



GÖTEBORGS UNIVERSITET

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Department of Cultural Sciences

**Invisible Wounds and Benevolent Harm
The Cultural Blind Spot
Reararticulating Obstetric Violence as Gendered Structural Violence**

Master's Thesis in Gendering Practices, 30 hec

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ABSTRACT

This thesis critically investigates the invisibility of obstetric violence, focusing on how coercive and harmful practices during childbirth are normalized, dismissed, or justified within institutional and cultural frameworks. The study draws on feminist theory and critical perspectives on power, discourse, and autonomy to explore how medical interventions that violate consent are often rendered socially acceptable through dominant narratives. Rather than attempting to define obstetric violence in fixed terms, the research analyses the mechanisms that obscure its recognition, particularly through what is described as cultural “blind spots” in healthcare and public discourse.

The aim of the study is to understand how women narrate their childbirth experiences and how these narratives function as potential forms of resistance. Methodologically, the thesis employs narrative analysis and critical discourse analysis (CDA) to examine both public cases and anonymous survey responses from women who gave birth in Brazil, Sweden, and Ireland. These personal stories reveal how structural power, gender norms, and institutional authority shape the way obstetric violence is experienced, interpreted, and often silenced.

The study concludes that storytelling can transform personal suffering into political critique, opening space for greater recognition of obstetric violence and contributing to broader efforts toward reproductive justice.

KEYWORDS: obstetric violence; childbirth; autonomy; gender; discourse; reproductive justice

“Freedom is not enough. What I desire does not yet have a name”

Clarice Lispector

Brazilian writer and journalist

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Abbreviations

CDA – critical discourse analysis

OV – Obstetric violence

WHO - World Health Organization

Table of Contents

Abstract.....	ii
Acknowledgements	iv
Abbreviations.....	v
1. Introduction.....	1
1.1 Background/Problem formulation	3
1.1.1 Making Harm Legible: The Politics and Power of Defining Obstetric Violence..	4
1.1.2 Obstetric Violence and the Cultural Blind Spot	6
1.2 Aim and research questions	7
1.3 Delimitations.....	8
1.4 Research field overview.....	9
1.4.1 Definitional debates	9
1.4.2 Theoretical and Empirical Contributions.....	10
1.4.3 Structural and cultural influences	11
1.4.4 Identifying research gaps and Positioning of This Study	12
2. Theoretical perspectives	13
2.1 Obstetric Violence, Discursive Intelligibility and Power	14
2.2 Motherhood as Institution and the Normalization of Suffering.....	17
2.3 Autonomy and Agency: Rethinking Choice and Coercion in Childbirth	19
3. Method and Material:.....	21
3.1 Material selection and justification.....	22
3.2 Method	23
3.2.1 Critical Discourse Analysis (CDA)	24
3.2.2 Narrative Analysis	25
3.3 Reflexivity, Limitations and Positionality	26
4. Analysis and Discussion – Navigating through Women Experiences.....	27
4.1 Public Narratives.....	27
4.1.1 Adélir’s case.....	27

4.1.2	Adelir’s case analysis.....	30
4.1.3	Shantal’s case.....	37
4.1.4	Shantal’s case analysis.....	39
4.1.5	Media commentary analysis	45
4.2	Personal testimonies.....	51
5.	Conclusion	64
5.1	Summary of the Research Findings and Their Implications.....	64
5.2	Reclaiming Birth – Narrative, Power, and Resistance.....	65
5.3	Contribution and call to Action.....	66
6.	References.....	68
7.	Appendix 1.....	73
8.	Appendix 2.....	75
9.	Appendix 3.....	80

1. Introduction

The autonomy of women in childbirth and reproductive healthcare has increasingly become a focal point of feminist critique. These discussions emphasize a fundamental right: that women must exercise control over their bodies, their medical decisions, and the way they experience childbirth. Yet, within medical institutions, this autonomy is often compromised, constrained, or outright ignored. One of the most alarming manifestations of this failure is obstetric violence – a systemic form of abuse in maternal healthcare that remains strikingly underrecognized in public, legal, and medical discourses.

My interest in this topic emerged from both personal reflections and academic engagement. When I mention that I study obstetric violence, I am often met with silence or confusion. This reaction reflects more than unfamiliarity with the term – it reveals a discomfort with naming certain medical practices as violent. This cultural blind spot became evident not only in theory, but through lived experience. I first encountered the emotional weight of childbirth not in a clinic, but in a classroom, when a school video exposed me to the raw vulnerability of birthing women. One particular scene – a woman, half-naked, screaming in pain as multiple people moved around her – left me with a deep sense of discomfort and despair. That day, I began thinking about childbirth not merely as a biological process, but as a profoundly emotional and often dehumanizing experience. It was a moment that shaped my academic path and, later, my professional focus. Years later, after completing my law degree, I began working as a legal advisor for the Public Prosecutor's Office in a small town in the interior of Brazil. It was during this time that the issue re-emerged in my life. Complaints regarding the mistreatment of pregnant women began to surface, prompting an investigation into the local hospital's maternal care practices. The inquiry, which spanned multiple volumes and involved over 50 interviews, revealed disturbing patterns: verbal abuse, non-consensual procedures, racial and socioeconomic discrimination, lack of adequate medical attention, and systemic indifference. Some testimonies were especially haunting – accounts of newborns being dropped, patients being mocked, and critical decisions being made without consent or compassion.

These institutional failures were not unique to Brazil. I have personally experienced the pressures embedded in both Brazilian and Swedish healthcare systems. Despite Sweden's

reputation for egalitarianism, I found the choice of delivery method here was often constrained by rigid institutional norms – more so than in parts of Brazil, where at least legal frameworks for reproductive choice exist. In both countries, I was labeled "old" during routine check-ups, and my reproductive choices were questioned, often in ways that felt condescending and coercive. As a woman over 35 who has never been pregnant, I was repeatedly told that my age required medical intervention if I ever decided to have children. The tone was rarely neutral or informative – it was judgmental, even offensive. This kind of interaction reinforced the same dynamic I observed in formal investigations: the erosion of bodily autonomy under the guise of medical expertise.

What disturbed me most was not only the abuse, but how easily it was accepted – justified even – as medically necessary. This normalization of harm pointed to what Milli Hill¹ (2019) describes as a societal "blind spot": the refusal to name coercion, disrespect, or consent violations as violence. The act of naming, I realized, is political. In a system that often silences, denying harm its name becomes a powerful form of control. This cultural and institutional blindness raises critical questions: Why is such violence not seen as violence? Why do so many women not identify themselves as victims? Why do harmful practices persist despite being discredited by medical authorities and condemned by ethical guidelines?

This thesis explores the hidden nature of obstetric violence, moving beyond documentation to analyse why it remains unrecognized. I will work with two types of materials and try to show what is behind those narratives. Key findings reveal how medical language obscures harm by framing interventions like C-sections as "necessary," while legal and clinical discourses dismiss resistance as irrationality, normalizing violence. The study shows that such abuse is not random but institutionalized, with practices like coercion and denial of consent embedded in a system prioritizing efficiency over patient autonomy.

My motivation is a pressing concern: obstetric violence is both widespread and underrecognized. Its victims are often silenced by institutional authority, cultural stigma, and legal ambiguity. Focusing on women's narratives – including my own – I aim to challenge that

¹ Milli Hill is a British feminist author, journalist, and advocate for women's rights in childbirth. She is the founder of the *Positive Birth Movement*, a global network promoting women's autonomy and informed choice in maternity care. Her book *Give Birth Like a Feminist* (2019), argue for reclaiming birth as a feminist issue.

silence. These stories are more than personal anecdotes; they are critical interventions that disrupt a system demanding obedience and invisibility. And they are the starting point for change.

1.1 Background/Problem formulation

Obstetric violence – defined as the mistreatment of individuals during childbirth within healthcare settings – has emerged as a critical and deeply gendered form of institutional violence. It reflects the intersection of patriarchy, power asymmetries in medical settings, and systemic disregard for women's autonomy over their reproductive bodies. As a form of gender-based violence, it is especially relevant to the field of gender studies, which interrogates how institutions, such as medicine, motherhood, childbirth, reinforce inequalities through both explicit and implicit practices.

Globally, the issue has been documented by organizations such as the World Health Organization (2014), which emphasizes that disrespect and abuse during childbirth constitute serious violations of women's fundamental rights – including the rights to dignity, bodily integrity, health, and non-discrimination. Obstetric violence includes non-consensual procedures, verbal abuse, denial of pain relief, unnecessary medical interventions, and neglect. While often normalized within clinical settings, these practices can result in significant physical, psychological, and emotional harm. More broadly, they erode trust in healthcare systems and undermine women's autonomy over their own bodies. I analyse how obstetric violence is made invisible, normalized, and institutionalized within medical practice.

Within this thesis, I situate obstetric violence as a deeply gendered and institutionalized form of structural harm that demands critical attention within both gender studies and health-related fields. Rather than viewing it as the result of individual misconduct, I approach obstetric violence as a manifestation of discursive, institutional, and epistemic power – normalized within medical systems and rendered largely invisible by dominant cultural narratives.

My theoretical perspectives help a comprehensive analysis of how obstetric violence is legitimized, why it is so difficult to challenge, and how women's narratives and acts of naming can become powerful tools of resistance and redefinition. This thesis centers these narratives

not only as sources of empirical insight but as acts of political and discursive reclamation, calling for a transformation of both how we understand care and how we structure it.

This problem is especially pressing in Brazil, where political and institutional resistance has hindered official recognition of obstetric violence. A notable example is the 2019 directive from the Brazilian Ministry of Health, which attempted to eliminate the term from public discourse². Although this move was reversed under pressure, the continued absence of legal frameworks and national data perpetuates the marginalization of the issue. Legal redress is difficult; victims must rely on broad categories such as negligence or bodily harm, which fail to capture the gendered dimensions of their experiences.

The relevance of this research lies in its potential to contribute to ongoing feminist debates around bodily autonomy, reproductive rights, and the deconstruction of institutional power in healthcare.

1.1.1 Making Harm Legible: The Politics and Power of Defining Obstetric Violence

Obstetric violence is frequently misunderstood or narrowly interpreted as intentional harm by medical professionals during childbirth. It encompasses a wider range of practices and power dynamics that often go unrecognized in clinical or legal terms. This section explores the contested meanings of “obstetric violence,” arguing that how we define it has serious implications – not just for law and policy, but also for cultural recognition, institutional reform, and feminist resistance. Some scholars, such as Camilla Pickles³ (2024), advocate for a narrower legal framing that focuses on explicit violations of physical or psychological integrity during specific stages of care. She warns that overly expansive definitions risk diluting the effectiveness of legal and policy responses. While I acknowledge the value of precision in law, I argue that a broader conceptualization is necessary to account for the full scope of harm women experience – before, during, and after childbirth.

² In 2019, Brazil’s Ministry of Health opposed the use of the term “obstetric violence”, arguing in official dispatch SEI/MS 9087621 that it carried a “complex connotation, adds no value, and undermines the pursuit of humanized care in the pregnancy-childbirth-puerperium continuum” (Domingues, 2019).

³ Camilla Pickles is an Assistant Professor in Biolaw at Durham Law School, specializing in women’s rights during pregnancy and childbirth, with a focus on obstetric violence. Her work spans human rights law, medical law, ethics, and reproductive justice. More about her can be found at <https://www.durham.ac.uk/staff/camilla-m-pickles/> – accessed 26/04/2025.

The term “obstetric violence” was first codified in the 2007 Organic Law on the Right of Women to a Life Free of Violence⁴ in Venezuela (Article 15), where it is defined as:

The appropriation of the body and reproductive processes of women by health personnel, expressed through dehumanizing treatment, excessive medicalization, and pathologization of natural processes, resulting in loss of autonomy and decision-making power over their bodies and sexuality, negatively affecting women's quality of life.

This legal framing foregrounds how obstetric violence is not merely about individual misconduct but part of systemic, gendered practices that undermine bodily autonomy. Clarifying terminology is thus essential. According to the Oxford English Dictionary (2025), obstetric originally referred to the practice of midwifery and now broadly includes all medical care related to pregnancy, childbirth, and the postpartum period. Obstetric care encompasses antenatal, intrapartum, and postnatal services – whether provided in routine or high-risk scenarios. From this perspective, obstetric violence includes any violation of a woman's autonomy, dignity, or well-being that occurs within these contexts. The term violence also warrants careful reexamination. The WHO (2022) defines violence as the intentional use of force or power – whether threatened or actual – that results in or is likely to result in harm. This definition includes physical, sexual, psychological, and neglectful actions. Importantly, it underscores that violence can be both direct and systemic, with consequences extending far beyond immediate physical injuries.

Lévesque and Ferron-Parayre⁵ (2021) argue that “intention is not a central component of violence, unlike the point of view of the people who are victims of it, which must be placed at the forefront of its conceptualization” (p. 3). This is particularly relevant in maternity care, where harmful practices – whether through neglect, coercion, or lack of informed consent – may not be seen as “violent” by healthcare professionals, yet they have profound physical and psychological effects on women. Obstetric violence, often misunderstood or normalized within the healthcare system, further disempowers women – many of whom already face a history of limited agency.

⁴ The full text of the Venezuela *Organic Law on the Right of Women to a Life Free of Violence* (2007) can be found at <https://www.consejoderechoshumanos.gob.ve/wp-content/uploads/2020/09/libroleyorganicamujer.pdf> – accessed 26/04/2025.

⁵ Sylvie Lévesque is a sexologist and public health scholar (PhD) specializing in reproductive health, violence, and perinatal care. She is an associate professor in the Department of Sexology at Université du Québec à Montréal (UQAM). Audrey Ferron-Parayre is a professor of health law at the University of Ottawa, with expertise in medical ethics, informed consent, and obstetrical violence. Both authors critically analyze the terminology and implications of “obstetric violence” in their cited work (Lévesque & Ferron-Parayre, 2021).

When violence is not clearly defined or is seen as just a routine part of medical care, it becomes harder for women to identify their experiences as violations and advocate for change. As Milli Hill says “every single denial of a woman’s autonomy and power in the birth room, great or small, is part of the same problem” (2019, p. 52-53). Additionally, if healthcare professionals do not perceive their actions as harmful – especially in the absence of clear intent – it may create resistance to acknowledging and reforming harmful practices. This ambiguity can slow progress in both policy and cultural shifts within maternity care.

Lévesque and Ferron-Parayre strongly advocate for using the term "obstetric violence" despite concerns about its impact on healthcare workers. They argue that naming the issue is a crucial step toward recognizing, addressing, and ultimately preventing systemic mistreatment in maternal care (2021). I align with their position that “denying that these forms of violence exist and denying a voice to women and persons who give birth means recreating and perpetuating the epistemic injustices that too often feature in scientific and academic research” (2021, p. 3).

In sum, understanding the full scope of obstetric violence requires a shift away from narrow or purely clinical interpretations of “violence” and “intention,” toward definitions centered on the experiences and autonomy of those who give birth. Ultimately, how we define obstetric violence is not a purely semantic matter – it has profound implications for legal accountability, cultural recognition, and feminist activism. A narrow definition may enable litigation, but risks excluding many forms of harm. A broader framework, by contrast, better captures the intersecting structures of gender, race, class, and medical authority that shape women's reproductive experiences. Naming these harms as violence is a critical step in challenging their normalization.

1.1.2 Obstetric Violence and the Cultural Blind Spot

Humans have a natural blind spot in their visual field where the optic nerve connects. Colloquially, the term "blind spot" refers to an obstructed area in one’s view, such as when checking a car’s side mirror. This topic briefly explores the idea of cultural blind spots – which are not necessarily visual (though they can be) nor biological limitations of sensory perception. Unlike physical blind spots, cultural blind spots cannot be identified in the brain or body;

instead, they must be recognized through social interactions and behaviours (Friedman, 2019). Cultural blind spots are collective patterns of inattention, shaped by social norms rather than biological limitations. Asia Friedman (2019) argues that cultural blind spots are foundational to the social construction of reality, as they determine which information is excluded or deemed irrelevant. She identifies two primary mechanisms behind these blind spots: habituation (unconscious inattention to the familiar or normative) and focusing (selective attention that ignores ambiguity or complexity).

These blind spots reinforce power structures by rendering oppressive practices "invisible" or "natural". Obstetric violence thrives in the shadows of cultural blind spots. As I discussed so far, by normalizing harmful practices and rendering them invisible we sustain obstetric violence. Dehumanization through habituation occurs when repeated exposure to invasive procedures, like non-consensual vaginal exams, desensitizes healthcare providers, making such violations seem routine. This institutionalized disregard for bodily autonomy makes it difficult for victims to recognize mistreatment, as abuse becomes framed as "just standard practice." Institutional blind spots prioritize efficiency and protocol over patient autonomy, dismissing obstetric violence as a trade-off for safety. Victims who challenge these practices are often gaslit, reinforcing the cycle of silence. To dismantle these patterns, strategies like defamiliarization (questioning normalized procedures), reversing the narrative (amplifying patient voices), and policy reforms (trauma-informed care mandates) are essential (Friedman, 2019). I argue that if we expose these hidden biases, we can shift toward a more equitable and humane maternal healthcare system.

1.2 Aim and research questions

The aim of this thesis is to investigate how obstetric violence is experienced, narrated, and made (in)visible within both personal and public discourse. Focusing on women's birth narratives, the study examines how institutional power and medical authority shape the way these experiences are constructed, understood, and potentially resisted. Rather than solely documenting instances of mistreatment, this research explores the discursive mechanisms through which obstetric violence is normalized, denied, or challenged. Analysing narrative accounts through feminist and poststructuralist frameworks, the thesis seeks to understand how language, silence, and power interact in the context of reproductive care. This study asks:

- How do women describe and interpret medical interventions during childbirth, and to what extent do they identify or resist these experiences as coercive or violent?
- How do institutional and cultural frameworks – such as medical authority, gender norms, and motherhood ideologies – influence the way women narrate and make sense of their birthing experiences?
- In what ways do public childbirth narratives function as forms of resistance, and what kinds of critique or transformation do they offer in response to dominant medical and cultural discourses?

These questions guide the investigation of obstetric violence not simply as a set of clinical practices, but as a discursive and structural phenomenon that unfolds through storytelling, silence, and power.

