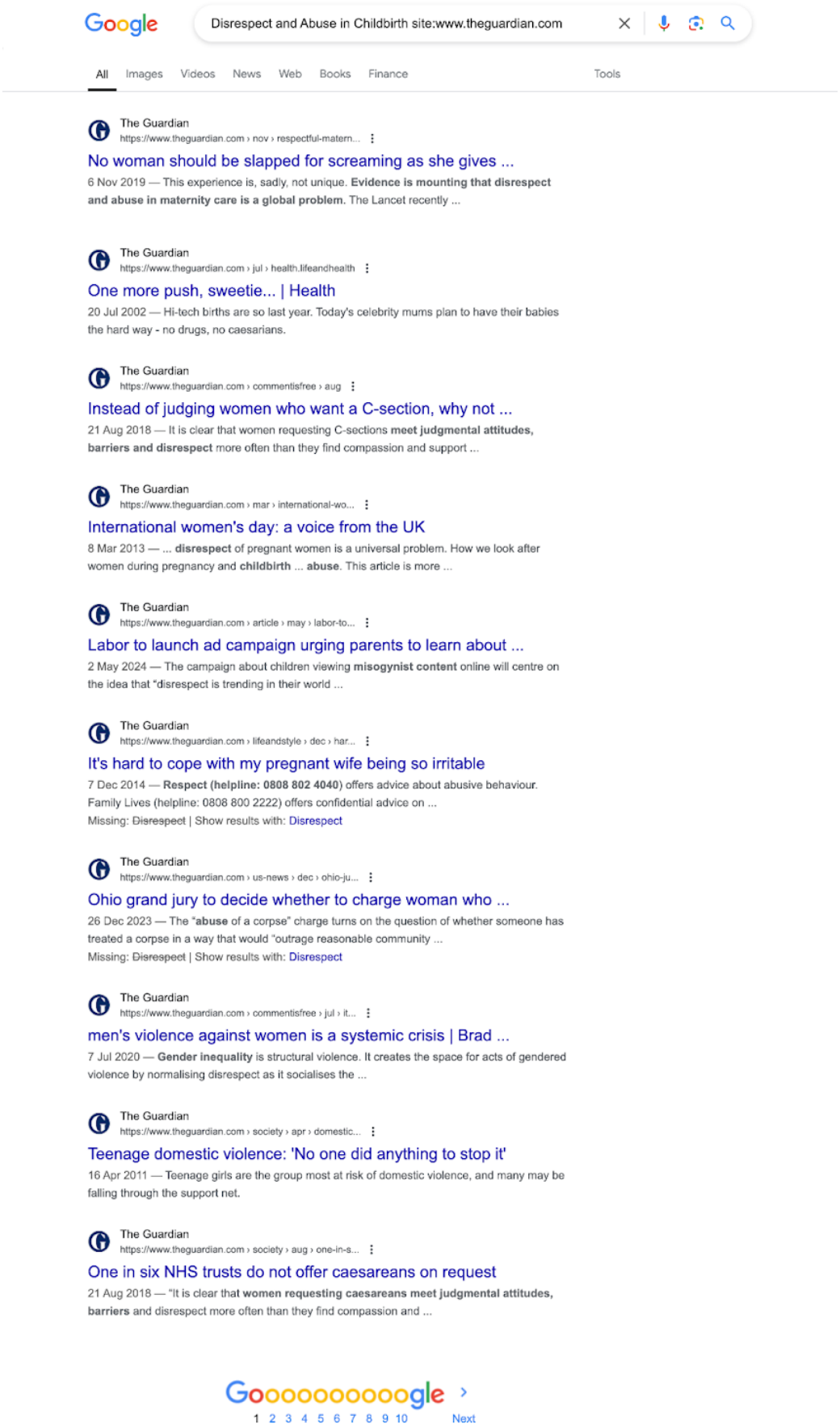
4. Google search results for the query "Desrespeito e Abuso no Parto no Brasil", conducted on 22 August 2024. Results may be influenced by the user's account settings, search history, and geographical location (Berlin, Germany).