1.3 Delimitations

This thesis focuses specifically on women's narrative accounts of obstetric violence, with a particular emphasis on how such experiences are articulated, interpreted, and sometimes resisted. While acknowledging that obstetric violence affects a wide range of individuals – including transgender men and non-binary people – this study does not explore gender-diverse or queer reproductive experiences in detail. This limitation is due in part to the composition of the sample: all participants, based on language use and group context, appear to self-identify as women. The research does not aim to evaluate individual healthcare providers or specific hospital policies, nor does it conduct a legal or institutional audit of obstetric practices in any of the countries involved. Although it acknowledges systemic and legal dimensions of obstetric violence, it leaves a full policy analysis – such as comparing jurisdictions with and without legal recognition of obstetric violence – outside its scope. The study's empirical material consists of six anonymous survey responses and two publicly known cases. These narratives offer important insights into lived experiences of reproductive care but are not statistically representative. The limited sample size, as well as the voluntary and self-selected nature of participation, restricts the generalizability of the findings. Additionally, because the survey was distributed in a Portuguese-speaking WhatsApp group for Brazilian women living in Sweden, there is a cultural and linguistic specificity to the data. While this allows for rich, contextualized

analysis, it also introduces selection bias and may exclude more marginalized or less digitally connected perspectives.

Moreover, the cross-national nature of some of the data (experiences from Brazil, Sweden, and Ireland) introduces variability in healthcare systems and cultural expectations. These differences are acknowledged but not systematically compared; this thesis focuses on how women themselves make sense of their experiences, rather than offering a country-by-country comparative analysis.

Finally, the choice to use anonymous written responses rather than interviews offers greater participant anonymity and safety, but limits the depth of follow-up questions and emotional nuance. The study prioritizes ethical sensitivity over data extensiveness, recognizing that this choice affects the scope of interpretation.

1.4 Research field overview

Obstetric violence (OV) is a contested concept at the intersection of medical, legal, and feminist discourse. The literature reveals ongoing struggles over how to define OV, how to address it in practice, and how to acknowledge the power structures that perpetuate it.

1.4.1 Definitional debates

At the core of academic and policy discussions lies a disagreement over the meaning and scope of OV. Feminist and human rights scholars define it as a systemic violation of women's autonomy and bodily integrity during childbirth, often rooted in gendered medical hierarchies. In contrast, some healthcare professionals resist the term, viewing it as accusatory and overly broad – potentially undermining legitimate clinical interventions.

As previously outlined, Camilla Pickles (2024) adds nuance to this debate, warning that an overly expansive use of the term "obstetric violence" risks diluting its conceptual clarity and legal usefulness. She stresses the need to preserve a focus on genuine violations of physical or psychological integrity during antenatal, intrapartum, and postpartum care, maintaining both

advocacy power and conceptual precision. Adding to this discussion, Ferrão et al⁶. (2022) underscore that the lack of consensus over terminology seriously impedes efforts to address obstetric violence at both the political and institutional levels. They argue that childbirth care has shifted historically from a woman-centered, social event to a highly medicalized, hospital-based procedure. These definitional tensions reveal a deeper conflict about who has the authority to name harm and what counts as legitimate care.

1.4.2 Theoretical and Empirical Contributions

Sara Shabot⁷ (2016) employs a feminist-phenomenological approach to critique conventional interpretations of obstetric violence. She argues that the terminology of “dehumanization,” “abuse,” and “loss of autonomy” aligns this issue with broader analyses of gendered violence, particularly sexual violence and the objectification of women. Some women’s use of the term “birth rape” to describe their experiences underscores the severity of perceived violations (Shabot, 2016, p. 237). Peggy Foster’s⁸ (1995) work critically examines the gendered power dynamics in healthcare, emphasizing disparities in access and the systemic marginalization of women’s needs. Her research highlights historical shifts in maternal care, noting how rising maternal and infant mortality rates in the 1990s reinforced women’s fears and demand for improved care. She warns that the dominance of obstetricians in childbirth settings risks further undermining women’s bodily autonomy (Foster, 1995, p. 46).

Empirical studies across diverse regions (e.g., Vacaflor⁹, 2016; van der Pijl et al., 2022¹⁰) confirm that mistreatment – whether through coercion, neglect, or non-consensual procedures – is widespread and frequently normalized. These studies reinforce the emotional and

⁶ Ana Cristina Ferrão (CHRC, University of Évora & Centro Hospitalar Barreiro-Montijo), Margarida Sim-Sim (CHRC, University of Évora), Vanda Sofia Almeida (Centro Hospitalar Barreiro-Montijo), and Maria Otilia Zangão (CHRC, University of Évora) co-authored the scoping review protocol "Analysis of the Concept of Obstetric Violence." Their interdisciplinary collaboration combines clinical obstetrics (Barreiro-Montijo Hospital) with public health research (CHRC).

⁷ Dr. Sara Cohen Shabot is Associate Professor and Chair of Women’s and Gender Studies at the University of Haifa, Israel, specializing in feminist philosophy and embodiment theories. She holds a PhD in Philosophy. For current research and publications, see her professional website (accessed April 26, 2025), <https://www.saracohenshabot.com/>.

⁸ Peggy Foster was a Senior Lecturer in Social Policy at the University of Manchester specializing in feminist health policy analysis. Her influential 1995 work *Women and the Health Care Industry* critically examined systemic gender biases in healthcare, particularly how medicalized childbirth practices compromised women's autonomy.

⁹ Carlos Herrera Vacaflor is a legal scholar and Visiting Scholar at the University of Toronto Faculty of Law specializing in reproductive rights and healthcare systems. His work on obstetric violence in Argentina pioneered frameworks for analyzing systemic barriers to maternal healthcare, particularly the intersection of medical practices, gender inequality, and human rights violations in perinatal care.

¹⁰ Marit S.G. van der Pijl (Amsterdam UMC) led a landmark Netherlands study (n=12,239) documenting how 36.3% of birthing women experience obstetric violence, particularly coercion (39.8%) and communication failures (29.9%). The research revealed systemic disparities, with primiparous and migrant women disproportionately affected.

psychological impact of obstetric violence, underscoring its long-term consequences for birthing individuals. Sadler et al.¹¹ (2016) and Amorim & Katz (2020) advocate for policy reforms that prioritize respectful maternity care. Their research aligns with Oakley & Houd's¹² (1990) comparative study of midwives and physicians, which illustrates how midwifery models often balance clinical judgment with patient preferences, whereas medicalized settings may prioritize efficiency at the expense of autonomy. Richards¹³ (1982) critiques the illusion of "choice" in childbirth, arguing that institutional constraints frequently render decision-making a mere formality rather than an exercise of true agency. He argues that "it is important not to reduce choice in these matters and many others and to ensure as far as possible that women and their companions can freely make decisions about their care and treatment" (1982, p. 253). He highlights a key tension between the clinical, often impersonal methods of obstetric care and the emotional and social needs of expecting parents. In the name of safety, childbirth has been reshaped in ways that diminish parental agency, making conversations about options seem irrelevant. Unless the underlying power dynamics between mothers and healthcare providers are addressed, meaningful progress remains unlikely. Some women may prefer to defer decisions and rely on medical oversight, while others seek a more active role in their birthing experience. Yet those who wish to retain control often struggle to resist excessive medical interference. He proposes that honoring women's preferences and emotional well-being during labor can frequently result in positive outcomes without heavy reliance on medical procedures. Although surgical interventions may be unavoidable in certain cases, he stresses the need for a respectful and empathetic approach in all births, including cesarean deliveries.

1.4.3 Structural and cultural influences

McCourt¹⁴ (2009) examines how the medicalization of childbirth disrupts natural labor rhythms, privileging institutional efficiency over individualized care. She connects these trends

¹¹ Michelle Sadler (Universidad de Chile) and international co-authors reframed obstetric violence as structural oppression in their seminal *Reproductive Health Matters* article (2016). Analyzing cross-cultural evidence, they demonstrated how institutional hierarchies, gender norms, and medicalized systems perpetuate systemic violations during childbirth beyond individual incidents of abuse.

¹² Oakley, Ann, and Susanne Houd (1990) in their book *Helpers in Childbirth*, explores the role of midwives in childbirth. It discusses the historical context, the changing role of midwives, and the challenges they face in modern healthcare systems. It is emphasized the importance of midwifery care in providing personalized support to women during childbirth.

¹³ Martin P. M. Richards was the Head of the Child Care and Development Group at the University of Cambridge. The referenced work is: Richards, M. P. M. (1982). The trouble with "choice" in childbirth. *Birth*, 9(4), 253-258.

¹⁴ Christine McCourt, Professor of Maternal and Child Health at City, University of London, directs the Centre for Research in Maternal and Child Health. Her anthropological work *Childbirth, Midwifery and Concepts of Time* (2009) critically examines how temporal structures in healthcare systems shape women's birth experiences, challenging industrialized models of maternity care through cross-cultural analysis of time perception in childbirth.

to broader power imbalances, where medical professionals exert control over women's birthing experiences. Martínez-Galiano et al.¹⁵ (2023) note that some midwives defend aggressive interventions as clinical necessities, while others recognize their harm – an internal divide that reflects the normalization of coercive practices. Historical and cultural factors further shape the discourse. Their aim is to assess the prevalence of obstetric violence (OV) as perceived by midwives in Spain, their knowledge of OV, and the professional factors associated with its perception. Physical aggression was widely recognized as OV, but non-physical behaviors (e.g., lack of information, delayed care) were often classified as "inappropriate treatment" rather than OV. The most severe OV practices were cesarean sections or instrumental births without clinical justification. The study highlights a gap between midwives' awareness of OV and their recognition of subtle forms of it, such as inadequate communication. It underscores the need for targeted training and systemic changes to align clinical practices with human rights standards in childbirth care. Loudon¹⁶ (1992) links maternal mortality rates to societal gender biases. In his book "Death in Childbirth: An International Study of Maternal Care and Maternal Mortality", he discusses socio-cultural influences on maternal health outcomes, including gender inequality and societal attitudes towards childbirth. These factors can contribute to obstetric violence by perpetuating harmful stereotypes, discrimination, and power imbalances between healthcare providers and birthing individuals (1992). Yilmaz Sezer et al.¹⁷ (2023) document the lasting emotional impact of traumatic births on both patients and midwifery students. Their findings highlight the intergenerational transmission of obstetric trauma, reinforcing the urgency of systemic reform.

1.4.4 Identifying research gaps and Positioning of This Study

Despite growing attention, significant gaps remain – especially regarding intersectional

¹⁵ Juan Miguel Martínez-Galiano (University of Jaén) and interdisciplinary colleagues surveyed 325 Spanish midwives (2023), revealing critical divides: while 92.6% knew the term "obstetric violence," only 26.5% regularly identified it in practice. Their study exposed normalization of coercive interventions, with midwives more likely to recognize physical aggression (97.5%) than informational neglect (56.9%) as violations. Work experience, gender, and training significantly influenced perceptions.

¹⁶ Irvine Loudon (1924-2015) was a British physician-medical historian who pioneered research in maternal mortality. His seminal work *Death in Childbirth: An International Study of Maternal Care and Maternal Mortality* (1992) provided the first comprehensive global analysis of obstetric trends from 1800-1950, demonstrating how improved hygiene and antenatal care reduced puerperal fever deaths. The Oxford-trained doctor combined clinical expertise with historical methodology to transform understanding of childbirth risks.

¹⁷ Neslihan Yilmaz Sezer (Ankara University), Menekşe Nazlı Aker (Ankara University), Beyza Öz (Mersin University), and Dilara Eren (Ankara Women's Hospital) conducted a 2023 study analyzing how midwifery students' exposure to traumatic births shapes their professional perceptions. Their interdisciplinary team (clinical midwives/public health researchers) revealed how obstetric trauma psychologically affects both caregivers and patients, demonstrating the cyclical nature of birth-related trauma transmission.

analysis (qualitative studies on OV in gender-diverse populations or comparative analysis of migrant vs. non-migrant OV experiences), long-term psychological consequences (impact on future pregnancies - avoidance of healthcare), and accountability mechanisms. Most research focuses on cisgender women in national contexts; comparative, cross-border studies and explorations of racialized and migrant experiences remain rare.

This thesis builds on existing feminist literature, but shifts focus toward the discursive and narrative construction of obstetric violence – investigating how it is named, normalized, or resisted in women’s stories. Rather than proposing a new definition, it interrogates how meaning is made, and how language itself can function as a site of institutional power or political resistance. In doing so, it aims to contribute to both the theoretical understanding and the cultural visibility of OV.

2. Theoretical perspectives

This thesis adopts a feminist poststructuralist framework to examine obstetric violence (OV) as a form of institutionalized harm that is rendered largely invisible through dominant medical, cultural, and maternal discourses. Rather than viewing OV as an aberration or exceptional failure within healthcare, this approach understands it as normalized through discursive and institutional structures that define what counts as care, harm, and legitimate experience in childbirth. These structures do not merely reflect reality; they shape it – constructing the birthing subject, regulating bodies, and legitimizing intervention under the guise of necessity or protection. Epistemologically, this framework assumes that knowledge is shaped by discourse and power relations. Drawing on theorists such as Michel Foucault, Mary Douglas, Judith Butler (2011), this framework understands obstetric violence not as an isolated or deviant occurrence, but as a systemically embedded form of institutional violence – one that is rendered unintelligible within dominant medical and maternal discourses. In analysing how certain forms of harm are legitimized as “care” while others are silenced, the thesis focuses on the discursive, institutional, and affective structures that shape maternal subjectivity and responsibility. These frameworks collectively privilege narrative, discourse, and everyday experience as valid and politically important sources of knowledge.

Ethically, this approach requires ongoing reflexivity. Feminist theory enables a structural

critique of violence, but it also risks over-theorizing trauma in ways that may feel alien to those who endure it. To address this, the thesis draws on Saba Mahmood's (2011) critique of liberal agency and Beate Rössler's relational concept of autonomy to rethink how we understand agency in childbirth. Mahmood (2011) reminds us that autonomy cannot be reduced to resistance or choice alone, while Rössler frames autonomy as interdependent and contextual, grounded in one's ability to relate to others and oneself without domination. Together, they inform an ethical posture that resists binary readings of "empowered" versus "oppressed" births and instead seeks to illuminate the structural conditions that limit or enable relational autonomy.

These theoretical choices directly shape the methodological design. The thesis analyses media cases, public discourse, and women's narratives using qualitative methods. Through critical discourse analysis, it examines how language configures authority, care, and harm across various texts – including medical protocols, online commentary, and personal testimonies. The analysis does not aim to rank suffering or generalize experiences, but to expose how discursive and institutional mechanisms normalize certain harms while denying them recognition as violence. This theoretical framework defines not only what can be known, but how it can be known, and with what ethical responsibility. It establishes clear boundaries: this research does not claim objectivity or neutrality. Rather, it embraces a situated, politicized knowledge production, one that seeks to make visible the gendered, institutional, and moral structures that produce and obscure obstetric violence. In doing so, it opens space for alternative understandings of care, harm, and maternal subjectivity – understandings grounded not in abstract ideals, but in the lived contradictions of giving birth in institutional settings. These theoretical perspectives construct a multi-layered understanding of obstetric violence as a discursive, institutional, and cultural phenomenon. They inform both the epistemological orientation and methodological choices of this study.

2.1 Obstetric Violence, Discursive Intelligibility and Power

Judith Butler's (2011) work on discourse and intelligibility provides a crucial framework for understanding why obstetric violence often remains unrecognized and unchallenged. Butler (2011) argues that power operates through discourse, shaping what is considered real, legitimate, and even sayable. If an experience is not recognized within dominant narratives, it

becomes unintelligible – difficult to name, contest, or resist. I reinforce here, that in obstetric care, medical discourse frames interventions such as episiotomies, induced labor, and C-sections as medically necessary or protective, rather than as potential violations of bodily autonomy. This framing creates a cultural blind spot that obscures experiences of coercion, disrespect, and non-consensual procedures. When violence is rendered unintelligible within dominant discourse, women's experiences are often dismissed, minimized, or reframed as routine care. The pregnant body is constructed as a passive object of medical control, not as an autonomous subject whose consent or trauma matters. However, Butler's (2011) framework also illuminates the potential of narrative acts to challenge this discursive invisibility. This is what she calls "the forcible reiteration of norms," whereby violence is not merely permitted but normalized through language (2011, p. xii). When women narrate their experiences and name them as violence, they disrupt dominant medical narratives and reclaim intelligibility. Testimonies – especially when shared publicly or amplified through media – can transform marginalized accounts into sites of recognition and resistance. In this way, storytelling becomes a political act: it contests the erasure of harm and demands new frameworks for understanding and valuing women's autonomy. This study draws on Butler's (2011) insights to examine not only how obstetric violence is normalized but also how women's narratives resist and rearticulate what counts as harm, violence, and injustice. Medical and cultural norms that define the acceptable treatment of birthing bodies often exclude the recognition of certain experiences as violent. In Butler's (2011) framework, making obstetric violence visible requires a reworking of discourse itself to expose the norms that determine which lives and violations "matter", and to open space for alternative narratives and recognitions of embodied experience.

While Butler (2011) foregrounds how discourse determines what is intelligible, Michel Foucault offers a complementary account of how power operates not only through language but also through institutional practices, surveillance, and the production of knowledge. Foucault (1991) argues that institutions, such as hospitals, are not neutral spaces, but disciplinary apparatuses that shape behavior, identity, and bodily norms. His concept of disciplinary power provides a useful framework for understanding how institutional structures, particularly in medicine, control and regulate women's bodies. As he writes, "the exercise of power is not merely a relationship between individuals... it is a way in which actions are

modified by others” (Foucault, 1982, p. 788)¹⁸. This control extends beyond scientific authority; it includes the moral regulation of subjects, especially women and children. Foucault’s (1982) notion of power/knowledge (*pouvoir-savoir*) emphasizes that knowledge is never neutral but is produced and organized through power relations. Fields such as medicine define what is “normal” or “deviant,” thereby legitimizing control over bodies and minds. Using his concept of regimes of truth (Foucault, 1991), this study also examines how institutions like hospitals determine what counts as truth and marginalize alternative perspectives. Medical discourse governs behaviour by dictating normative identities – such as the “good mother” or the “healthy body”. Obstetric care exemplifies what Foucault (1982) also terms as pastoral power: a form of governance that appears protective and benevolent yet systematically manages the subject’s body and conduct. Pastoral power, originally associated with the Christian pastor’s guidance of the soul, evolves into modern institutional practices that shape individual behaviour under the guise of care. It operates through moral authority, individualization, and internalization of norms. In obstetric settings, this power is exercised through surveillance, routines, and protocols that claim to act in the pregnant woman’s best interest yet often disempower her.

The birthing woman is positioned as a patient in need of monitoring and correction, her body subjected to interventions that are framed as necessary but are frequently coercive and depersonalizing. This power functions not through force but through what Foucault (1991) calls technologies of the self – mechanisms through which individuals internalize discipline, adapting their behaviour to align with institutional expectations. Women are thus encouraged to embody the norms of compliance and deference to medical authority, often in the name of being a “good patient” or “responsible mother”.

Expanding on this concept, Iris Marion Young (2003) draws on Foucault’s idea of pastoral power to critique what she terms the *masculinist logic of protection*. In her analysis of post-9/11 security discourse, Young (2003) argues that the modern state, like the medical institution, assumes a paternalistic role under the guise of care and protection. The protector – typically a masculinized figure or institution – claims to act selflessly in the best interests of the protected, who are feminized, passive, and expected to comply. This protector/protected relationship

¹⁸ For those who don't know, Michel Foucault was a French philosopher, historian, and social theorist, best known for his work on the relationship between power and knowledge and how they shape social institutions. He was a professor at the Collège de France from 1970 until his death in 1984.

mirrors pastoral power: it is framed as caring, yet it imposes hierarchical control, fosters dependency, and demands obedience in exchange for safety. Young (2003) critiques this dynamic as both patriarchal and anti-democratic, as it obscures coercion behind the language of virtue and responsibility. In the context of obstetric care, this logic positions the medical institution as the benevolent protector of both mother and fetus, legitimizing intrusive practices through a rhetoric of risk management and maternal duty. Women are expected to submit to medical authority out of gratitude and trust, even when their bodily autonomy is compromised. Like Foucault's pastoral power, Young's (2003) masculinist protection governs through affection, moral obligation, and internalized duty – thus making it even more difficult to recognize and resist. It masks domination with care, and in doing so, reinforces gendered hierarchies that structure both security politics and biomedical authority. Exposing these logics, this topic foregrounds the political significance of resisting and re-narrating obstetric experience, not only as personal testimony but as a form of critical disruption to the regimes of knowledge and power that render such violence both possible and invisible.

2.2 Motherhood as Institution and the Normalization of Suffering

Adrienne Rich¹⁹ (1986) makes a critical distinction between motherhood as an individual experience and motherhood as an institution. The former can involve genuine love, connection, and creativity, while the latter is a patriarchal system that dictates and limits what mothers should be. According to her “patriarchy has told the woman in labor that her suffering was purposive – was the purpose of her existence; that the new life she was bringing forth (especially if male) was of value and that her own value depend on bringing it forth” (1986, p. 159). Within this system, suffering becomes a requirement and expectation, not a condition to be questioned or alleviated. While the experience of becoming a mother can be deeply personal and empowering, the institution of motherhood imposes rigid societal expectations and gendered norms that shape how childbirth is managed. As she states: “pain, like love is embedded in the ideology of motherhood” (1986, p. 157). The suffering might become associated with women value in the world. Rich (1986) argues that this institutionalized control over motherhood reinforces women's subordination within medical systems. In obstetric care,

¹⁹ Adrienne Rich (1929–2012) was an American poet, essayist, and feminist whose work evolved from formalist early poetry to radical feminist critique. A central figure in second-wave feminism, Rich's later writings – including *Of Woman Born* (1986) – interrogated the patriarchal institution of motherhood, arguing that the personal experiences of women must be politicized to dismantle systemic oppression. For a biographical overview, see “Adrienne Rich,” *Poetry Foundation*, accessed April, 27, 2025, <https://www.poetryfoundation.org/poets/adrienne-rich>.

this means that pain, sacrifice, and loss of autonomy are framed as natural and inevitable parts of motherhood. Women who experience mistreatment during childbirth are often told that it is “just how it is” (Hill, 2019, p. 8), or that enduring discomfort and interventions is part of being a “good mother”. This expectation aligns with Rich’s (1986) critique that the institution of motherhood functions not to empower women but to discipline them, enforcing compliance with medical authority. This perspective is crucial to understanding why obstetric violence is both widespread and difficult to challenge. If suffering and disempowerment are normalized within the institution of motherhood, then challenging obstetric violence means not only confronting individual cases of mistreatment but also questioning broader cultural and institutional norms. I contend that it is not merely a matter of power and discourse; the issue is more complex, as it also revolves around motherhood. When women make choices during childbirth that prioritize their own bodies, their legitimacy as mothers is called into question.

To deepen this analysis, Mary Douglas’s theory of institutions offers a powerful framework for understanding how the institutions, like motherhood, or the hospital, for example, constructs, legitimizes, and conceals suffering. Mary Douglas’s institutional theory offers an essential analytic framework to explain how this normalization operates. In *How Institutions Think* (1987), Douglas writes that “institutions have their own processes of classification and recognizing” (p. 3). These processes shape what counts as legitimate knowledge and acceptable behaviour. Her framework demonstrates how institutions – operating through formal structures (medical bureaucracies, legal systems), informal norms (cultural expectations of “natural motherhood”), and cognitive classifications (“good” vs. “bad” mothers) – collectively construct childbirth as a ritual laden with symbolic power. Hospital births become the unquestioned default, breastfeeding transforms into a moral imperative, and medical interventions like C-sections are framed as either “lifesaving” or “convenient” based on institutional priorities rather than maternal agency. These norms gain traction through classification systems that dichotomize experience (like framing birth as either “natural” or “medicalized”), through moral boundaries that stigmatize deviations (such as judging mothers who refuse epidurals), and through controlled memory that marginalizes alternatives (including the historical erasure of midwifery knowledge). Douglas (1987) highlights the ways in which institutions silence dissent. She describes a kind of “selective deafness in which neither of two parties to a debate can hear what the other is saying” (1987, p. 3). This is especially visible in obstetric contexts, where women’s narratives of pain, fear, or violation are often met with institutional denial or

minimization. When a woman's embodied experience contradicts the dominant medical narrative, she is frequently rendered unintelligible – an outcome not of misunderstanding, but of systemic refusal to hear. She exposes how institutions render their constructions invisible – making historically recent arrangements like hospital births seem timeless, while framing resistance (home births, birth plan, doula advocacy) as radical rather than restorative. The institution operates as a cognitive machine: it filters what is thinkable (birth plans as "optional" rather than essential), legitimizes certain knowledge (medical models over embodied wisdom), and disciplines behavior through internalized surveillance ("mother guilt"). Douglas's (1987) argument that "who shall be saved and who shall die is settled by institutions" (1987, p. 4) carries stark implications in maternal health. It underscores how life-and-death decisions in childbirth, such as whether to perform an emergency C-section, administer anesthesia, or honor a birth plan, are often not made by the individuals most directly affected. As Douglas puts it, "the conclusion will be that individuals in crises do not make life and death decisions on their own" (1987, p. 4). These decisions are shaped by institutional protocols, professional hierarchies, and structural biases, all of which constrain maternal agency. Linking Rich's (1986) feminist critique with Douglas's (1987) institutional theory, we can see how the suffering of mothers is not just ignored, but actively organized, legitimized, and depersonalized. It is structured into the very operation of medical and cultural systems, where pain becomes evidence of commitment, and compliance becomes evidence of maternal virtue.

2.3 Autonomy and Agency: Rethinking Choice and Coercion in Childbirth

The concept of autonomy is central to the issue of obstetric violence, as violations in childbirth often occur under the guise of medical necessity or professional authority. Beate Rössler's²⁰ (2002) framework of autonomy as self-determination, self-realization, and self-reflection provides insight into how systemic power structures limit women's ability to exercise full autonomy in childbirth. Self-determination involves the ability to make choices freely, without external coercion or manipulation. In childbirth, this means that women should have the right to make informed decisions about their labor and delivery – whether to have a vaginal or cesarean birth, to use pain relief, or to refuse unnecessary medical interventions. However,

²⁰ Beate Roessler is a professor of ethics at the University of Amsterdam and chair of the Philosophy and Public Affairs research group. Her work critically examines the conditions for autonomous agency in contexts of social power, coercion, and institutional constraints – a framework particularly relevant to analyzing how obstetric violence undermines women's bodily self-determination. For her academic profile, see University of Amsterdam, "Beate Roessler," accessed April, 27, 2025, <https://www.uva.nl/en/profile/r/o/b.roessler/b.roessler.html>.

many women experience coercion in the birth room, where healthcare providers dismiss their preferences, impose medical interventions without proper consent, or use paternalistic justifications to override their decisions. This aligns with Rössler's (2022) critique of repressive socialization, which conditions individuals, especially women, to perceive themselves as dependent and to internalize the authority of others over their own bodies. Obstetric violence, in this sense, represents a direct violation of women's self-determination, as their ability to make autonomous decisions is overridden by institutionalized medical authority. Self-realization refers to the ability to develop one's full potential and live in accordance with personal values and goals. In childbirth, this means that women should be able to experience labor and delivery in a way that aligns with their personal and cultural beliefs, rather than being subjected to rigid medical protocols. However, the systemic medicalization of childbirth often limits self-realization, positioning medical professionals as the ultimate authority and discouraging alternative birthing practices, such as midwifery-led care or home births. Rössler's (2002) emphasis on autonomy as a process shaped by both individual agency and external conditions highlights how institutional structures can either facilitate or hinder a woman's ability to exercise bodily autonomy. When women's choices are constrained within a pre-established framework of medical authority, their ability to achieve self-realization is significantly diminished. Self-reflection involves critically examining one's own beliefs, actions, and experiences. This aspect is particularly relevant to the cultural invisibility of obstetric violence. Many women may not initially recognize the mistreatment they experience during childbirth as a violation of their autonomy, as these practices have been normalized within medical and social discourse. Rössler's (2002) argument that autonomy is acquired in social relations is crucial here: when autonomy is systematically undermined, women may internalize narratives that dismiss their agency and reinforce compliance. Raising awareness about obstetric violence and encouraging women to critically reflect on their birth experiences is essential for reclaiming bodily autonomy and challenging oppressive medical practices.

Saba Mahmood's (2011²¹) theory of agency offers a crucial rethinking of how we understand women's actions and choices, particularly in contexts often misread through a Western feminist lens. Rather than viewing agency as synonymous with resistance to authority or patriarchal

²¹ Mahmood (1961–2018) was a professor of anthropology at UC Berkeley whose work critically engaged feminist theory, secularism, and Islamic revival movements. In *Politics of Piety*, she examines the women's piety movement in Cairo, challenging liberal feminist assumptions about agency, freedom, and resistance. Drawing on ethnographic research, Mahmood argues that embodied religious practices – such as veiling and ritual prayer – constitute forms of ethical self-cultivation that complicate secular notions of autonomy.

structures, Mahmood (2011) urges us to consider how agency can be expressed through adherence to cultural and religious norms, as long as these choices are made through ethical deliberation and personal commitment. Her work on the Islamic revivalist women's movement in Egypt demonstrates that practices like veiling or participating in mosque study circles are not signs of passive submission but are instead rooted in a deeply embodied, moral engagement with faith – what she calls *active subjectivity*. This framework is particularly relevant when examining autonomy in childbirth, where the binary of coercion versus free choice often fails to capture the nuanced ways women navigate authority, expertise, and personal values. Just as Mahmood's (2011) subjects exercised agency through religious devotion rather than overt resistance, women in childbirth may affirm their autonomy by either embracing medical interventions or rejecting them – depending not on defiance, but on alignment with their ethical, cultural, or spiritual frameworks. Mahmood's relational understanding of agency invites a broader, more culturally attuned lens for interpreting women's choices in birth, moving beyond rigid binaries of oppression and liberation (2011).

In the context of obstetric violence, the concept of agency and autonomy is complex and multifaceted. Mahmood (2011) contribute to a critical understanding of autonomy, while Rössler's (2002) optimism about achieving autonomy, even within constraints, adds a valuable dimension. Together, these perspectives enrich our understanding of autonomy within feminist discourse. While their perspectives differ, both can contribute to understanding how autonomy operates (or is denied) in medicalized childbirth settings. Both theorists highlight that autonomy is not just about formal consent but about the conditions under which choices are made. While Mahmood (2011) explores how women negotiate power, Rössler (2002) demands structural change to make autonomy possible. If we apply both perspectives, we see that while women may exercise agency within violent obstetric systems (Mahmood, 2011), true autonomy (Rössler, 2002) can only be achieved when those systems are transformed to respect bodily integrity, informed consent, and women's self-defined needs.

3. Method and Material:

In this study, I use a qualitative approach to investigate the discursive construction and invisibility of obstetric violence. To capture the complexity of this phenomenon, I work with two types of material: (1) publicly available narratives and (2) data collected through an

anonymous online survey. I analyse the materials using critical discourse analysis (CDA) and narrative analysis, complementary methods that enable a deeper understanding of how obstetric violence is experienced, expressed, articulated, and socially normalized.

3.1 Material selection and justification

To explore the violation of women's autonomy in childbirth, I selected two high-profile cases from Brazil: the case of Adelir Carmen Lemos de Góes (2014), which drew significant public attention due to its legal and ethical implications; and the case of Shantal Verdelho (2021), which reignited debates on obstetric violence through media coverage and public discourse. Additionally, I analysed a comment posted under a video interview with Shantal Verdelho, offering a glimpse into public perceptions and societal reactions to obstetric violence.

I also conducted an anonymous online survey aimed at Brazilian women who have given birth in different countries (Brazil, Ireland, and Sweden). The survey, administered in Portuguese, is included in Appendix 1, while the collected narratives are in Appendix 2. Participants were asked to share their experiences during pregnancy and childbirth, particularly focusing on moments when they felt uncomfortable or mistreated. I received 06 responses. The survey was distributed through a private WhatsApp group of approximately 50 Brazilian women living in Sweden (Appendix 3). The group functions as a space for mothers and expectant mothers to share experiences, particularly around cultural differences in maternity care abroad. I joined the group solely for academic purposes and did not personally know any of the members. To protect participant anonymity, no identifying information or images from the group are included. To comply with ethical research standards, identifying information (such as names or phone numbers) was excluded. Participants' narratives reflect childbirth experiences across Brazil, Sweden, and Ireland, offering a cross-cultural perspective on institutional practices and maternal care. Narratives are labeled sequentially (e.g., Narrative 1, Narrative 2) to ensure anonymity while allowing clear reference during the analysis. To ensure ethical rigor, the study followed strict safeguards: no identifiable data was collected; participation was fully voluntary, and participants were informed of their right to withdraw; and the analysis was conducted sensitively to avoid retraumatization and sensationalism. Although the group had 50 members, only 06 women responded. This limited participation may stem from factors such as time constraints, lack of interest, or perceived irrelevance to personal experience. While these

factors could themselves offer insights into how obstetric violence is recognized or minimized, analysing non-participation falls outside the scope of this study. While the small sample size limits broad generalizations, the narratives collected provide rich and valuable perspectives on obstetric violence. Future research could build on these findings by conducting larger-scale studies, including cross-country comparisons. Moreover, while the use of an anonymous online survey allowed participants to speak more freely, it limited the possibility for follow-up questions or deeper exploration, potentially constraining the emotional nuance and complexity that in-depth interviews might otherwise capture.

3.2 Method

Given the dual nature of my material – personal testimonies and public narratives – I employed two complementary qualitative methods: critical discourse analysis (CDA) and narrative analysis. Critical discourse analysis, drawing on Fairclough's²² (2013) approach, extends the investigation to the level of social structures and power relations. It interrogates how institutional and societal discourses shape, constrain, and sometimes silence individual experiences. Narrative analysis, as outlined by Maitlis²³ (2012) and Riessman²⁴ (1993), is particularly useful for understanding how individuals construct meaning and identity through storytelling. It examines how people communicate lived experiences not merely as recollections but as interpretive acts shaped by broader social and cultural frameworks. Employing both methods allows for a multi-layered analysis: narrative analysis illuminates the subjective meaning-making processes of women recounting their childbirth experiences, while CDA reveals how dominant discourses about childbirth, medical authority, and motherhood influence and normalize these personal accounts. Together, narrative analysis and critical discourse analysis offer a comprehensive investigation into the dynamic interplay between personal meaning-making and structural forces. This dual approach is particularly suited to examining the discursive construction and persistent invisibility of obstetric violence, a form

²² Norman Fairclough is an emeritus Professor of Linguistics at Lancaster University and a key figure in the development of Critical Discourse Analysis (CDA).

²³ Sally Maitlis is a Professor of Organisational Behaviour and Leadership at Saïd Business School, University of Oxford, and a Fellow of the British Academy. Previously, she held a professorship at the University of British Columbia and holds degrees in Psychology (UCL), Counselling Psychology (UBC), and a PhD in Organisational Behavior (University of Sheffield).

²⁴ Catherine Kohler Riessman is an American sociologist and pioneer in narrative inquiry, known for her contributions to qualitative research, women's studies, and social work. A Research Professor at Boston College and Professor Emerita at Boston University, her work emphasizes narrative analysis and researcher reflexivity.

of harm that remains underacknowledged precisely because it is embedded in normative cultural and institutional practices.

3.2.1 Critical Discourse Analysis (CDA)

This study applies Norman Fairclough's (2013) three-dimensional model of Critical Discourse Analysis (CDA) to examine how obstetric violence is discursively constructed in the public cases of Adelir and Shantal. CDA is a critical, interdisciplinary approach that views language as a form of social practice deeply embedded in power relations. Fairclough's framework enables a layered analysis across three dimensions: textual analysis, discursive practice, and social practice. At the textual level, I analyze linguistic choices – such as medicalized terminology and the use of passive voice – that serve to obscure agency and accountability (e.g., “the delivery was complicated” or “fetal distress occurred”). These strategies not only depersonalize the experience but also legitimize institutional authority. The discursive practice dimension explores how these texts are produced, distributed, and interpreted, particularly by media and legal institutions. I examine how certain narratives – especially those privileging medical expertise – are elevated, while women's testimonies are sidelined or framed as emotionally unreliable. This level of analysis highlights how language can shape, limit, or redirect public understanding of obstetric violence. At the level of social practice, I investigate how these discourses reflect and reinforce broader cultural norms, such as gendered hierarchies and the medicalization of childbirth. Language becomes a vehicle through which institutional power is naturalized; mistreatment is often portrayed as routine or necessary, embedded in normalized practices that go unquestioned. Phrases like “I thought all births were like this” signal the internalization of systemic violence through dominant discourses. Employing CDA, this study reveals how language not only describes but actively constructs social realities. It enables a critical interrogation of how obstetric violence is sustained through discourse – and how counter-discourses may resist and reframe it. This approach is essential for uncovering the ideological mechanisms that legitimize mistreatment in childbirth and for identifying opportunities for transformative change in public discourse.