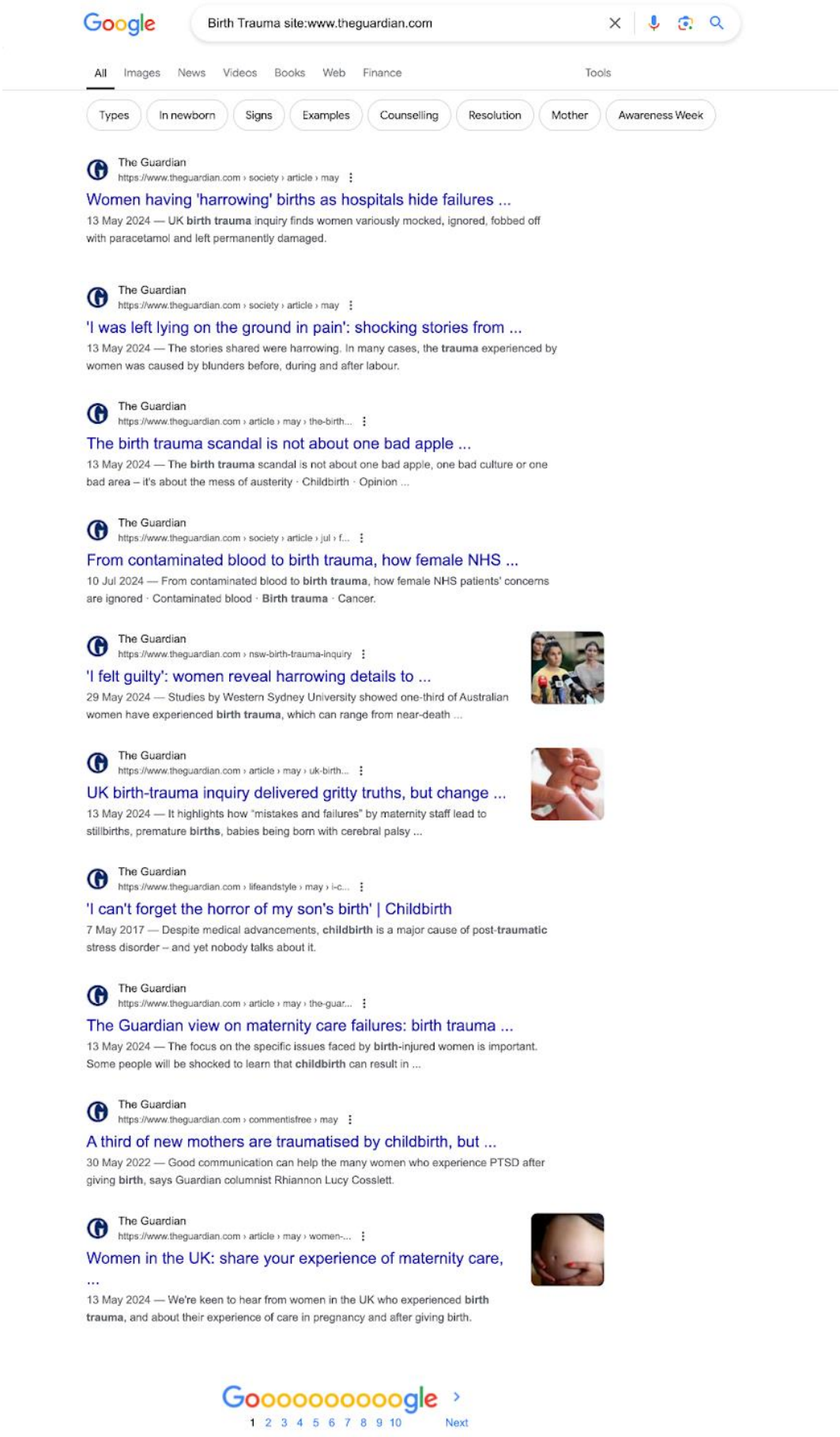
5. *The Guardian* search results for "Obstetric Violence" on 22 August 2024.