3.2.2 Narrative Analysis

For the personal testimonies collected through the anonymous survey, I applied narrative analysis. As Maitlis (2012) emphasizes, narratives are not simple sequences of events but structured, meaningful constructions that organize experience toward valued endpoints. Narratives reveal how individuals understand and interpret their realities, exercise agency, and negotiate identity. Through narrative analysis, I examine how women describe their experiences of childbirth and obstetric violence, paying attention to both thematic elements (what is said - thematic) and structural features (how it is said - structural). This allows me to explore key themes such as trust, autonomy, pain, coercion, and resistance, and to analyze how women's storytelling reflects both personal resilience and confrontation with systemic oppression. In line with Riessman (1993), I treat each narrative as a socially situated performance, sensitive to the ways women position themselves against medical authority, and how they resist or reproduce societal norms. Narrative analysis thus provides insights into the subjective dimensions of obstetric violence – how it is experienced, internalized, contested, and sometimes transformed into acts of empowerment and resistance. While surveys lack the dialogic interaction of interviews, anonymity may empower women to share experiences they might otherwise withhold, though the format may also truncate narrative complexity. So, to conduct a narrative analysis of the narratives that I collected using Riessman's (1993) framework, I try to examine the story through four key approaches she outlines: thematic, structural, interactional, and performative. Using the thematic approach, I identified recurring patterns such as loss of autonomy, institutional coercion, fear-based communication, and cultural disrespect, which revealed systemic inequalities in obstetric care. Through the structural approach, I examined how the women organized their stories—highlighting turning points, retrospective reframing, and emotional climaxes—to understand how meaning was constructed over time. The interactional approach allowed me to explore the dynamics between women and healthcare providers, focusing on how dialogue, silence, or lack of reciprocity shaped each woman's sense of agency and involvement in decision-making. Finally, using the performative approach, I looked at how women crafted and presented their identities—whether as informed, betrayed, resilient, or silenced—showing how storytelling itself became a way to reclaim power, voice, and moral authority in the face of institutional control.

3.3 Reflexivity, Limitations and Positionality

Throughout this research, I maintained a reflexive stance, acknowledging my dual role as a researcher and someone with prior legal experience in this field. My personal background inevitably influences my interpretations; therefore, I continuously reflected on my position to mitigate potential biases. My engagement with the study of obstetric violence is shaped by my dual position as both a lawyer and a woman committed to advancing women's rights. These roles inform my interpretation of the issue, allowing me to analyse it through both a legal-structural lens and a broader feminist framework that interrogates how institutional power erodes women's autonomy. My legal training equips me to dissect how laws, policies, and institutional discourses perpetuate obstetric violence, while my feminist perspective drives my commitment to challenging these systems. At the same time, my personal distance from childbirth introduces both strengths and limitations. Never having been pregnant or given birth, I approach this issue primarily through the lens of autonomy rather than embodied maternal experience. This detachment enables a more critical engagement with institutional discourse, as I am less influenced by personal childbirth narratives that might otherwise shape my perspective. However, it also means my understanding of obstetric violence is mediated through secondary accounts – patients, medical professionals, and scholars – rather than lived experience. This may constrain my ability to fully grasp the emotional and physical toll of these violations, particularly as experienced by those who have endured them. Donna Haraway's (1988) concept of *situated knowledges* underscores that all knowledge is partial, shaped by the knower's standpoint. She rejects the myth of objective, god-like neutrality in research, advocating instead for accountable, embodied perspectives – what she terms “embodied objectivity.” My analysis is no exception: it is inevitably filtered through my legal training, which prioritizes structured argumentation, evidentiary scrutiny, and normative frameworks. This lens may lead me to emphasize legal definitions, rights-based discourse, and institutional accountability over the affective or deeply personal dimensions of obstetric violence. While this approach is valuable in exposing systemic failures, it risks marginalizing the nuanced, lived realities of those subjected to these practices. Recognizing these positionalities is essential, as no research is free from the researcher's situated perspective. My interpretation is shaped by my legal and feminist commitments, framing obstetric violence as a systemic issue rooted in gendered power imbalances and institutional control over women's bodies. Yet I remain mindful of the need to engage critically with counter-perspectives, including medical narratives

that resist labelling certain interventions as “violence”. Maintaining reflexivity, I aim to balance advocacy with rigorous engagement across disciplines, ensuring my analysis contributes meaningfully to both academic discourse and the broader struggle for reproductive justice.

4. Analysis and Discussion – Navigating through Women Experiences

4.1 Public Narratives

This section examines women's testimonies and experiences to contextualize obstetric violence and explore the factors contributing to its invisibility. As outlined in the methodology topic, I analyse two publicly documented cases of obstetric violence in Brazil – each occurring under different circumstances. I begin by summarizing each case and incorporating excerpts from interviews, public statements, newspapers, and magazines to illustrate the events. This is followed by a critical analysis.

For the first case, I draw on various sources, including interviews with those involved, critical commentary from the book *Give Birth Like a Feminist*, and media coverage of the "We Are All Adelir" movement. For the second case – Shantal's experience – I focus on her interview with journalist Flávia Cintra (2022), which addresses the incident in detail, includes excerpts from her birth video, and features commentary on the footage.

4.1.1 Adelir's case

The first case, from 2014, involves Adelir Carmen Lemos de Góes, a Brazilian mother who was forcibly subjected to a caesarean section against her wishes, despite her desire for a vaginal birth. After a court order was issued, armed police removed her from her home, and doctors determined that a vaginal birth was too risky, even though the risks associated with a caesarean were higher (without her consent). That day, she visited the hospital for an ultrasound exam but was neither informed of the results nor given access to the images. Instead, she was advised

to be admitted for surgery without further explanation. Doubting the accuracy of this single medical evaluation, she signed a liability waiver, intending to seek a second opinion. She stated in an interview that she was forced to sign the document: “I agreed to sign it, even though I was a fugitive from here, because the agreement I had made with the nurses at the clinic was that I would come here just to be evaluated and they wanted to hold me back for a cesarean section” (Mendes, 2014). However, before she could do so, the doctor and hospital filed a lawsuit with the Children's Court the same day. The court swiftly granted an order allowing her to be forcibly transported for surgery, denying her the opportunity to contest the decision. In the early hours of April 1, 2014, the surgery was performed without her being allowed to witness the birth of her daughter, as her vision was deliberately obstructed. Her partner was also barred from being present, despite Brazil’s “Companion Law”, which guarantees pregnant women the right to have a companion during childbirth. Throughout the procedure, she endured hostile treatment from healthcare professionals, including mockery and belittling remarks, leaving a lasting psychological impact on what should have been a significant and intimate moment. In an interview, Adelir begins by saying that she feels frustrated: “When the contractions were happening every five minutes, the police arrived, the bailiff arrived with a patrol car, with an ambulance. (...) They kept terrorizing me, saying that if I didn't comply with the order, my husband, at that time when I needed him, would be arrested” (Mendes, 2014). In another interview, Adelir's husband mentions that there was a police officer with handcuffs on his hand who was getting upset, and that he felt like a “criminal” (Ribeiro, 2014).

Adelir's case has since gained national and international attention. The movement “We Are All Adelir” was organized in solidarity with her, bringing together activists against obstetric violence. This movement underscores the growing concern about the violation of women’s rights in childbirth and advocates for the importance of respecting women’s autonomy over their bodies. As Rebecca Schiller (2014) emphasized in her article, the case highlights the troubling tendency of medical professionals to make decisions based on patriarchal assumptions, rather than honouring women's control over their own pregnancies and deliveries. Mili Hill references Adelir's case in her book *Give Birth Like a Feminist*, where she argues that:

Trying to judge the rightness or wrongness of her decision, we fall into the same trap as the Brazilian authorities declaring that a grey zone exists in which a pregnant woman can be compelled to make the decision that others judge is best for her, regardless of what she

would choose for herself (Hill, 2019, p. 35).

Elizabeth Prochaska, a human rights barrister and founder of the UK charity Birthrights, is quoted by Hill, stating:

Risk might sound appealingly scientific and rational, but it is not. When it is used to compel women to receive medical interventions, it is an expression of violent patriarchy, pure and simple. Would a Brazilian court order a man to undergo an invasive kidney transplant to save his dying child? No. Only women's bodies are treated as public objects to the whims of the medical professional backed by the coercive power of the state (Hill, 2019, p. 35).

The Brazilian government released an official statement²⁵ (2014) on April 11, 2014 expressing solidarity with Adelir, highlighting the violation of her human rights and defending women's right to choose their childbirth, in addition to reinforcing the importance of humanized obstetric care in the country. Adelir's doula, Stephany Hendz, suggested to the ambulance medical team that they take her to the city of Araranguá, where a humanized birth team could support a natural delivery. "But they refused and brought me here, to Torres," she recounted (Mendes 2014). "I wish I could feel happier since my daughter is healthy," she reflected, "but if it had been a natural birth, I would already be home – I have another child – and my milk would have come in. It hasn't yet, because with a cesarean, it takes longer for that to happen" (Mendes 2014). The father explained (Ribeiro, 2014):

We weren't refusing a C-section – we just didn't want to put her at risk. We were waiting for her body to be ready for labor. There was nothing dangerous about the situation; we monitored her blood pressure and the baby's heartbeat. But ultimately, it's my word against the doctor's – and she's clearly not in favor of natural birth.

According to the father, the traumatic birth had an impact on the baby, whose name honors both her paternal grandmother and the patron saint of the Romani people, Sara Kali. "She cried nonstop for 40 minutes and only calmed down when I held her and spoke to her," he recalled. Guimarães believes that a natural birth would have spared them the chaos and trauma associated with the surgical procedure (Ribeiro, 2014). "They took away my wife's dream of having a natural birth. They took away my right to witness my daughter's birth," he said. "When I asked the doctor to record the delivery, she refused – so there would be no evidence contradicting her actions." To him, the decision to proceed with surgery was motivated by

²⁵ Available: <https://www.gov.br/mdh/pt-br/sdh/noticias/2014/abril/governo-manifesta-solidariedade-a-adelir-carmem-lemos-de-goes>

convenience. "It's what works best for them. But are women really unable to give birth, or are doctors pushing C-sections just to speed things up?" The hospital justified itself by saying that, "due to the facts, the child's father was upset. To ensure the safety of the procedure, it chose to perform the cesarean section without the father's presence" (Mendes, 2014). The doctor involved in the case declined to give interviews. In an official statement, the Nossa Senhora dos Navegantes Hospital asserted that it "took all necessary steps to carry out the appropriate procedures in accordance with care protocols," and emphasized that both mother and baby received full attention from its medical team. According to the same statement Adelir (who was 42 weeks and two days pregnant) sought medical care due to lower back and abdominal pain:

After evaluating the patient and conducting clinical examinations, the attending physician concluded that an immediate cesarean section was necessary to preserve the lives of both the mother and the baby. However, the patient disagreed with the diagnosis and insisted on a natural birth. She signed a liability waiver and returned home to wait for labor to begin, as reported to the on-call medical team (Mendes, 2014).

Concerns about the situation had already been raised days earlier. On March 28, doula Stephany Hendz expressed her alarm in a Facebook post (Mendes, 2014):

Pregnant woman being persecuted for refusing an elective cesarean section. Baby is active, with a reassuring heart rate, and the mother's blood pressure is 120/80. Pregnancy at 41 full weeks (by ultrasound), and the health center keeps calling (...). Fortunately, empowerment doesn't disappear overnight. I'm proud of this couple who, for the third time, are fighting for a natural birth. The only difference is that this time, they'll succeed – oh yes, they will!

The hospital stated that "the objective was to preserve the health and integrity of the mother and baby" (Mendes, 2014). These are some of the extracts I collected to discuss Adelir's case. I now begin my analysis using Norman Fairclough's (2013) three-dimensional model of CDA to examine how obstetric violence is discursively constructed in this case (see section 3.2.1).

4.1.2 Adelir's case analysis

At the linguistic level, I examine how the framing of Adelir as irrational or irresponsible – through implicit assumptions in medical and legal discourse – may delegitimize her voice, positioning her as a subject to be corrected rather than respected. This raises questions about how such discursive practices function and what alternative interpretations might emerge.

Adelir's desire for a natural birth²⁶, her refusal to undergo a cesarean, and her assertion of bodily autonomy were not recognized as valid or credible choices within the dominant medical discourse. I contend that her refusal was systematically constructed as irresponsible (Brum, 2014), dangerous, and even criminal – a portrayal reinforced by the court-ordered intervention and police involvement. This aligns with Butler's (2011) arguments that power operates through determining which experiences are "sayable" or "recognizable as harm", which explain how Adelir's experience of coercion and trauma was discursively transformed into a story of medical necessity. Her pain, fear, and sense of violation are sidelined in favor of a narrative that privileges institutional authority and scientific "risk" management. My understanding is that terms such as "fetal distress" (narrative 2) or "risk to life" (Adelir's case) are used without explanation or evidence, reinforcing the authority of biomedical discourse and framing the intervention as medically necessary, rather than contestable. By contrast, Adelir's own testimony – "I felt like a criminal," "they terrorized me," "they mocked me" – reveals a stark dissonance between institutional rhetoric and embodied experience. These personal expressions of trauma are often framed as anecdotal or emotional, whereas the hospital's language is clinical, authoritative, and devoid of emotion, establishing a hierarchy of credibility.

Phrases like "I wish I could feel happier" and "I was forced to sign" (Mendes 2014) indicate not only trauma but the normalization of subordination, reflecting Butler's theory of discursive intelligibility (2011). As Shabot (2016) argues, women's accounts of obstetric violence often resemble experiences of bodily violation akin to sexual violence (section 1.4.2). Adelir's language – "I felt like a criminal" – resonates strongly with such affective registers of trauma, confirming Shabot's (2016) feminist-phenomenological observations. This expression also challenges the dominant discourse. It suggests that even within a context of coercion, she retained reflective agency. This aligns with Rössler's (2002) notion of self-reflection – the ability to evaluate and act upon one's desires and beliefs.

From a Foucauldian perspective, the hospital and judicial response (this reveals how discursive practices shape institutional interpretations of her case) to Adelir exemplifies the interplay between disciplinary power and pastoral governance (1982). Adelir was subjected to surveillance (through medical assessments), normalization (via institutional definitions of a

²⁶ I understand that her desire is an expression of *active subjectivity* in Saba Mahmood's terms (2011). Her refusal of a cesarean was not merely passive compliance with medical authority nor simplistic resistance to it, but a deliberate, ethically grounded choice rooted in her own values and understanding of bodily integrity.

"safe" birth), and coercion framed as care – a hallmark of pastoral power, which justified overriding her autonomy in the name of her and her baby's "well-being". Foucault's (1982) concept of pastoral power is shown in the hospital's moral authority, which positioned its intervention as protective, deploying risk discourse and institutional protocols to enforce compliance. This power was not merely external but also internalized: Adelir, under pressure, signed a waiver against her will, while the threat of her husband's arrest intensified her fear, demonstrating how disciplinary mechanisms and pastoral rationalities work together to produce submission (social practice – Fairclough, 2013 – the broader sociocultural and ideological structures shaping this). The hospital function as arbiters of truth, determining which knowledge counts as legitimate while marginalizing alternative perspectives (Foucault, 1991). This aligns with Foster's (1995) critique of the medicalization of maternal care, where obstetric authority displaces women's embodied knowledge (section 1.4.2). Why can't we have a balance? why is it so difficult for people to accept this other side of our knowledge about our own bodies? Medical professionals, backed by legal and bureaucratic systems, established their definition of risk and safety as the dominant truth, dismissing Adelir's own understanding of her body and birth choices. The hospital's protocols, diagnostic criteria, and legal threats operated as truth-producing mechanisms, reinforcing institutional authority while silencing dissent. This process exemplifies Foucault's (1991) argument that power and knowledge are inseparable – what is deemed "true" is often what upholds existing structures of control.

I also identify Young's (2003) logic of masculinist protection in this case. In my view the medical system assumes the role of the paternalistic protector, positioning itself as the sole arbiter of "safety," while the pregnant woman is cast as irresponsible or untrustworthy – a dependent in need of supervision. This protector/protected binary not only justifies coercive intervention but also systematically negates agency, recasting bodily autonomy as a threat to be managed. The hospital's rhetoric of saving lives obscures the gendered violence of this dynamic, transforming what should be a site of autonomy into one of institutionalized subjugation. Here, both institutions, the state (via court order) and medical authority (via forced intervention) collaborate to enforce what Young (2003) would recognize as institutionalized gendered domination. The pregnant woman becomes a governed object within this system – her capacity for self-determination erased under the guise of care, mirroring the authoritarian bargain Young (2003) critiques: submission in exchange for "protection".

Rich's (1986) distinction between motherhood as experience and as institution is salient here. Adelir's embodied desire for a natural birth reflects a personal, experiential relationship with motherhood. But the institutional model of motherhood, in which pain, compliance, and sacrifice are idealized, overrides her lived experience. Her suffering was valorized as maternal duty, and her noncompliance was pathologized. For me, this maternal duty invokes the patriarchal expectation that women prioritize fetal/child "safety" over their own bodily autonomy framing compliance as a duty. Beyond language, the institutional response to Adelir's choices reflects a broader nexus of disciplinary power and patriarchal protectionism.

The system weaponizes care ethics to justify domination (echoing Young's – 2003 – critique of how "good women" are those who accept protection). The hospital's rationale, cloaked in care and protection, served to reassert institutional control over childbirth, stripping Adelir of agency and reframing resistance as irresponsibility (Brum, 2014). I argue that her capacity for autonomous decision-making was entirely undermined. Informed consent was rendered hollow, not just by the medical professionals' refusal to communicate clearly, but by institutional refusal to recognize her legitimacy as a decision-maker. This incident reveals how structural conditions failed to support autonomy – instead, her actions were criminalized, and her rights subordinated to institutional convenience and ideology (which reflect an entrenched culture). In my view even complex forms of agency were denied to Adelir. Her attempt to negotiate – seeking a second opinion, signing a waiver under pressure, engaging with care providers – was overridden by state and institutional power. What Mahmood (2011) helps us see is that agency is not always about outright resistance, but the capacity to act meaningfully within given norms. Adelir's agency was not only suppressed but unrecognized as valid within the institutional system that cast her as irresponsible for deviating from the norm.

Framing the C-section as necessary for fetal life, the mother's agency is subordinated to a moral imperative to sacrifice control for the child's safety. Could Adelir's actions be seen as both resistance and compliance simultaneously? How does this complicate liberal feminist readings of agency?

I maintain that her case illustrates the failure of institutional structures to support women's autonomy, but it also poses deeper theoretical challenges to what autonomy means in practice. Beate Rössler's (2002) conception of autonomy – as composed of self-determination, self-

realization, and self-reflection – offers a valuable normative framework for assessing these failures. However, when applied to Adelir’s case, her account also reveals the fragility of autonomy under conditions of structural inequality. Adelir’s refusal of a cesarean was not respected as a legitimate decision. Instead, her agency was recoded as irrationality, invoking what Rössler (2002) calls the legacy of repressive socialization – especially prevalent for women – where individuals are conditioned to defer to external authority and taught to distrust their own judgment. I believe that Adelir’s experience reflects precisely the kind of socially contingent autonomy Rössler describes: one that cannot be exercised fully if the surrounding structures do not recognize the subject as competent or credible.

In my understanding Adelir’s and her husband’s testimonies are positioned as emotional, subjective, or oppositional, challenging but not overriding the dominant narrative of medical necessity. This illustrates how women’s voices are structurally marginalized in public discourse around birth.