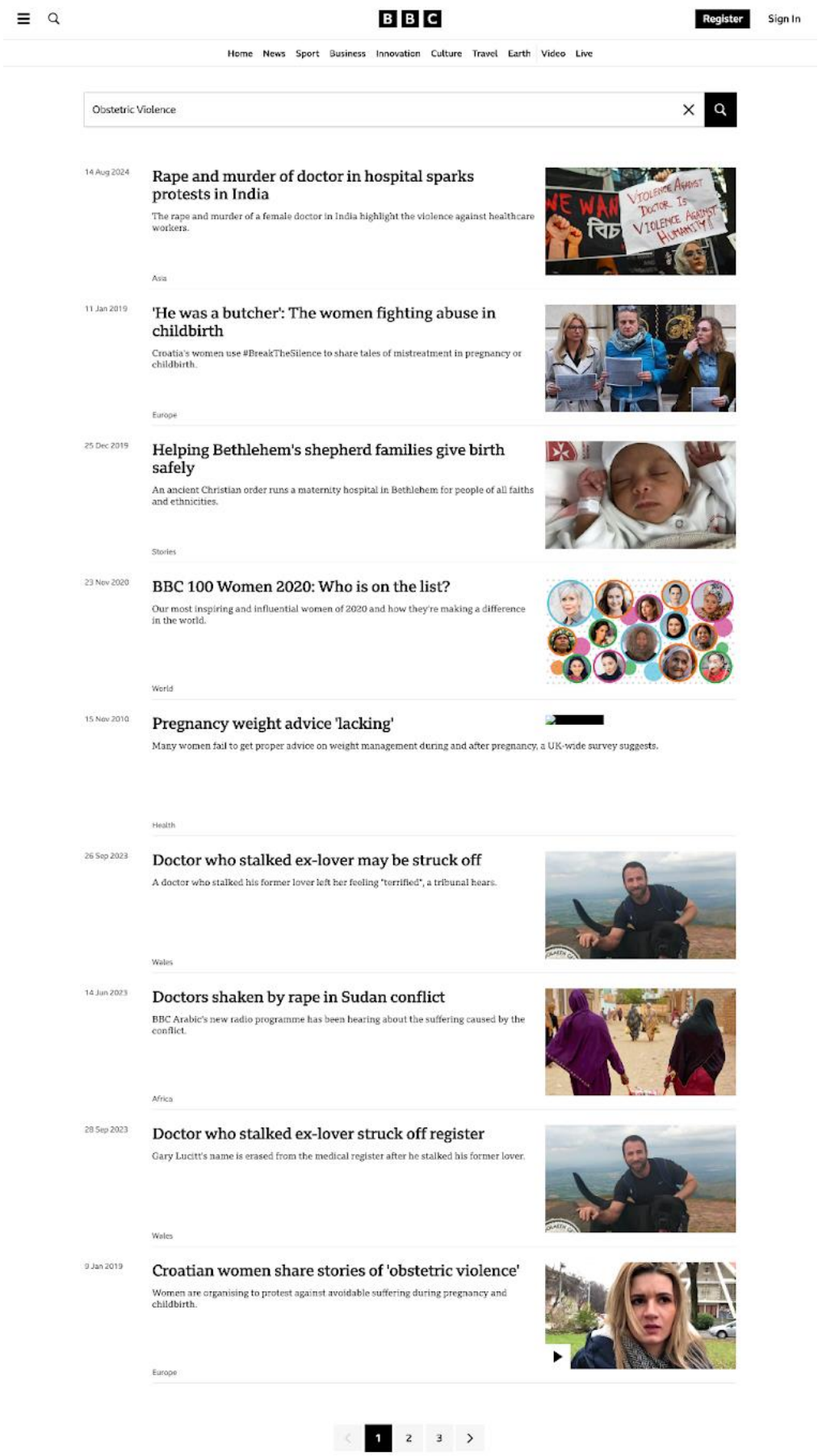
6. *The Guardian* search results for "Disrespect and Abuse in Childbirth" on 22 August 2024.



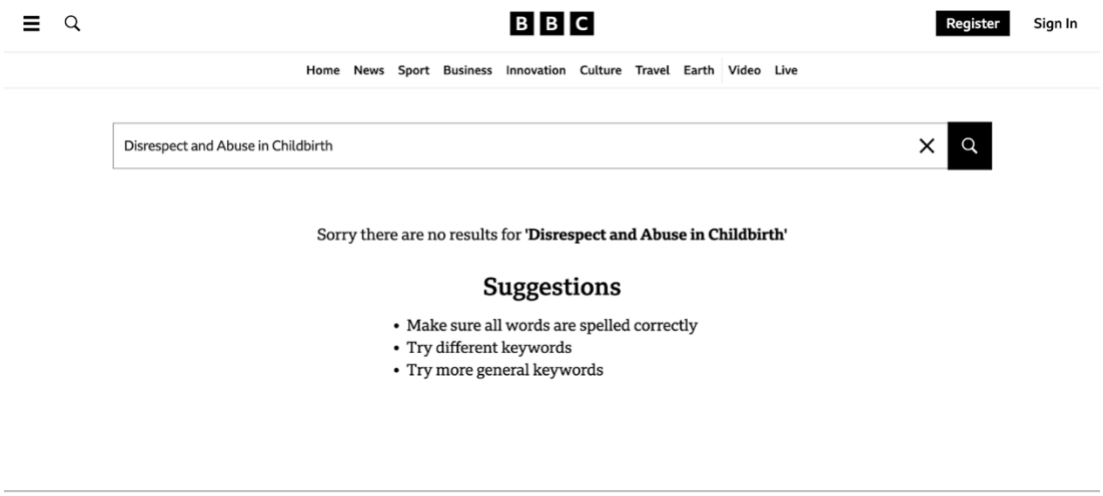
7. *The Guardian* search results for "Birth Trauma" on 22 August 2024.

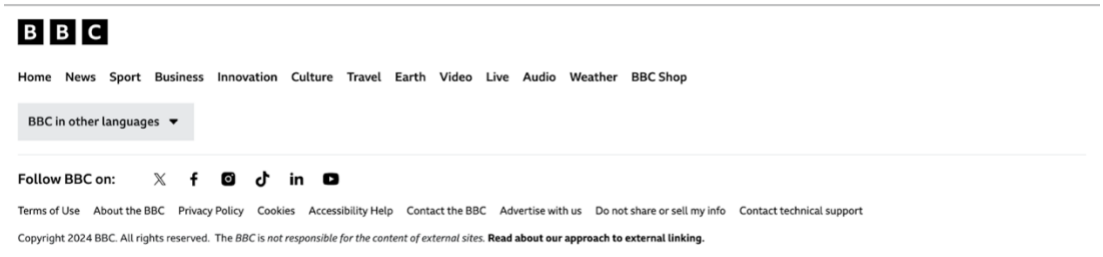


8. *BBC* search results for "Obstetric Violence" on 22 August 2024.