The media coverage of Adelir Carmen Lemos de Góes’ case plays a crucial role in shedding light on the broader issue of women's autonomy in childbirth. Movements like “*Somos todos Adelir*” (“*We Are All Adelir*”) and critiques from figures like Rebecca Schiller (2014) or Mili Hill (2019) function as resistant discursive practices, seeking to reclaim autonomy, voice, and credibility for birthing women, and reframing the event as obstetric violence, not medical routine. This exposure helps reveal the troubling reality that women's rights are often disregarded during childbirth, with medical and legal authorities making decisions about their bodies without consent. This observation powerfully captures how institutional structures – particularly in medicine and law systematically override women’s autonomy during childbirth, framing their choices as secondary to institutional priorities. Mary Douglas’s (1987) theory deepens this critique by revealing how the institution not only disregards women’s rights but actively *organizes* their marginalization through classification systems, moral boundaries, and controlled memory. Her assertion that “*who shall be saved and who shall die is settled by institutions*” (1987, p. 4) is chillingly applicable here.

Douglas’s (1987) concept of “selective deafness” explains why women’s protests are dismissed—not as accidental oversights but as systemic erasures. When a woman’s refusal of a cesarean is overridden, her pain minimized, or her trauma ignored, the institution is not

failing; it is functioning *as designed*, filtering out dissent to maintain its authority. The naturalization of medicalized birth (e.g., framing interventions as "lifesaving" while obscuring their iatrogenic harms) exemplifies how institutions render their power invisible, casting coercion as care.

The attention given to her case serves as an important platform for raising awareness about obstetric violence, making it impossible to remain invisible any longer. My argument is that it encourages a deeper understanding of the complexities surrounding bodily autonomy, particularly in childbirth, and challenges societal and institutional norms that undermine women's control over their own reproductive decisions. Discussing Adelir's story fosters an essential dialogue about how such cases reflect wider patterns of gendered control and the urgent need for systemic change to protect women's rights and dignity in pregnancy and birth.

The denial of her right to a companion²⁷, the obstruction of her vision during the procedure, and the mockery she endured are discursive and physical acts that collectively dehumanize the birthing woman. I believe these practices reinforce the biopolitical management of women's bodies, where institutions exercise power not through overt violence alone, but through the normalization of certain "acceptable" birth experiences and the silencing of dissent.

Adelir's experience is not isolated. Studies such as Vacaflor (2016) and van der Pijl et al. (2022) document similar non-consensual interventions, highlighting a systemic pattern of coercive practices framed as routine care. While Pickles (2024) warns against overextending the term 'obstetric violence' (section 1.4.1), Adelir's case – where psychological coercion, legal threats, and physical control were used – clearly aligns with the term's core definition as a violation of bodily and moral autonomy.

Another striking aspect of Adelir's case is that only one of the reports I analysed used the term "*obstetric violence*" (Brum, 2014) – and even then, not directly. The Brazilian government's statement indirectly alludes to it, urging Brazil to "expand the debate on obstetric and neonatal care, including obstetric violence in all its forms and the observance of

²⁷ Brazilian Law n° 11.108, of April 7, 2005: to guarantee women in labor the right to the presence of a companion during labor, delivery and immediate postpartum.

Human Rights in Health”²⁸. While this implies that Adelir experienced obstetric violence, there seems to be a reluctance to name it outright – echoing the broader difficulty in acknowledging violence, as discussed in section 1.4. Notably, a 2017 article (Moreira, 2017) explicitly frames her case as obstetric violence, highlighting how perceptions evolve over time.

Thinking in my research questions, my analysis demonstrates how language, institutional discourse, and power relations operate to normalize the denial of women's autonomy during childbirth and reinforce structural gender inequality, and also how institutional discourse constructs the female body as public property, subject to control (here they use a court decision to save the child's life because the mother was considered irresponsible). Her case underlines the need, as outlined in 1.4.5, for studies that interrogate how legal systems reinforce medical control over birthing bodies, especially in countries lacking clear legal frameworks for informed consent in childbirth. Although Adelir's case has received media attention, my argument is that her story also exposes the lack of intersectional and policy-aware frameworks for understanding how legal, medical, and social forces converge to enforce gendered obedience – gaps noted in the literature (1.4.5). Her partial resistance – seeking a waiver, voicing dissent – calls for broader theoretical tools to recognize non-binary forms of agency, as Mahmood (2011) suggests.

I illustrate that Adelir's case shows how institutional and cultural frameworks normalize obstetric violence by reframing coercion as care. There is an influence in how women interpret childbirth. Medical hierarchies, legal authority, and patriarchal constructs of motherhood work in tandem to invalidate women's autonomy under the guise of protecting life. These frameworks rely on entrenched assumptions: that the female body is public, the fetus is paramount, and the woman is inherently untrustworthy – assumptions that structure power relations and deny embodied knowledge. Storytelling emerges as a critical counterforce to these logics. Adelir's own words – emotive, subjective, embodied – challenge the bureaucratic narrative of medical necessity. Her testimony, along with media attention and social movements like *We Are All Adelir*, reclaims space for emotional truth, making visible the trauma, fear, and disempowerment that institutional discourse seeks to erase. Storytelling here is not just testimony but resistance: it asserts the validity of lived experience and calls out

²⁸ Secretaria de Direitos Humanos da Presidência da República, 2014. Available at: <https://www.gov.br/mdh/pt-br/sdh/noticias/2014/abril/governo-manifesta-solidariedade-a-adelir-carmem-lemos-de-goes> - Accessed in June, 2025.

violence disguised as benevolent care. Yet, tensions arise when these stories disrupt the dominant logic. The childbirth system is not designed to accommodate disobedient voices or alternative truths; thus, narratives like Adelir's are either sidelined as anecdotal or dismissed as irrational. Adelir's story is not just about an individual violation; it signals a broader systemic failure. It calls for a redefinition of care that centers on consent, respect, and trust – not control. It demands a shift from protective paternalism to shared decision-making. And it reminds us that until storytelling, emotion, and embodied experience are treated as legitimate forms of knowledge, autonomy in childbirth will remain precarious and conditional.

4.1.3 Shantal's case

The second case analysed occurred in 2021 and involves digital influencer Shantal Verdelho. In an interview with journalist Flávia Cintra (2022)²⁹, Shantal shared harrowing details of the obstetric violence she endured during the birth of her daughter. A video of the delivery – recorded by Shantal herself – is publicly available on YouTube³⁰ and can be accessed by searching her name. In this footage, the attending physician can be heard using profanity, exerting verbal pressure on Shantal, and repeatedly addressing her husband regarding medical decisions – particularly the performance of an episiotomy – as though the authority rested with him, not with the patient.

Throughout the birth, Shantal expressed opposition to receiving labor-inducing medication. Despite her objections, the doctor attempted to persuade her to accept the drug, which she recognized as contraindicated due to a previous cesarean section. She emphasized the associated risks, including uterine rupture and potential fatal hemorrhaging for both mother and baby. A medical expert featured in the interview later confirmed that this medication is not recommended for patients with a history of cesarean delivery.

The interview begins with a clip from the birth video, where the doctor is heard shouting, “Come on, come on, Shantal, push, damn it... she doesn't push, that little faggot” (Cintra, 2022). Shantal explains that she initially chose not to release the video because she didn't want her daughter to one day learn that her birth had been so traumatic. In the video, she states, “He

²⁹ Available at: <https://globoplay.globo.com/v/10196296/> Accessed in June, 1, 2025.

³⁰ Available at: https://www.youtube.com/watch?v=SWRYZs0S_mU Accessed in June, 1 2025.

curses me the whole birth, he curses a lot”, and describes how the doctor attempted to “tear her vagina with his hands”. She demonstrates the hand motion he used, mimicking how he tried to forcefully open her.

Shantal had opted for a humanized birth at one of São Paulo’s most prominent hospitals. She labored for approximately 12 hours before the doctor arrived during the final two hours, which she says marked a significant change in the atmosphere. He appeared rushed and impatient, saying things like, “Go on, keep going, are you meditating?” She recalls, “He kept insisting that Mateus do the episiotomy”, and further noted that, “He kept talking to Mateus as if I wasn’t there, as if the decision wasn’t mine” (Cintra, 2022).

She recalls the doctor saying to her husband, “Look here, oh, it’s going to tear here”, referring to the area they would have sexual relations in the future, before suggesting that, “it would be better to cut it here”. In one of the most distressing parts of her account, Shantal describes how the doctor performed the Kristeller maneuver – applying pressure to her abdomen to force the baby out – despite this technique being discouraged by Brazilian obstetric guidelines since 2001 (Brazil, 2017)³¹. “My belly was pressed from the moment he arrived”, she recalls. “He asked a doctor on his team to do this maneuver, then he asked the anesthesiologist to do it because the anesthesiologist was stronger”.

Shantal says she told them it was painful, and in the footage shown during the interview, a male hand is seen pressing down hard on her belly while she visibly winces in pain. “You can see in the video that he is shaking from how hard he is doing it. He puts his entire body on top of my belly and still pushes”. Another obstetrics expert interviewed in the report confirmed that the Kristeller maneuver can cause serious harm, including broken ribs, injuries to organs such as the liver and spleen, and uterine rupture.

Shantal’s husband appears emotional during the interview, saying, “I was by my wife’s side and did nothing. It’s a very bad situation, very upsetting – a feeling of helplessness”. After reviewing the footage, the couple decided to send the video to the doctor, pointing out the

³¹ In 2001, Brazil’s Ministry of Health classified such practices as “clearly harmful or ineffective” and recommended their elimination. This position was reaffirmed by Norm No. 353 in 2017. Information about the *Diretrizes Nacionais de Assistência ao Parto Normal* (National Guidelines for Care in Normal Childbirth) can be found on the Brazilian government’s official website: https://www.gov.br/conitec/pt-br/midias/protocolos/diretrizes/ddt_assistencia_partonormal.pdf/view – accessed 26/04/2025.

moments they found abusive. Shantal recounts, “He gave a mocking response and blocked me on WhatsApp. In other words, he even silenced me”. She explains that seeing other women come forward with even more severe experiences gave her the strength to act: “But then, seeing all the reports of stories that emerged and were shared – of much worse stories – I saw that the problem really was deeper”. Motivated by a sense of responsibility, she filed a formal complaint and demanded an investigation into the physician’s conduct.

After Shantal’s case became public, more allegations against the same doctor surfaced. In response, the doctor – through his lawyer – issued a statement claiming: “He deeply regrets that a medical case has been discussed in the media and on social networks, based on small, edited excerpts from a video”. Citing medical confidentiality and ethical standards, the statement asserted that he was unable to publicly address the case in detail. It also claimed that “the medication mentioned was not prescribed by him, nor administered”, and that “all obstetric procedures followed technical-ethical-scientific rigor”. The physician denied committing obstetric violence, stating that “the editing of the videos and the way they are spoken can lead to misinterpretation”. At the end of the interview, Shantal reflects on her decision to speak out: “For things to change, people need to report it. I don’t want any woman to go through what our family went through”. Despite her courage and the public reaction, Brazil’s Superior Court of Justice ultimately dismissed the case, ruling that the doctor’s conduct fell within the scope of standard medical practice.

Now I start my analysis exploring how language and media representations serve as instruments of power – shaping the intelligibility of the victim’s experience as well as public perceptions of OV. My analysis draws upon theoretical insights to unpack the complex and layered dynamics at play.

4.1.4 Shantal’s case analysis

Before beginning, I must express that watching the full report – particularly the excerpts from the shared video – was deeply unsettling. It is important to highlight that the Portuguese swear words used carry a far greater severity than their English translations suggest. This linguistic gap must be acknowledged, as it obscures the true intensity and violence of the encounter.

At a textual level I argue that Shantal's account and the doctor's defense contain telling linguistic choices that reflect the discursive struggle over meaning and legitimacy. As highlighted in Section 1.4.1, definitional debates reveal the ongoing struggle to determine what counts as violence, and who gets to decide. It is within this ambiguity that institutional and cultural frameworks, including medical hierarchies and gendered ideals of motherhood, operate most effectively: by normalizing coercion under the guise of professional care, responding my research question.

The doctor's use of vulgar and coercive language ("Push, damn it... she doesn't push, that little faggot") exposes the raw aggression often obscured in sanitized medical discourse. It breaks with the expected neutral or benevolent tone of medical authority and reveals a rupture in the normative script. The exclusionary discourse (speaking to the husband, not Shantal) reinforces patriarchal medical authority, aligning with Iris Marion Young's (2003) critique of the masculinist logic of protection. The physician's paternalistic framing of intervention – ostensibly for the baby's safety (when he mentions "that's all it takes for the baby to be born", referring to episiotomy – Cintra, 2013) – performs care while masking coercion, reducing Shantal to a passive, feminized subject whose autonomy is subordinated to male decision-making. The framing of the episiotomy as a decision about future sexual relations ("it's going to tear here") in my view reduces Shantal's body to an object of male control. Shantal's first-person narrative ("He curses me the whole birth", "He tried to tear my vagina") highlights embodied suffering, while the doctor's legal statement erases her voice through claims of "misinterpretation". In my understanding the doctor's statement framing his actions as "technical-ethical-scientific", reinforce institutional legitimacy while avoid direct responsibility. The *Kristeller maneuver* is not named as "violence" but rather as a medical decision, masking its brutality. The use of passive voice in legal and medical discourse (e.g., "the medication was not prescribed by him") deflects agency. This aligns with Fairclough's (2013) view that textual structures reflect and reproduce power, particularly when agency is concealed or violence is naturalized.

I argue that Shantal's experience challenges dominant medical and maternal discourses that frame childbirth as a site of benevolent care. Her pain, dissent, and trauma are dismissed both during the event (when the doctor bypasses her consent) and after (when her formal complaint is invalidated by the court). This reflects Butler's (2011) concept of discursive intelligibility:

experiences that don't conform to accepted narratives, become unsayable and unbelievable. Again, "He curses me the whole birth", "He tried to tear my vagina" – such language and actions don't register within the hegemonic frame of what counts as harm in a clinical setting. Thus, her trauma is rendered discursively unintelligible, especially when the court deems it within "standard medical practice". I align the doctor's behaviour with Butler's (2011) concept of "forcible reiteration". His attempt was not a rupture but a reproduction of gendered norms within institutional power.

The hospital, as a site of medical authority, functions as a disciplinary institution that produces compliant, docile birthing subjects, which align with Foucault's (1982) theories of disciplinary power and pastoral care. I believe the ostensibly protective procedures – including forced episiotomy and medically contraindicated labor induction – function not as care but as mechanisms of bodily control, disciplining the subject through the guise of clinical benevolence. In my understanding, the Kristeller maneuver used on Shantal, represents the institution taking control of the maternal body for its own operational priorities – efficiency, predictability, control. I argue that the doctor's framing of actions as "technical-ethical-scientific" illustrates Foucault's concept of "regimes of truth", where medical knowledge legitimizes domination while disqualifying embodied knowledge. This logic of risk management and "technical necessity" becomes a powerful discursive tool that can render coercive actions – such as non-consensual procedures or verbal aggression – intelligible as ethical, even benevolent. As Ferrão et al. (2022 – section 1.4) argue, this logic is embedded in routine practices that appear neutral but are fundamentally shaped by gendered hierarchies and professional dominance.

Shantal's expressed refusal of labor-inducing medication, a medically informed and autonomous choice, that I argue was ignored and actively overridden by the attending physician. Despite stating the risks, she was pressured to comply, showing that her self-determination was not only dismissed but pathologized as irrational. I understand that the doctor's attempts to persuade her and his exclusive communication with her husband mirrors Rössler's (2002) critique of repressive socialization, in which individuals (particularly women) are conditioned to defer to authority, often against their own bodily knowledge and preferences. Shantal planned for a humanized birth – a choice rooted in her values about autonomy and

minimal intervention³². However, the moment the doctor entered, the birthing environment transformed from supportive to coercive. His use of demeaning language ("she doesn't push, that little faggot") and insistence on performing an episiotomy without consulting Shantal directly, undercuts her ability to experience birth in a way consistent with her self-conception and goals. The *Kristeller maneuver*, applied in violation of national guidelines, further stripped her of agency. I argue that these moments indicate that her ability to realize a birth aligned with her values was systematically obstructed by institutional practices.

Shantal's initial acquiescence to certain interventions, or her husband's silence during abusive moments, may not reflect passivity but rather a complex negotiation of safety, authority, and fear. Here I agree with Mahmood (2011), that we need to resist binary thinking – coercion vs. resistance – and instead recognize that women may navigate oppressive systems by making choices that are strategic, situational, and shaped by social constraints. So, I interpretate that Shantal's decision to stay silent initially was not merely submission, it was shaped by fear, trauma, and the prevailing medical discourse that delegitimizes women's accounts of birth.

At the discursive practice dimension, I examine how narratives are produced, circulated, and interpreted (Fairclough, 2013). The YouTube video (recorded by Shantal) serves as counter-discourse, challenging medical authority by documenting abuse (media representation). The journalistic interview amplifies her testimony but also risks sensationalizing trauma (e.g., replaying distressing clips). My argument is that the doctor's legal response re-centers professional authority, framing the case as a media distortion rather than systemic violence. The court's dismissal – justified as "standard medical practice" – reinforces institutional impunity by normalizing obstetric violence. As a lawyer, I find this unacceptable, as the case violates multiple rights and contravenes Brazilian regulations, particularly the Gender-Based Judgment Protocol³³ (published in October 2021, prior to Shantal's complaint). The judiciary should have assessed her case through a gender lens, as mandated by the protocol. Its failure to do so underscores the systemic barriers to justice and the persistent challenges in dismantling such institutionalized injustices. I argue that the institutional discourse positioned the doctor as the victim of "public misunderstanding", weaponizing the medical confidentiality defense to silence critique, which reflects the institutional machinery Rich (1986) critiques,

³² Here I also align with Mahmood (2011) concept of active subjectivity.

³³ You can find the Brazilian Gender-Based Judgment Protocol in the National Council of Justice (CNJ) website: <https://www.cnj.jus.br/programas-e-acoas/protocolo-para-julgamento-com-perspectiva-de-genero/>

where patriarchal systems discipline women into accepting pain and disempowerment as natural. Shantal's case sparked broader allegations against the same doctor, illustrating how social media enables counter-narratives. Yet, the legal system's refusal to recognize her claims demonstrates how dominant discourses (medical, legal) suppress dissent. Also, my argument is that this exemplifies normalization, reinforcing the idea that obstetric violence is not an aberration but an expected, even justified, aspect of childbirth.

Douglas's (1987) insight that "who shall be saved and who shall die is settled by institutions" resonates here: the court's decision was not neutral but a product of institutional logics that prioritize professional authority over maternal agency. In my view, Shantal's counter-narrative, despite its viral reach, was rendered "unintelligible" by the legal system, which is illuminated by Douglas's (1987) institutional theory, and also Butler (2011). Institutions, as Douglas (1987) argues, classify and legitimize certain forms of knowledge while silencing others. Considering that, my argument is that the judiciary's refusal to apply the Gender-Based Judgment Protocol (a tool designed to disrupt institutionalized gender bias), demonstrates this "selective deafness". When Shantal's trauma is dismissed as a "media distortion", I argue that the court upheld the medical institution's authority, reinforcing the classification of obstetric violence as acceptable behavior rather than systemic violence.