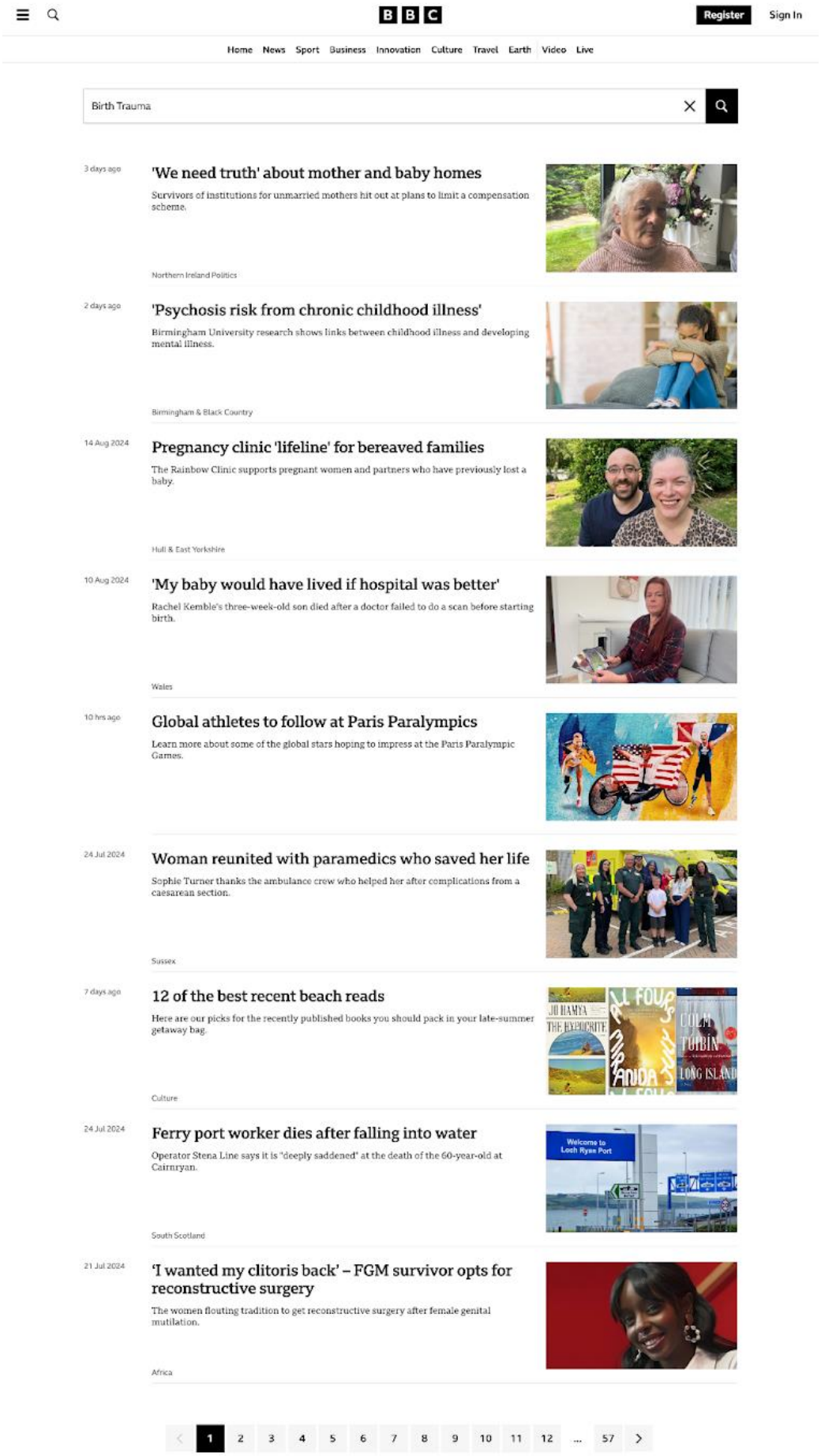


9. *BBC* search results for "Disrespect and Abuse in Childbirth" on 22 August 2024.

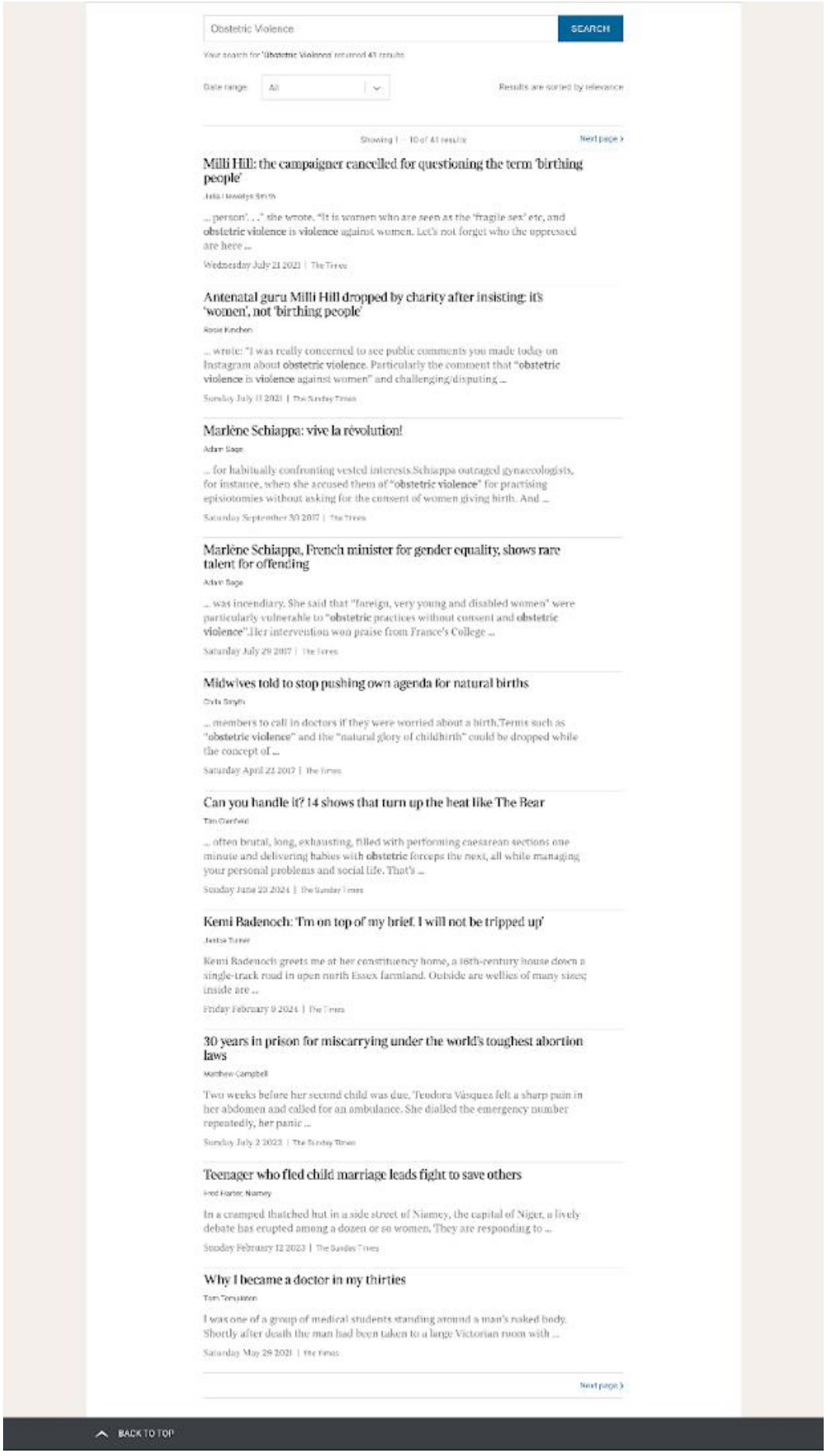




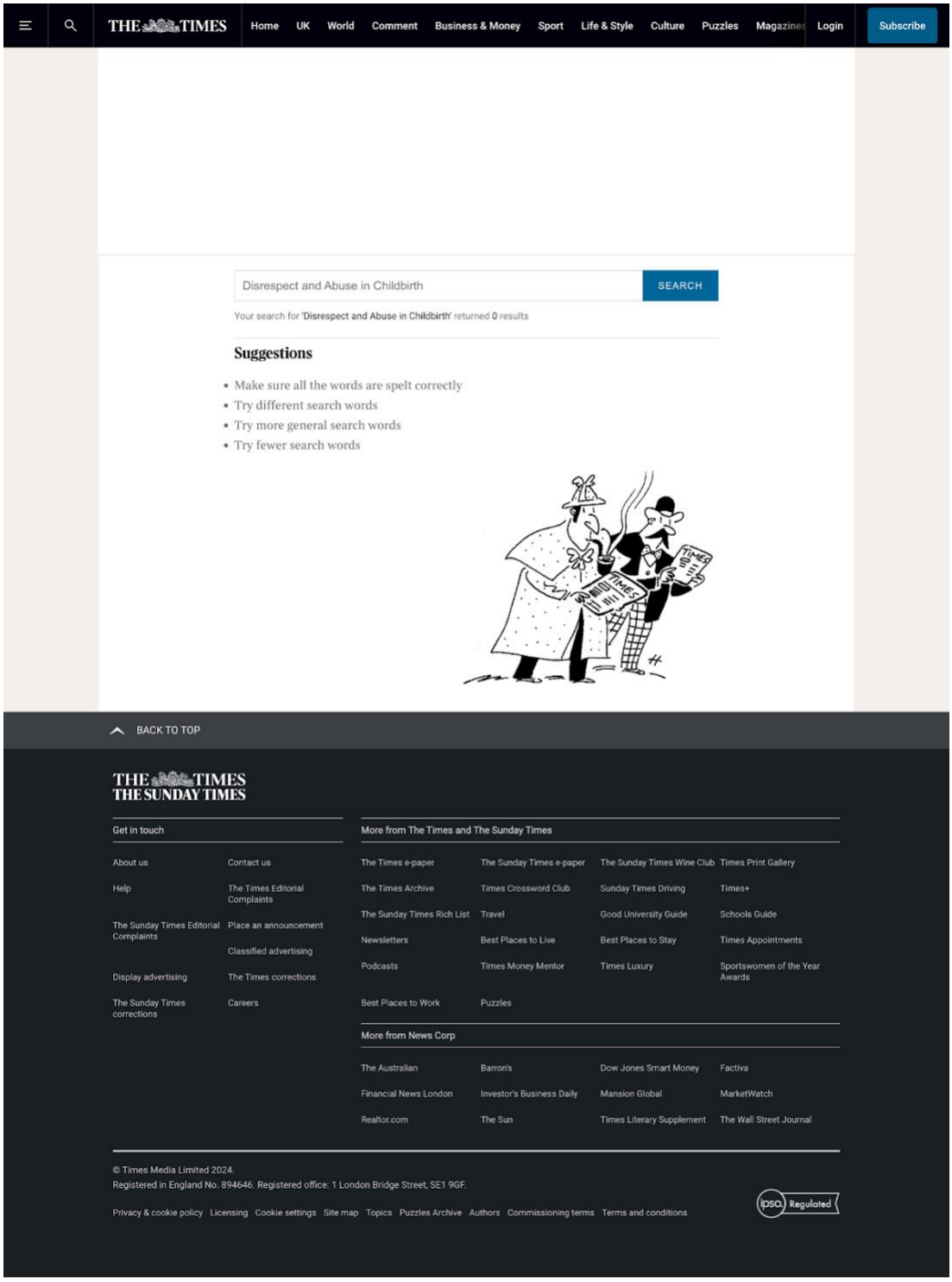
10. *BBC* search results for "Birth Trauma" on 22 August 2024.