I argue that the way the medical and legal discourses suppress Shantal's testimony aligns with Rich's (1986) argument that the institution of motherhood normalizes suffering as an inherent part of womanhood, framing it as purposive and even virtuous. The Shantal's pain during childbirth mirrors Rich's (1986) observation that pain is embedded in the ideology of motherhood.

At the social practice level, Shantal's case reflects broader ideological norms. The doctor's blatant disregard for Shantal's consent and his insistence on directing medical decisions to her husband rather than her reflects the deep-seated misogyny embedded in obstetric care, where women's autonomy is routinely undermined. The use of the Kristeller maneuver exemplifies how women's pain and bodily integrity are dismissed as mere procedural necessities in a system that prioritizes institutional efficiency over patient well-being. Shantal's statement – "For things to change, people need to report it. I don't want any woman to go through what our family went through" – reveals how systemic obstetric violence is often obscured by

institutional narratives that frame such abuse as routine or medically justified. Her initial hesitation to publicly share her traumatic birth video (“I didn’t want my daughter to one day learn that her birth had been so traumatic”) reflects the silencing mechanisms embedded in medical culture, where women’s suffering is dismissed or privatized. Yet, her eventual decision to speak out (“seeing all the reports of stories that emerged and were shared – of much worse stories – I saw that the problem really was deeper”) underscores how collective testimony can challenge dominant discourses that naturalize mistreatment. This reflective process aligns with Rössler’s (2002) idea that autonomy involves not just isolated decisions but critical engagement with one’s social conditions. In reclaiming her narrative, Shantal disrupted the normalization of violence in childbirth and began to resist the cultural silencing of such abuses. Her decision to speak out, in my view exercised what Mahmood (2011) calls active subjectivity. Her decision to file a formal complaint, confront the physician, and bring her story into the public sphere wasn’t just an act of personal empowerment; it was a collective ethical act meant to transform broader structures of power. This aligns with Mahmood’s (2011) argument that agency can emerge from within, even when the external structures are repressive. While watching the video, I noticed that Shantal was giving birth in the supine position – legs open and strapped to supports – a posture that appears to prioritize the doctor’s convenience over her comfort or autonomy.

The court’s dismissal of her case – legitimizing the doctor’s actions as “standard medical practice” – further illustrates how institutional power reinforces these norms, conditioning both patients and professionals to accept violence as an inevitable part of childbirth.

The fact that Shantal’s social media exposure sparked further allegations against the same doctor yet failed to secure legal accountability underscores the institution’s resilience in maintaining its norms. The institution of motherhood, as they reveal, is not passive but actively constructs and naturalizes suffering. Thus, Shantal’s case is not just about a single instance of abuse but about the systemic refusal to see childbirth as a site of potential liberation rather than control. The judiciary’s failure to apply a gender lens – despite the protocol’s mandate – exposes how institutions reproduce hierarchies by rendering alternative frameworks (like feminist critiques) invisible. My argument is that Shantal’s suffering was not an accident but a product of institutional designs that frame maternal pain as inevitable, weaponize professional authority, and systematically erase dissent.

For me, Shantal’s case exemplifies how discourse sustains oppression – but also how counter-narratives can disrupt it. For meaningful change, transformative discourse must challenge institutional power, centering women’s agency in childbirth. I argue that Shantal’s account of her childbirth experience offers a vivid example of how institutional and cultural frameworks normalize obstetric violence, often under the rhetoric of care. Her story does not simply recount events – it interrogates the structures that shaped them. In doing so, it illuminates the tensions between lived experience and institutional rationality, offering insight into how storytelling can function as both a critique and a reclamation of agency.

The tension between Shantal’s account and the hospital’s narrative is not merely emotional, but also ontological. They operate within incommensurable systems of meaning. Where the hospital views irth through the lens of procedure and liability, Shantal positions it as a site of dignity, vulnerability, and motherhood. This clash creates a productive disruption. It forces a reckoning with the assumptions underlying maternity care – particularly the idea that institutional knowledge is always superior to experiential knowledge.

In this tension, possibilities for resistance emerge. I argue that in articulating the violence of being rendered voiceless, Shantal’s story exposes the fault lines in institutional logic and points to the need for a model of care that is not merely technically safe, but relationally just. Moreover, the fact that she tells her story – despite pressure to “move on” or accept what happened – signals a broader refusal to normalize what should be unthinkable. It is a call for recognition, but also for transformation: not only of attitudes, but of policies, hierarchies, and norms that permit such violations under the cover of care.

4.1.5 Media commentary analysis

While watching the video about the Shantal case, I decided to read through the comments, which helped deepen my understanding of the situation, and reinforce my argument for the topic above. Among the many comments shared, one particular statement stood out to me. As of May 2, 2025³⁴, the video had 3,368 comments, many of which came from people who

³⁴ You can see the video and the comments (Betioli, 2021) here: https://www.youtube.com/watch?v=SWRYZs0S_mU – Accessed on 02, May, 2025.

identified with the story (Betioli, 2021). However, one response especially captured my attention. Since the comments were in Portuguese, I've translated:

I went through this kind of situation 10 years ago... I was in the room when I felt that my son was already being born, I felt a lot of pain and I was pushing when I felt the pressure of his little head... No nurse was with me, they simply put me on a drip and went there only to measure the dilation... when my son was already being born... my sister called the doctor who sat me in a wheelchair and took me to the delivery room... after she did this the pain I felt simply disappeared, she cursed me, told me to push when I felt the pain, but the pain didn't come... she said that I was going to kill my son if I didn't push, but I tried to do it even without the pain, she ordered two nurses to push on my belly... until she had to remove my son with forceps... when my son was born she cursed me even more in front of everyone and said she never wanted to do another birth again My birth... I cried and asked her for forgiveness and said that I tried but I couldn't... She stitched me up so brutally that in the first few days after giving birth I could barely sit or stand with my son in my arms because of the pain I felt from the stitches. I took a lot of tea baths to avoid inflammation... It was my first and only birth and it caused me a terrible trauma... I never reported it because I always thought that all births were like that... Today, watching this report, I see myself in her place... Having the birth of a child is such a special day in our lives and having to live through situations like this is very sad... I took my camera to take pictures and I have no memory of how hectic and sad my birth was... The only memory I have are those terrible moments that I had to live through without knowing that I was suffering an obstetric aggression. 😞 (Betioli, 2021)

Linguistically, the narrative is marked by expressions of guilt, fragmented recollection, and the erasure of the woman's voice and agency. The violence here was masked as care. This narrative is deeply moving. I argue that the doctor's verbal abuse ("cursed me", "said I would kill my son"), physical coercion (nurses pressing on her belly), and punitive stitching ("she stitched me up so brutally") reflect how medical power frames violence as necessary for the baby's survival. This aligns with how discourse obscures coercion as "care", as I mentioned in both analyses before, and is a perfect example of the masculinist logic of protection (Young, 2003). As discussed earlier (section 1.4), the term "obstetric violence" remains largely unrecognized until it gains public attention and is widely shared. In this case, the narrator endured both psychological and physical violence but, due to cultural normalization, did not initially identify as a victim. This illustrates how institutions, in my view, shape perceptions by legitimizing certain forms of knowledge while marginalizing others. The woman is treated as passive, irrational, in need of control, and expected to express gratitude for her own mistreatment. The absence of staff during labor ("no nurse was with me") highlights institutional neglect. Here I

see Foucault's (1982) disciplinary power in action (intervention as discipline, the fact that she was left alone, and this internalization of norms). She apologizes – an example of “technologies of the self” (Foucault, 1991). In my view, she has internalized the idea that her failure to perform “correctly” justifies mistreatment. Here I can see the “cultural blind spot” that I mentioned in the beginning.

The mother blames herself ("I asked for forgiveness"), showing how systems shift accountability onto victims. This reflects Fairclough's (2013) idea that dominant ideologies are internalized through repeated discursive formations. This analysis highlights how medical authority functions not just as clinical power but as a structural and discursive tool of patriarchal control, transforming what should be an empowering reproductive experience into one of subjugation and trauma. Also, textual analysis reveals how ideologically loaded medical terms (e.g., 'risk') function to legitimize coercive practices – what Fairclough (2013) would call naturalization.

At a discursive practice level (Fairclough, 2013), the survivor's belief that "all births were like that" reveals how societal norms naturalize mistreatment, rendering obstetric violence invisible as a structural issue. The doctor's threats and the forced episiotomy/stitches exemplify control – the body is treated as an object to be managed, not a subject with agency. The abrupt loss of pain ("the pain simply disappeared") and subsequent shaming ("push when I felt the pain, but the pain didn't come") underscore how medical discourse pathologizes non-compliance. The verbal abuse ("cursed me even more in front of everyone") and trauma ("terrible moments") align with feminist critiques of obstetric violence as gendered harm, rooted in the systemic devaluation of women's pain and autonomy. I understand that these statements: “They simply put me on a drip and left... No one was with me... I felt pain but had to stay lying down...” highlights the medicalization and routinization of birth, critiqued by Martínez-Galiano et al. (2023) and Loudon (1992). According to Shabot (2018), obstetric violence can lead to postpartum post-traumatic stress disorder (PPTSD) and long-term emotional trauma. I identified the issue in this statement: “... It was my first and only birth and it caused me a terrible trauma”.

In the statement: “I cried and asked her for forgiveness and said that I tried but I couldn't... I never reported it because I always thought that all births were like that...” I argue that this

internalization of guilt shows precisely what Butler (2011) means by discursive unintelligibility: the narrator couldn't recognize or name the experience as violence because medical discourse frames such treatment as normal, necessary, or deserved. The very structure of intelligibility denied her access to a language of resistance or complaint. Her pain was not "legible" as harm. Also, at a discursive practice level (Fairclough, 2013), highlights the reframing potential of counter-discourses in media. Exposure to other women's stories facilitates a re-interpretation of one's own experience as violence, not failure. Naming the event as "obstetric aggression" reclaims intelligibility and begins the process of resistance. Here mirrors exactly what Lévesque and Ferron-Parayre (2021) describe as the epistemic challenge in defining obstetric violence from the patient's standpoint rather than the caregiver's intent. "She didn't even wait for the effect of the anesthetic... just went in with a needle and thread... I screamed and she said: 'Do you want to be pretty or not?'" The disregard for pain, consent, and autonomy aligns with Shabot's (2016) notion of obstetric dehumanization – not just a clinical lapse, but a gendered violation of embodied dignity. Additionally, Peggy Foster's (1995) work on outdated, patriarchal practices reinforces this: even in contemporary settings, routine violence is often framed as care, echoing the historical shift from woman-centered to physician-controlled childbirth. What stands out in these narratives is how patriarchy is upheld not only by men but also by women – whether doctors, nurses, or midwives – who perpetuate the same cycle of violence.

This comment is a form of testimonial discourse, emerging in a participatory media space (YouTube comment sections), which allows traditionally silenced voices to be heard. The commenter explicitly identifies with Shantal creating a shared discourse of suffering that connects individual pain to collective trauma. She admits she only recognized her experience as violence after hearing another story, highlighting how dominant discourses obscure abuse by framing it as normal ("I always thought that all births were like that"). I agree with Sadler et al. (2016) and Yilmaz Sezer et al. (2023) in this context, when they explicitly warn that obstetric trauma can have intergenerational and lasting emotional impacts – which we see when the narrator's awareness is triggered by seeing another woman's story years later: "I see myself in her place, and I started to cry...". This is not merely a personal catharsis – it reflects a collective, structural failure, and validates Amorim & Katz's (2020) and Richards' (1982) insistence on restoring agency and respect as prerequisites for reform. This expression also marks a rupture in dominant discourse – a moment of re-narration Butler (2011) would see as

political.

At a social practice level (Fairclough, 2013), I interrogate the cultural and institutional structures that shape and are shaped by these discourses. The institutional emphasis on protocol (e.g., forceps, pushing on the belly) over empathy or informed consent reveals how medical discourse marginalizes experiential knowledge. The “pain disappeared” after being moved implies a misalignment between bodily knowledge and clinical interpretation. “The only memory I have are those terrible moments...” - the erasure of celebratory memory through trauma critiques the cultural denial of obstetric violence. This echoes systemic patterns where women’s pain is treated as expected or exaggerated.

The harrowing birth story recounted here is not merely an isolated case of medical negligence but a stark illustration of how institutions – particularly the medical-patriarchal system – structure childbirth as an experience of subjugation rather than empowerment. Using Mary Douglas’s (1987) theory of institutions, my argument is that this narrative reveals how classification, moral boundaries, and institutional silencing transform what should be a profound biological and emotional event into one of trauma and disempowerment. Institutions impose binary classifications (Douglas, 1987) to control behavior. I argue here that the medical system enforces the expectation that a laboring woman must follow orders (push on command, endure pain silently) or risk being labeled uncooperative, dangerous, or even murderous (“you’re going to kill your son”). My point is that the doctor’s reaction – cursing, shaming, and ultimately using forceps and brutal stitching – reinforces this institutional logic: compliance is rewarded (or at least not punished), while resistance is met with violence. The mother’s subsequent apology (“I cried and asked for forgiveness”) tragically demonstrates how institutions internalize guilt in those they oppress. Do institutions manage bodies, or they just enforce moral narratives? I have the feeling that we are often puppets. The doctor’s insistence that the mother push *despite the absence of pain* (a physiological impossibility if the body was not contracting) reflects a deeply ingrained institutional belief: that suffering is intrinsic to “proper” motherhood (Rich, 1986). I note that moralizing pain (“you must suffer to deserve your child”) turns a natural process into a performance of submission. Also, the fact that the nurse pressed her belly illustrate how institutions discipline women’s bodies under the guise of medical necessity. I agree with Douglas (1987) when she mention that institutions control memory, not just by omitting alternatives (like midwife-led

care) but by reshaping personal narratives. In the narrative I see her trauma being dismissed, as I already talked about it; her documentation efforts failing (when she mentions that her camera captured nothing of the violence, leaving only fragmented, painful memories); and her suffering being depersonalized (she did not even recognize it as "obstetric aggression" until later). This aligns with Douglas's concept of "selective deafness" – the institution (here, the medical system) refuses to hear or validate her pain, instead framing her distress as personal failure. The doctor's final humiliation ("she never wanted to do another birth again") reinforces this institutional gaslighting: the violence is recast as *her fault*, not the system's. But how can we challenge the system?

I also argue that beyond clinical power, this narrative expose how institutions enforce patriarchal domination. The use of forceps and fundal pressure (pushing on the belly) are not just medical choices but acts of coercive control, ensuring the mother's body is rendered passive. This aligns with Rich: "the forceps and its monopoly by male practitioners were decisive in annexing childbirth to the new male medical establishment" (1986, p. 167). The stitching as punishment (so brutal she could barely hold her newborn) reflects a misogynistic tradition where women's pain is deemed irrelevant post-birth. How many other women have been similarly broken by this system, only to believe – as she did – that "this is just how birth is"? This trauma was not an accident but a predictable outcome of institutional design. The medical system, as an arm of patriarchal control, classifies women's bodies as problems to be managed, moralizes their suffering as necessary, and erases their testimonies to maintain power.

In order to understand how systemic power imbalances manifest in obstetric care, I want to move from discourse to the more narrative aspects of the anonymous survey. My claim is that this material helps us understand more deeply the emotional and structural complexities embedded in women's birth experiences. Building on this critique of institutionalized control over childbirth, I now turn to personal testimonies to illustrate how these dynamics are experienced, narrated, and resisted by those directly affected.

Now, thinking in my research questions, my argument is that women's testimonies – via surveys, interviews, media, and social platforms – emerged as acts of discursive resistance. Sharing their stories publicly, women challenge the dominant medical narrative that frames

interventions as neutral, technical, or benevolent. Framing institutional mistreatment as obstetric violence, women challenged the legitimacy of institutions and medical authority and reframed their trauma as systemic rather than personal failure. In doing so, they asserted interpretive authority and demanded both recognition and justice. Public disclosures like those by Shantal and Adelir became catalysts for broader awareness, community solidarity, and policy critique.

4.2 Personal testimonies

In this section, I analyse the narratives collected through the anonymous survey, with all complete responses available in Appendix 2. To support the discussion, I draw on the most relevant excerpts. As outlined in Appendix 1, the survey began with a brief personal introduction and a short explanation of obstetric violence. I included a few guiding questions to assist participants in beginning their stories if needed, but the format was intentionally open-ended to allow for the free expression of both positive and negative experiences.

In my analysis, I focus on how women describe their experiences of childbirth and obstetric violence drawing on Catherine Kohler Riessman's (1993) framework, as previously outlined in the methodology section.

The **Narrative 1** demonstrates the complexities of navigating obstetric care in a new cultural context ("I am Brazilian and had my first baby in Sweden"), revealing how personal experience intersects with institutional structures and emotional vulnerability, underscoring the tension between institutional protocols and bodily autonomy. Initially distrustful of her midwife due to rushed visits and inadequate care – such as unchecked blood pressure – she later gains confidence after switching providers and educating herself about natural birth, marking a shift from skepticism to empowered agency.

Thematically some key points emerge in her story: coercion disguised as medical protocol, fear-based persuasion, and the emotional toll of laboring within rigid systems. A central thread is the narrator's evolving relationship to choice. Although she begins by adapting to Sweden's "standard procedure" of natural birth – "I personally didn't like... that I would not be able to choose natural or c-section labor" – she gradually embraces it through information and dialogue

with a new midwife. The disparity between promised (“Before going to the hospital we called them and they were very friendly”) and actual care is exemplified when she is told she can rest at the hospital only to be sent home in pain: “They didn't let us stay and they gave me just a kind of paracetamol for my pain that didn't help me at all to sleep.... The pain was getting more difficult to handle as I was very tired because I couldn't sleep the night before”. She called the Hospital again complaining about the pain and tiredness. She went to the Hospital and met different people, and they did exactly what they told her in the phone, helping with the pain (which aligns with Martinez-Galiano et al, 2023, and the difference in treatment.). What is interesting is that behind the institution there are people who can make a difference. See that she arrived at the Hospital and was attended to by other employees who were receptive and careful, providing exactly what she asked for.

In my understanding the initial sense of her agency collapses when her pleas for a c-section are repeatedly dismissed by the medical team, even as pain escalates and fetal distress becomes a concern: “The strong pain, the tiredness and the idea that my baby could be under stress because the birth was taking so long shook me emotionally. I started to ask for a c-section, but the team insisted on trying a natural birth”. She was forced to *scream* to be heard – a moment that encapsulates her emotional distress and the erosion of trust. This echoes Rich’s assertion that the medicalization of childbirth often demands compliance, not informed, supported choice (Rich, 1986).

Her retrospective assessment – “I consider my birth experience traumatic because they were insisting to keep natural labor” – underscores how institutional norms often override individual limits, even when risks emerge. Despite the trauma, she acknowledges the staff’s efforts and expresses gratitude for the positive outcome: a healthy baby and postnatal care: “I believe that the professionals tried to do the best they could for me, but I consider my birth experience traumatic...”. This narrative transcends childbirth, becoming a story of negotiating identity, power, and agency within an inflexible medical system.

My argument is that, structurally, the narrative follows a progressive unraveling of control, beginning with optimism and trust, shifting to frustration and disillusionment. The structure mirrors the birth process itself – delayed progression, cycles of hope and setback, and eventual crisis. Notably, retrospective framing is crucial; earlier events (like being sent home with

ineffective painkillers) take on deeper meaning when viewed through the lens of cumulative exhaustion and fear. Turning points are clearly marked: *“That shook me a lot,”* she says after learning her baby may be in distress – signalling an emotional shift that reframes her perception of the staff’s prior decisions. The resolution arrives with the eventual cesarean and healthy birth, followed by supportive postnatal care, yet the coda reframes the experience as ultimately traumatic despite acknowledging the staff’s efforts. This structure reflects a cyclical pattern of raised hopes and systemic letdowns, culminating in a crisis that demands extreme advocacy.

My interactional analysis highlights the dialogic nature of the storytelling, where the narrator anticipates and addresses potential reader judgments. She justifies her mistrust, explains her evolving perspective, and underscores the disconnect between institutional promises (“you can stay”) and reality (“they didn’t let us stay”). Reported dialogues – her husband’s interventions, staff contradictions, and her own desperate pleas – expose the power imbalances and her strained agency. Far from passive, she emerges as an active participant who, though repeatedly thwarted, ultimately forces recognition through sheer vocal resistance (“screaming”). The narrator’s voice is often minimized or ignored until it reaches the point of escalation: “I had to scream that I couldn't take the pain any longer... I started screaming that I couldn't take the pain and that I didn't want my baby at risk for another hour”. My point is that her clear verbal communication was insufficient without heightened emotional expression or the intervention of her husband, who had to “talk to the team asking for something to be done”. Does anyone truly understand a patient's body better than the patient themselves? If a cesarean section is requested, why prolong the suffering by refusing it outright?

Performatively, I argue that the narrative constructs the narrator’s identity as both reasoned and resilient (someone who tries to conform, questions respectfully, and only resorts to emotional outcry when pushed to her limit). She presents herself as informed and cooperative yet compelled to perform distress to breach systemic indifference. Emotional outbursts become acts of resistance against a system that rewards silent compliance. Her nuanced appraisal – praising individual care while condemning institutional failures – reflects a deliberate balancing act, acknowledging kindness without absolving harm. As a Brazilian in Sweden, her story also performs a cultural negotiation, framing the trauma as not just medical but existential, a clash of expectations and unspoken norms. Together, these layers reveal birth not merely as a physical event but as a contested site of autonomy, voice, and identity. Her identity

as an informed and proactive mother is carefully staged through details such as researching midwives on Google Maps, reading about labor, and asking questions. Yet, her voice gains authority not through calm reasoning alone, but through desperation and intensity. This tension is part of the performative contradiction: a woman must perform distress to be heard yet is often judged for doing so.

Sweden's strong preference for natural birth³⁵ (vaginal delivery as "standard procedure") creates a systemic bias that overrides individual needs. The mother's request for a cesarean was initially dismissed despite her exhaustion, stalled dilation, and fetal distress – highlighting how institutional norms prioritize "successful" natural birth metrics over patient autonomy. The hospital's inconsistent responses (friendly phone calls vs. rigid in-person denials of pain relief) reveal systemic fragmentation. Trust is eroded when institutional promises ("we'll help you sleep") clash with reality ("just paracetamol").

The narrator's birth story exposes the profound tensions between institutional medical protocols and individual bodily autonomy. Through structural, interactional, and performative lenses, we see how her experience – marked by dismissals, delayed interventions, and eventual traumatic resolution – reflects broader systemic failures. The narrator's journey – from initial mistrust to forced advocacy – reveals the high stakes of navigating such a system, where trust is eroded by broken promises and power imbalances. Yet, her nuanced reflection – acknowledging both kindness and coercion – demonstrates resilience and a refusal to be reduced to a passive victim. Ultimately, this narrative is not just about childbirth but about the struggle for dignity, voice, and autonomy within rigid institutional structures. How many women in Sweden internalize their traumatic births as "just how it is", never realizing that the institution, not their bodies, failed them?

While the clinical outcome – a healthy baby and smooth surgery – aligns with biomedical "success," the story complicates that narrative by centering the emotional and moral cost of delayed response, institutional rigidity, and the conditional nature of patient agency. Through her story, the narrator not only reclaims her voice but critiques a system that, despite moments of care, ultimately failed to honor her limits until she had no choice but to shout.

³⁵ We can see that in Narrative 1 and 3.

As I already demonstrate before, I argue that institutions impose categories that dictate what is "normal" or "deviant", which align with Douglas (1987) theory. In Sweden, natural birth is the institutional ideal, so much so that the mother was not allowed to choose a C-section. The delay in approving surgery ("wait an hour") reflects institutional adherence to protocol over bodily autonomy (this is the same in narrative 3). The classification of natural being the best is not neutral – it is a socially constructed hierarchy enforced by the institution, regardless of individual circumstances. The institutional insistence on a natural birth over her lived experience of pain, fear, and exhaustion reflected the very alienation Rich (1986) warns about: “The labor of childbirth has been a form of forced labor... [women] have found themselves at the center of purposes, not theirs, which they have often incorporated and made into their own” (Rich, 1986, p. 160).

The **Narrative 2** shows how systemic gaps and provider attitudes shape childbirth experiences. While the narrator ultimately had a positive outcome, her account exposes key tensions in informed consent, racialized bias, and pressured interventions – themes that structure her story both thematically and structurally. As the Narrative 1 we also need to consider the cultural context (Brazilian who lives in Ireland). Her identity is also as an informed and proactive mother.

The narrator’s journey begins with an assertion of self-education and autonomy, as she actively seeks external information to compensate for the hospital’s lack of guidance – a reflection of structural epistemic injustice, where healthcare systems fail to provide equitable education. Her statement, "If we have doubts, we need to bring up all the points and ask, and unfortunately, they don’t always provide the information," critiques a system that treats patient knowledge as optional rather than a right, in my opinion. This reflects Rich’s (1986) argument that women are not encouraged to see childbirth as a process of bodily knowledge, but instead are often left uninformed or mystified: “Rarely has it [childbirth] been viewed as one way of knowing and coming to terms with our bodies, of discovering our physical and psychic resources” (Rich, 1986, p. 157). In my view, the fact that the narrator must exit the system to gain knowledge confirms that institutionalized maternity care remains hierarchical and exclusionary.

The complicating action arises when she faces pressure to induce labor at 41 weeks (despite no

signs of fetal distress) and later when staff insist on gas use during labor. Both moments reveal institutional tendencies toward unnecessary alarmism and disregard for refusal, requiring her husband's intervention to enforce her choices – a stark example of how women's autonomy is often overridden until a man validates it.

Despite this systemic gap, the woman reports that no procedure was performed without consent. This aligns with Rich's (1986) vision of reclaiming bodily authority, a central goal of resisting the alienation imposed by patriarchal motherhood structures. Her ability to refuse induction and push back against unwanted interventions (e.g., gas) is an example of asserting subjectivity within a system designed to minimize it. Still, her resistance was necessary precisely because the default institutional response was not neutral: "They insisted a lot, even putting it [gas] in my hand". I argue that this pressure supports Rich's (1986) idea that the institution of motherhood disciplines women, rewarding compliance and resisting deviation.

I argue that the interactional layer of the narrative shows how the storyteller anticipates skepticism, justifying her decisions by emphasizing their successful outcomes. Her account is not just a recollection but a co-constructed dialogue with the healthcare system, where she negotiates, resists, and sometimes collaborates. This dynamic is especially clear in the midwife's discriminatory remark – "*women from your country ask too many questions*" – which the narrator performatively reclaims as a point of pride: "*we are well-informed and seek preventive care*". Here, storytelling becomes identity work, challenging the stereotype that informed patients are "difficult" rather than empowered. This moment exemplifies institutional othering, where racial and cultural bias creates barriers to respectful care.

Here, I argue that exist this conflict between women's autonomy and institutional authority in childbirth, which is illustrated in Kitty Holland's (2018) article³⁶, "*Are middle-class 'birthzillas' harassing hospital staff?*". In it, Dr. Aoife Mullally, a consultant obstetrician, critiques what she describes as a growing number of middle-class women seeking "perfect births" free of medical interventions. While she frames these preferences as unrealistic and even harmful to hospital staff, her argument reinforces the medicalization of childbirth and

³⁶ Holland, K. (2018, May 4). Are middle-class 'birthzillas' harassing hospital staff? *The Irish Times*. [https://www.irishtimes.com/news/social-affairs/are-middle-class-birthzillas-harassing-hospital-staff-1.3484471:contentReference\[oaicite:16\]{index=16}](https://www.irishtimes.com/news/social-affairs/are-middle-class-birthzillas-harassing-hospital-staff-1.3484471:contentReference[oaicite:16]{index=16})

subtly delegitimizes women's efforts to assert control over their birth experiences. The term "birthzillas", finds a stark counterpoint in the narrator's experience in Ireland, where her legitimate requests for informed consent and refusal of unnecessary interventions were framed as disruptive rather than agential. So, if the narrator is well informed or have a birth plan, is she a "birthzilla" (a monster or troublemaker)?

Also, I argue that being a non-Irish woman seeking proactive care led to an institutional reaction that attempted to shame her for asserting knowledge and agency. This moment embodies what Rich (1986) describes as the intersection of gendered power with other systems of control, such as racism. This midwife's response is also an example of how institutions maintain boundaries of legitimacy – those who conform to expected patient behavior (passivity, gratitude) are treated more respectfully, while those who question are framed as problematic ("birthzilla").

The performative aspect of her narrative further reinforces her identity as an assertive, culturally proud woman who resists passive patienthood. She contrasts the excellent labor and postpartum care with the dismissiveness of prenatal providers, illustrating how institutional priorities – not patient needs – dictate the quality of care. Birth itself is handled respectfully, yet the prenatal phase – where education and consent are most critical – is marked by neglect and condescension.

Her story exposes how structural obstetric violence operates even in seemingly "humane" settings. The pressure to comply with interventions, the burden of self-education, and the racialized dismissal of her questions all point to a system that demands systemic accountability rather than relying on individual resilience. The narrator's experience validates the necessity of patient-centered care, where informed choice is a right – not a privilege earned through relentless advocacy. Performing her strength and rationality, she compels the audience to recognize these systemic failures, transforming her personal story into a broader critique of institutional power.

In both narrative I argue that the husband voice supports the women agency, which align with Mahmood's (2011) theory that agency isn't just resistance but can involve navigating power structures in complex ways. If the husband assumes control (e.g., making decisions *for* her,

overriding her voice under the guise of "protecting" her), he may replicate the same coercive structures as medical staff.

The following analysis focuses on key themes of obstetric violence: coercion, disrespect, loss of autonomy, and systemic failures. While all accounts describe medically safe outcomes, they reveal varying degrees of psychological and physical harm, illustrating how institutional protocols and provider attitudes can undermine patient agency.

Narrative 3 is shaped by an underlying tension between respectful conduct and limited agency. My thematic analysis suggests, although the narrator begins by affirming that she felt informed and respected, she later states, "I believe they should have opted for a cesarean section", that despite apparent consent, key medical decisions were not collaboratively made. The repetition of "they were following protocol" indicates that institutional procedure substituted for individualized care, masking a lack of responsiveness. The birth is retrospectively labeled as "anything but normal," revealing how technical success can coexist with emotional unease and dissatisfaction. From my structural view, the narrative starts with affirmations of good care and professionalism, building a tone of compliance and trust. However, midway, the narrator reframes the experience, revealing frustration with the prolonged labor and the delayed c-section decision. This retrospective contradiction – between surface satisfaction and deeper regret – functions as a structural pivot, showing how narratives evolve in hindsight. Interactions appear one-sided: the narrator is informed, but not invited to participate in decision-making. The phrase "I had no choice" signals that medical decisions were made for her, not with her. Even respectful communication is framed as procedural rather than dialogic, reinforcing the idea that protocol dominated over patient preference. I argue that the narrator performs a measured, restrained identity – someone who does not overtly challenge the system but still hints at emotional discomfort. She asserts herself subtly through phrases like "I believe they should have..." and by ending with a poignant contradiction: "the birth that should have been normal was anything but". This performative stance blends gratitude with critique, offering a complex view of care that avoids binary judgments.

As demonstrated in narrative 1 and 2, also in narrative 3 "natural birth" is framed as the ideal. Here, I argue that C-section is treated as a failure or last resort ("they should have opted sooner"), which align with Douglas (1987), where the institution's classification system

(normal vs. abnormal birth) dictates care, not the mother's needs. The retrospective label "anything but normal" exposes how institutions pathologize variation, casting the mother's body (not the protocol) as the problem. My argument here is that institutions enforce moral narratives to justify control. The mother's "consent" is procedural – she is *informed* but not *empowered* ("I had no choice"). The repeated phrase "they were following protocol" moralizes institutional inflexibility as "good care", masking its coercive nature. Her subtle critique ("I believe they should have...") hints at unspoken guilt – as if her body, not the system, failed. Her restrained language ("a bit scary," "anything but normal") performs institutional loyalty, avoiding direct blame while still signaling trauma (I have the feeling that she didn't share everything in her narrative). The absence of overt conflict ("No, I wasn't disrespected") reflects how institutions sanitize coercion through bureaucratic politeness. This narrative exemplifies "selective deafness" (Douglas, 1987).

Communication is not dialogue but monologue – she is informed of decisions, not consulted in them. Time, rather than being a neutral factor, is weaponized: prolonged labor is framed as a test of maternal endurance rather than a legitimate medical consideration. Even the praise of "excellent care" functions as a smokescreen, where polished professionalism disguises rigid protocols that strip away agency, rendering her a passive object in the machinery of institutional birth. As sociologist Mary Douglas (1987) cautioned, oppression need not be overtly brutal; it can just as effectively enforce compliance through the cold efficiency of bureaucratic civility. How many women leave "respectful" births feeling unsettled, unable to articulate why – because the institution has trained them to mistake protocol for care? My analysis shows that trauma is not just about overt violence – it thrives in systems where control is polished to a sheen of professionalism.

The **Narrative 4** explores the paradox of medical authority framed in a "respectful" tone that nonetheless instills fear, revealing how technical explanations can manipulate rather than inform. The narrator's central theme is fear arising from clinical explanation, which ultimately shaped her birth choices. Although she reports being treated respectfully, she also reveals how the doctor's technical language about inducing labor – specifically the use of a balloon – was so unclear or overwhelming that it caused panic: "*I was scared to death!*". The narrative contrasts politeness in manner with emotional inaccessibility, and she later reflects that perhaps a natural birth could have worked, suggesting regret rooted in misunderstood information (this

also captures a painful awareness of lost agency, reframing the initial decision as constrained rather than freely made). At a structural level the story pivots on a pressured moment of decision-making, followed by regret, illustrating how fear shapes compliance. This narrative progresses chronologically across two pregnancies, each ending in cesarean births. In my view, the structural turning point is not a clinical event but a retrospective realization prompted by her sister-in-law's explanation. The narrative ends with "Overall it was great", but this feels ironic or reconciliatory, softening the subtle emotional critique that precedes it. There is a clear disconnect between technical expertise and empathetic communication. While she states that the doctor was respectful, the communication failed to empower her with understanding. The doctor explained the procedure, but in a way that excluded her emotionally, leading to choices she now questions. The absence of a companion during her first birth due to COVID further underscores the isolating nature of the experience (which also violates the Brazilian law, that I mentioned before). Interactionally, the dynamic was asymmetrical; though the doctor maintained a veneer of respect, the informational framing was one-sided, prioritizing institutional imperatives over dialogue. Performatively, the narrator portrays herself as rational yet vulnerable – someone who trusted medical advice but later reclaims authority by critically reassessing her experience and exposing the emotional toll of fear-based persuasion. She performs a reflective, diplomatic self, careful not to criticize openly but still allowing the reader to infer emotional discomfort and missed opportunities.

Narrative 5 frames neglect as a form of systemic violence, where the absence of support – whether from staff or a partner – leaves the storyteller physically and emotionally abandoned. The theme of physical immobility mirroring institutional abandonment is powerful – highlighting how lack of communication and presence during critical moments creates lasting emotional imprints. Despite being a scheduled medical event, the experience is framed by fear, exposure, and lack of support. Moments of vulnerability, like the fear of falling or being unable to move ("I remember my huge belly, I couldn't turn around, I remember that I was afraid of falling, the stretcher was high and narrow, I was face up, I didn't move for fear of falling, they left me alone"), symbolize a deeper loss of bodily autonomy within an indifferent system.

Structurally, the story unfolds through fragmented episodes rather than a linear progression, each snapshot – such as being left alone in distress – highlighting institutional apathy. The first birth is brushed over with "I don't remember having anything to say," indicating either

satisfaction or emotional suppression. The second, in contrast, unfolds moment by moment, emphasizing sensory and emotional details: “my huge belly,” “afraid of falling,” “they left me alone.” This shift reflects how emotional memory shapes narrative priority.

Interactionally, the harm stems not from overt conflict but from silence and absence; the lack of meaningful engagement underscores how institutional care can dehumanize by simply ignoring needs. The waiting period, devoid of updates or reassurance, signals a rupture in relational care, where the institutional voice is silent when most needed. This is not just a failure of dialogue, but a failure of presence.

Performatively, the narrator embodies quiet endurance, emphasizing helplessness rather than resistance, yet this very act of bearing witness serves as a critique of a system that fails its patients in subtle but profound ways. In this narrative I argue the existence of freedom of choice in the form of birth, which demonstrates autonomy and agency: "The choice of cesarean was mine, the doctor agreed, because I always had a lot of cramps during my periods. I didn't want to feel the pain of childbirth".