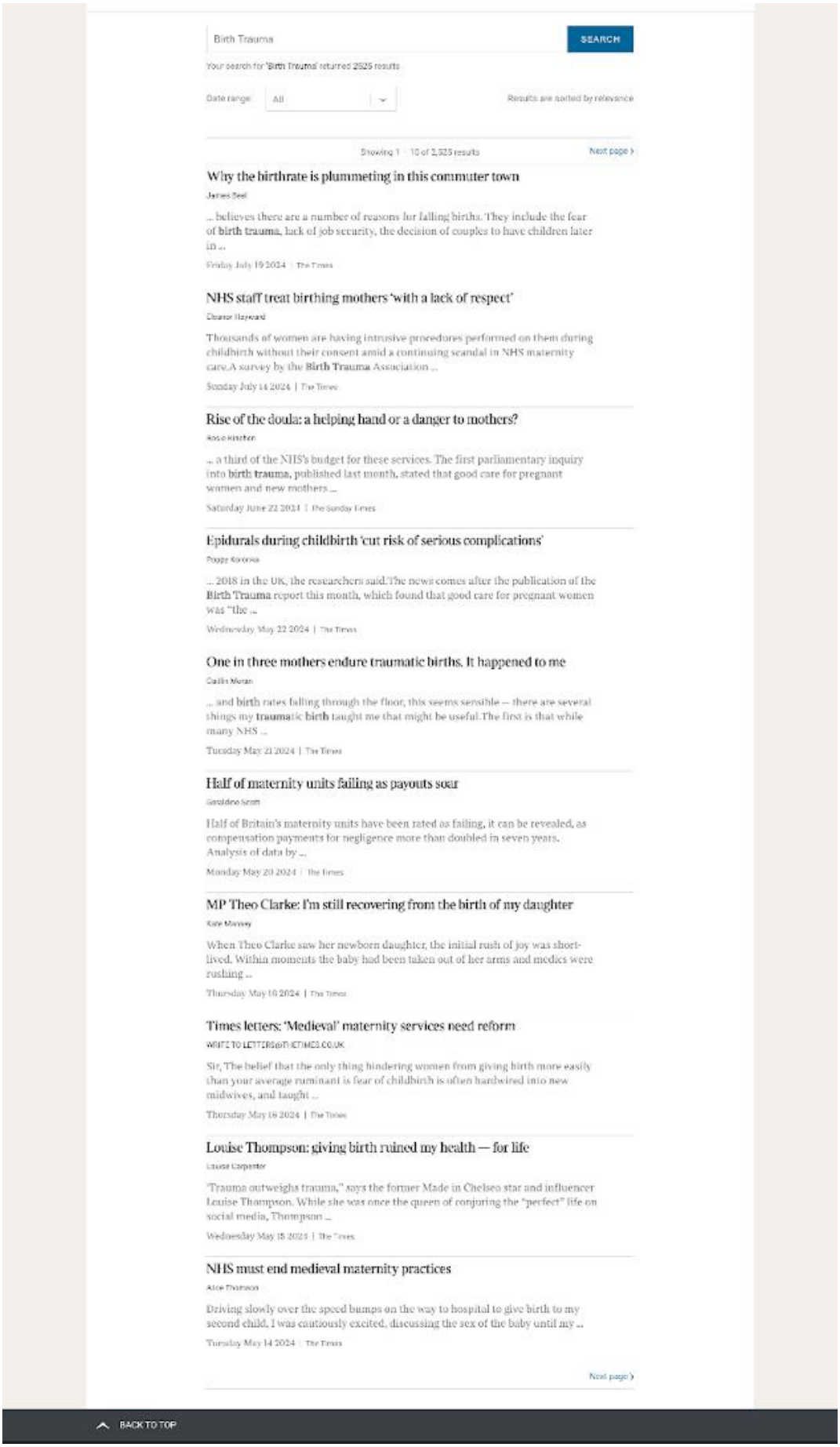
11. *The Times* search results for "Obstetric Violence" on 22 August 2024.



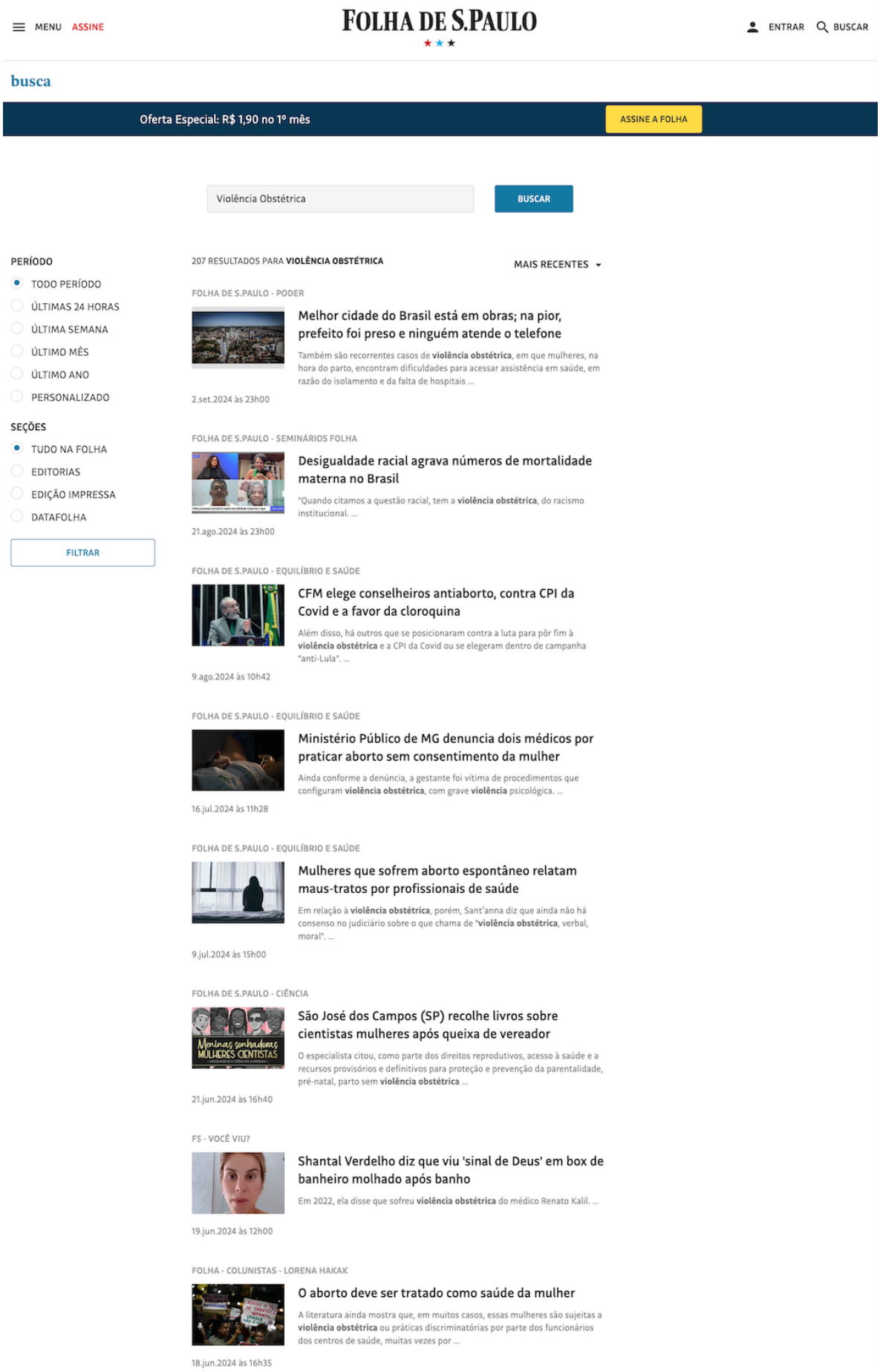
12. *The Times* search results for "Disrespect and Abuse in Childbirth" on 22 August 2024.



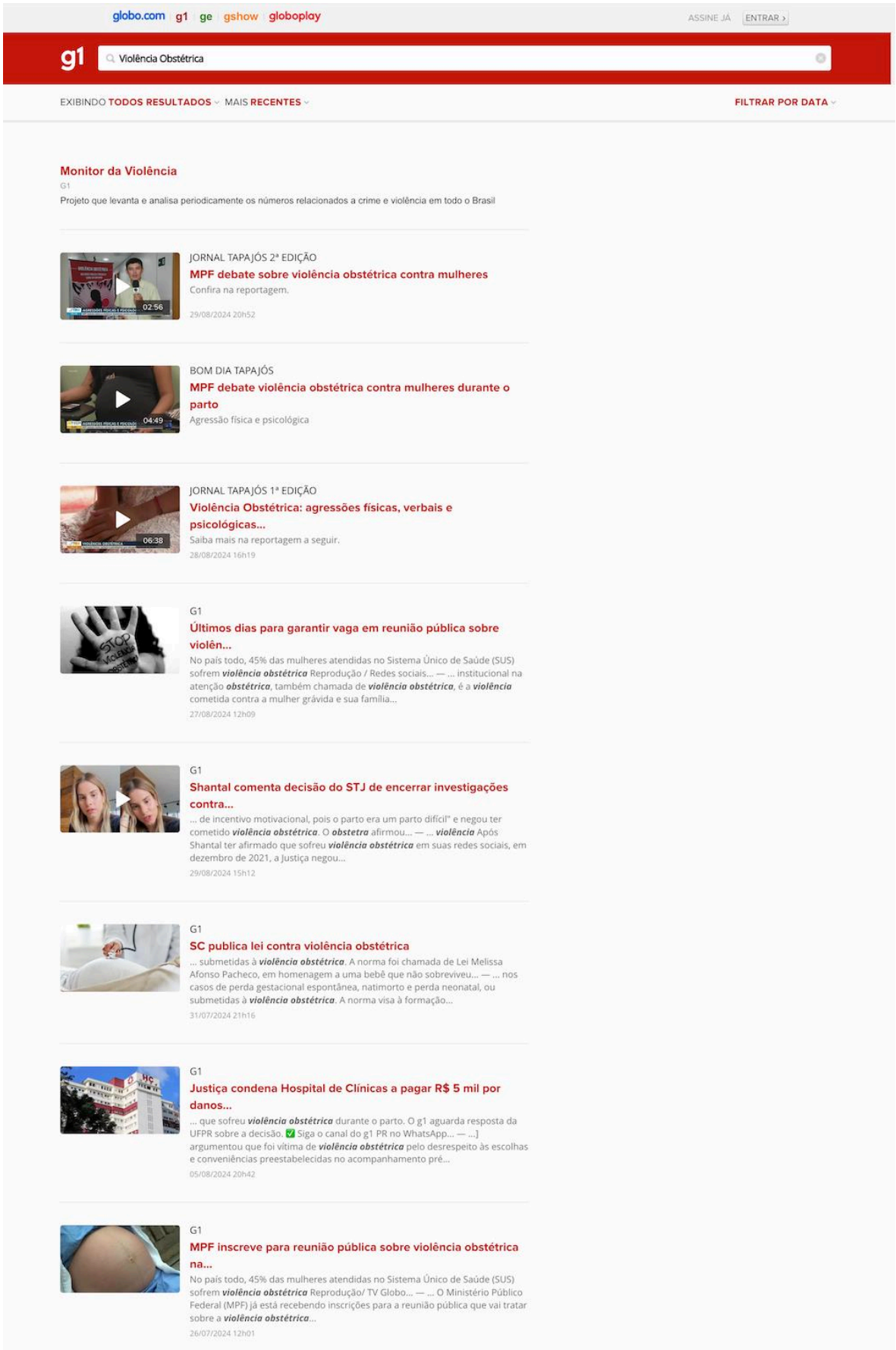
13. *The Times* search results for "Birth Trauma" on 22 August 2024.



14. *Folha de S.Paulo* search results for "Violência Obstétrica" on 22 August 2024.



15. *G1* search results for "Violência Obstétrica" on 22 August 2024.



16. *Brasil de Fato* search results for "Violência Obstétrica" on 22 August 2024.