From Mahmood’s (2011 – perspective, the woman’s choice could be seen as an exercise of *active subjectivity* – her decision to opt for a cesarean was not simply compliance with medical authority but a deliberate, ethically grounded choice based on her personal history (painful menstruation) and fear of childbirth pain. Rather than framing agency solely as resistance, Mahmood would highlight how this woman’s alignment with medical intervention (a choice often criticized in natural birth discourses) still constitutes agency, as it emerges from her own embodied experience and values. The fact that the doctor *agreed* suggests a negotiation of power rather than pure submission, fitting Mahmood’s (2011) relational view of agency. However, Rössler’s (2002) more structural approach would push further, asking: Under what conditions was this choice truly autonomous? While the woman frames the decision as hers, Rössler would scrutinize whether her preference was formed in a context free from coercion – whether implicit (e.g., cultural narratives equating vaginal birth with "real motherhood") or structural (e.g., lack of access to holistic pain management options). If her fear of pain was shaped by a medical system that disproportionately emphasizes birth trauma over informed, supportive alternatives, her autonomy may be *procedural* (she consented) but

not fully *substantive* (was her choice truly self-determined, or a product of constrained options?).

My claim is that these three narratives reveal how institutional politeness, and procedural clarity can coexist with emotional harm, limited agency, and miscommunication. In Narrative 3, protocol is respected, but individual needs are muted; in Narrative 4, respectful tone fails to compensate for emotionally ineffective communication; and in Narrative 5, bodily exposure and silence produce a memory of physical and emotional abandonment. Each storyteller performs their identity in nuanced ways – restrained, reflective, or vulnerable – using narrative to critique the disconnect between clinical care and emotional experience, and to reclaim moral voice in systems that often neglect it.

The performative resistance in these accounts (screaming, refusing interventions, critiquing retrospectively) mirrors Richards' (1982) insistence that true progress requires centering women's voices, not just clinical outcomes.

The **Narrative 6** centers on violated expectations, structural neglect, and cumulative trauma. The narrator expresses a strong desire for a humanized birth – a theme that recurs as an unfulfilled aspiration, thwarted not by personal failure but by systemic limitations: “I really wanted a humanized birth that was not available in the city”. Throughout the story, coercion is framed as medical insistence, with the narrator noting she had little freedom, especially during her first cesarean, yet retrospectively acknowledging that the doctor's decision may have saved her baby's life. Still, this moment of medical “success” does not erase the broader emotional harm. Deeply embedded are themes of disrespect, dehumanization, and hygienic neglect – from being told to be quiet during labor pain to medication being administered *without gloves* during a miscarriage. Verbal abuse (“*be quiet, you're exaggerating*”) and unsanitary conditions compound the violation, illustrating how systemic disrespect can escalate into re-traumatization. The theme of cultural and institutional betrayal crescendos when her previously agreed-upon birth plan is reversed: “I told the doctor that I didn't want to go back to that hospital... he said it had to be there. I felt cheated and disrespected.” The recurring emotional injury, layered across multiple reproductive events, reflects a systemic failure to center women's voices, bodies, and trauma histories.

Structurally, the narrative follows a non-linear, episodic format, where past and present events are woven together to build a sense of accumulated harm. The structure reflects discontinuity and circularity – each pregnancy, miscarriage, and delivery revisit a site of trauma, specifically the hospital she wished to avoid. The narrative highlights failed or one-sided interactions, particularly between the narrator and medical staff. Her voice is consistently undermined, ignored, or silenced. When she expresses pain (“I moaned loudly in pain”), she is told she’s “being dramatic”. When she refuses to return to a hospital that traumatized her, her doctor overrides the decision.

The interactional breakdown is stark during her miscarriage, when staff administer medication without proper hygiene or communication. The absence of respectful dialogue and shared decision-making indicates a care environment where patients’ knowledge, consent, and dignity are treated as secondary. Even when medical staff comply (e.g., the doctor initially agreeing to avoid a particular hospital), their follow-through is unreliable, reinforcing the narrator’s sense of betrayal (“I felt cheated”).

Performatively, the narrator performs an identity that is informed, emotionally aware, and morally grounded, yet repeatedly disrespected. She does not present herself as passive or unknowing; she is clear about her preferences and tries to advocate for herself: “I told the doctor that I didn’t want to go back to that hospital.” Her repeated use of morally charged language – “cheated,” “disrespected,” “offended” – shows how she positions herself not just as a patient but as someone wronged. The contrast between her desire for humane care and the institutional coldness and neglect she receives intensifies the performative contradiction: she must endure the system while resisting its terms. Even when she acknowledges the cesarean may have been necessary, this is not a surrender – it’s a layered evaluation, one that leaves room for critique of how those decisions were imposed rather than collaboratively reached.

All the narratives describe medical interventions during childbirth using deeply personal and often traumatic language. Many women normalized their trauma. They recount not only the physical procedures, but also the emotional toll, including fear, humiliation, and loss of agency.

5. Conclusion

5.1 Summary of the Research Findings and Their Implications

This research explored how childbirth narratives function not merely as personal testimonies, but as contested sites of political and epistemic struggle. Centering the lens of obstetric violence, the study examined how women narrate experiences of coercion, loss of autonomy, disrespect, and systemic failure. As expressed by participants, childbirth emerges as a space where autonomy and violation, empowerment and trauma, are continuously negotiated. These narratives reveal how coercion is often misrecognized as care, pain is normalized, and systemic violence is rendered invisible through clinical language and institutional protocols – reinforcing the "cultural blind spot" discussed in section 1.2.3.

Analyzing six detailed narratives from diverse cultural and geographical contexts, the study amplified women's voices using Riessman's (1993) framework to uncover the structural, interactional, and performative dimensions of their storytelling. The open-ended survey design enabled participants to move beyond reductive binaries of "good" or "bad" care, instead revealing a complex emotional landscape where clinical success (e.g., a healthy baby) often coexisted with psychological trauma.

By highlighting the gap between institutional definitions of care and women's lived experiences, the research underscores how medical protocols can obscure coercion, and how emotional harm persists even within seemingly respectful frameworks. The analysis of Adelir and Shantal's cases – both marked by coercion, denial of consent, and institutional disregard – demonstrates that obstetric violence is not incidental but systemic, deeply embedded in gendered power structures and institutional hierarchies. Through CDA (Fairclough, 2013), the study showed how language legitimizes or resists violence. Interventions framed as "technical" or "necessary" often mask the erosion of autonomy, as seen in the criminalization of Adelir and the silencing of Shantal.

Notably, public narratives explicitly used the term "obstetric violence" and identified the storytellers as victims. However, in anonymous narratives – despite exposure to the concept

via the survey form – participants rarely labeled their experiences as violent. They mentioned mistreatment, discomfort, or lack of agency, yet often perceived healthcare staff as simply “doing their job” or “following protocol”. This suggests that without the discursive framing of events as violence, such experiences remain invisible, unrecognized even by those who endure them.

While public narratives often adopted a clearly political tone—naming obstetric violence and asserting victimhood—the six detailed narratives analyzed in this study revealed a more ambiguous and nuanced relationship to the concept. Strikingly, most participants did not frame their experiences in terms of “violence,” even when describing events that involved coercion, neglect, or trauma. This divergence suggests that private, anonymous accounts may resist or avoid political labeling, potentially due to internalized norms, emotional ambivalence, or a desire to preserve trust in the healthcare system. The absence of explicit identification with the term “obstetric violence” in these narratives points to the complex affective and discursive terrain women must navigate when making sense of their births. It also raises critical questions about how and when experiences become politicized, and the role of narrative form, audience, and context in shaping such articulation.

I argue that without naming these actions as violence, we cannot effectively address or challenge them. Storytelling, particularly in public forums, enables retrospective empowerment – transforming formerly passive subjects into active narrators of their own experience. These narratives are transformative: they reframe obstetric violence as systemic, center emotional and embodied knowledge, and call for structural reforms grounded in consent and dignity.

5.2 Reclaiming Birth – Narrative, Power, and Resistance

These childbirth narratives disrupt the bureaucratic scripts of medical records and institutional discourse, replacing them with lived accounts that foreground suffering, resistance, and agency. Shantal’s decision to publicize her birth video and file a formal complaint – despite legal dismissal – demonstrates how testimonial discourse reframes institutional behavior as abusive rather than routine. Supported by feminist analysis and medical expertise, her story contests the legitimacy of unchecked medical authority and reveals the emotional and physical harms often concealed behind procedural justifications. Similarly, Adelir’s experience sparked the

“We Are All Adelir”³⁷ movement, reframing her forced cesarean as a human rights violation. Her story became a symbol of resistance against systemic, gendered control in obstetrics. The power of these narratives lies in their ability to trigger collective recognition, as echoed by anonymous women who stated (regarding Shantal’s case), “I see myself in her place”. In this identification, a counter-public emerges – challenging patriarchal norms and calling for accountability.

A striking insight from these narratives is that patriarchal violence in obstetrics is not limited to male practitioners. Female healthcare professionals also enforce institutional logics, revealing that patriarchy operates as a structural, not merely demographic, phenomenon.

Crucially, storytelling is not merely a therapeutic outlet – it is a political act, as I defended previous. Naming an experience as “violent,” rejecting euphemisms, and speaking out in the face of institutional silencing constitute acts of resistance. These women assert epistemic authority over their bodies and challenge the systems that would render them voiceless.

This thesis calls for a fundamental rethinking of how authority, consent, and care are conceptualized in reproductive contexts. Documenting harm is not enough – we must interrogate the conditions that enable it. The dissonance between lived experience and institutional logic reveals the limits of current paradigms and opens the door for transformative models of care grounded in empathy, informed consent, and genuine respect.

To speak of obstetric violence is to refuse its erasure. It is to insist that childbirth is not merely a private event but a matter of public concern, human rights, and institutional accountability. In these narratives – raw, resistant, and resolute – we find both testimony and blueprint for a more just model of maternity care.

5.3 Contribution and call to Action

This research contributes a nuanced understanding of obstetric violence by avoiding reductive categorizations. It centers emotional truth, cultural context, and systemic critique, offering a

³⁷ “We Are All Adelir”: *Event on Obstetric Violence*, YouTube video, 1:23:15, posted by *Rede TVT*, April 12, 2014, accessed April, 24, 2025: <https://www.youtube.com/watch?v=rV0PLtMzTvs>.

lens that challenges prevailing healthcare narratives. It affirms the validity of women's emotional and embodied knowledge and critiques medical models that prioritize protocol over personhood.

One of the central implications is the urgent need for formal legal recognition of obstetric violence. The absence of an international legal framework for defining and addressing such violence impedes systemic accountability. Without clear definitions and enforceable patient rights, abuse is too easily dismissed as miscommunication or procedural necessity – as seen in the case of Shantal, where coercion was excused as “just protocol.”

Future research should incorporate the perspectives of healthcare providers to examine whether they, too, experience institutional pressure or moral conflict (for example in narrative 1 she had different treatment by different healthcare providers). Exploring both sides may open space for collaborative dialogue and reform. Comparative studies across national healthcare systems could also reveal how ideologies, policy frameworks, and cultural expectations shape birth experiences and determine the boundaries of agency.

Ultimately, this thesis argues that childbirth is a human rights issue. A respectful, autonomous, and safe birthing environment requires more than better training – it demands structural accountability, gender-sensitive legal protections, and international advocacy. These changes cannot happen on their own; they must be written in law and policy, supported by education, and informed by those whose stories have too long been ignored.

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7. Appendix 1

Original version:

Olá!

Meu nome é Gianna, sou advogada e atualmente faço mestrado de Práticas de Gênero na Universidade de Gotemburgo. Minha pesquisa é sobre violência obstétrica, e estou buscando relatos para compreender melhor as experiências das mulheres nesse contexto.

Gostaria de convidá-la a compartilhar, de forma anônima, sua experiência de parto. Sua contribuição é essencial para dar visibilidade a essa realidade e auxiliar no desenvolvimento da minha pesquisa.

Para ajudar a entender um pouco sobre o tema, trago o conceito de violência obstétrica, conforme definido na Lei Orgânica da Venezuela (art. 15): "A apropriação do corpo e dos processos reprodutivos das mulheres por parte dos profissionais de saúde, expressa em um tratamento desumanizado, no abuso da medicalização e na patologização de processos naturais, resultando na perda da autonomia e da capacidade de decidir livremente sobre seus corpos e sua sexualidade, impactando negativamente sua qualidade de vida."

Se você se sentir confortável, gostaria que compartilhasse sua vivência no período pré-parto, durante e pós-parto. Algumas perguntas que podem te guiar nesse relato:

- Você se sentiu respeitada e informada sobre os procedimentos realizados?
- Teve liberdade para tomar decisões sobre seu próprio corpo?
- Sentiu-se pressionada ou forçada a aceitar alguma intervenção médica?
- Se sentiu desconfortável em algum momento em relação ao atendimento, em relação a estrutura do hospital?
- Teve alguma dificuldade para ter contato com seu filho?
- Houve alguma situação em que você se sentiu desrespeitada, desvalorizada ou violentada?

Não é necessário se identificar, mencionar nomes de hospitais, médicos ou outros profissionais. O importante é registrar sua experiência (seja ela boa ou ruim), e como você se sentiu (feliz, triste, ansiosa, assustada, etc). Também gostaria de saber se você observou algo durante esse processo que você ache que precisa ser melhorado (seja nos atendimentos, no hospital, etc). Agradeço imensamente por sua colaboração. Sua história pode ajudar a ampliar a compreensão sobre esse tema e fortalecer a luta por um atendimento mais humanizado. Obrigada!

English version:

Hello!

My name is Gianna, I am a lawyer and I am currently studying for a Master's degree in Gender Practices at the University of Gothenburg. My research is on obstetric violence, and I am looking for stories to better understand women's experiences in this context.

I would like to invite you to share, anonymously, your experience of childbirth. Your contribution is essential to give visibility to this reality and to help in the development of my research.

To help you understand a little about the subject, I bring the concept of obstetric violence, as defined in the Organic Law of Venezuela (art. 15): "The appropriation of women's bodies and reproductive processes by health professionals, expressed in dehumanized treatment, in the abuse of medicalization and in the pathologization of natural processes, resulting in the loss of autonomy and the ability to freely decide about their bodies and their sexuality, negatively impacting their quality of life."

If you feel comfortable, I would like you to share your experience in the pre-partum period, during and after childbirth. Some questions that can guide you in this report:

- Did you feel respected and informed about the procedures performed?
- Did you have the freedom to make decisions about your own body?
- Did you feel pressured or forced to accept any medical intervention?
- Did you feel uncomfortable at any time regarding the care or the structure of the hospital?
- Did you have any difficulty in having contact with your child?
- Was there any situation in which you felt disrespected, undervalued or violated?

It is not necessary to identify yourself, mention the names of hospitals, doctors or other professionals. The important thing is to record your experience (whether good or bad), and how you felt (happy, sad, anxious, scared, etc.). I would also like to know if you observed anything during this process that you think needs to be improved (whether in the care, in the hospital, etc.). I am immensely grateful for your collaboration. Your story can help to broaden the understanding of this topic and strengthen the fight for more humanized care. Thank you!

8. Appendix 2

Narrative 1

Hello, I am Brazilian and had my first baby in Sweden. The monitoring of the baby with the midwife was not satisfactory in the beginning, I didn't trust the professional due the visits were too quick and she didn't check basic things like my blood pressure, for example. After changing the health center (I checked comment at Google maps), I met a new midwife that was very good and answered all my questions in a very welcoming and professional way. Regarding my labor, everything was planned to be natural as it is the standard procedure in Sweden. I personally didn't like in the beginning the idea that I would not be able to choose natural or c-section labor, but after talking with the midwife and reading more about natural labor I felt more confident and less afraid about it. When my baby was 39 weeks I started to feel the contractions at 5am in a Monday, they were very painful and coming irregularly but often, every 10min or 15min. We called the hospital and they said we should stay home and just go to the hospital when the contractions are like every 5 minutes. That same day, we decided to go to the hospital to check if everything was going ok, as it was our first baby, we were very anxious. I also was already tired from the pain and couldn't sleep. Before going to the hospital we called them and they were very friendly saying that we could go there and they would check me and the baby and give me medicine to be able to sleep and that we could even sleep there and in the next morning they would decide if I should stay or go home again. What happened there when we arrived was totally different. They didn't let us stay and they gave me just a kind of paracetamol for my pain that didn't help me at all to sleep. We went back home and we spent the entire Tuesday at home. The pain was getting more difficult to handle as I was very tired because I couldn't sleep the night before. On Tuesday night we called again to the hospital and again they said we could go there and they would help me to sleep. This time we met different people and they were super nice and did exactly what they said by phone. So, me and my husband got a room and they gave me medicine to stop the pain I was feeling and I slept the whole night. On Wednesday morning the contractions started again but the dilation did not progress. Then they started giving me medication to induce more contractions so that the dilation could progress. Everything was explained to me, and I felt quite safe in the process. I asked for an epidural and I had more energy to continue the process. However, late in the afternoon of that Wednesday, I started to have a fever and the baby's heartbeat accelerated because of it. They tried to give me IV fluids to see if the fever was not because I was

dehydrated. It didn't work and at that moment I started to feel strong pain with each contraction again, but the dilation still didn't progress. It was already night and the doctor came to check if my baby could be under stress and that shook me a lot. The strong pain, the tiredness and the idea that my baby could be under stress because the birth was taking so long shook me emotionally. I started to ask for a c-section, but the team insisted on trying a natural birth. I had to scream that I couldn't take the pain any longer so the doctor could come back and make sure that the dilation wasn't progressing and then finally give me the option of a c-section. The midwife said that they were going to prepare the operating room and that it would take an hour to do so. I started screaming that I couldn't take the pain and that I didn't want my baby at risk for another hour. I feel like they wanted me to wait another hour to see if the dilation wasn't progressing and to have a natural birth. My husband talked to the team asking for something to be done, that we couldn't wait that long. The team came back to the room and said that they were going to prepare me for surgery and that they were going to do the c-section right then. Finally, the birth happened, the surgery went very smoothly, and all the professionals who participated were very welcoming too. My baby was born healthy, and I stayed with him after I went to the room. We stayed in the hospital for another 4 days because of my infection and because the baby wasn't gaining weight, but we were well looked after during that time. I believe that the professionals tried to do the best they could for me, but I consider my birth experience traumatic because they were insisting to keep natural labor, even though I couldn't handle the pain, my dilation wasn't progressing and the risk to my baby.

Narrative 2

- Você se sentiu respeitada e informada sobre os procedimentos realizados? - Na Irlanda os atendimentos durante a gravidez são divididos e intercalados entre médicos do hospital maternidade e o seu médico de família. No início eles informam certinho todas as semanas e datas a serem feitas as consultas, fica sobe nossa responsabilidade marcar as consultas. - Porém senti muita falta em relação a instruções de como é um parto, quais as fases, o que pode acontecer, quais as minhas opções. Se temos dúvidas, nós temos que trazer todos os pontos e perguntar e infelizmente nem sempre eles informam. Busquei muita informação por fora e isso foi essencial. - Jamais eles realizaram qualquer tipo de procedimento sem minha permissão ou sei avisar.
- Teve liberdade para tomar decisões sobre seu próprio corpo? - Tive liberdade para tomar minhas decisões, mas entendo que isso aconteceu porque me informei muito sobre o que era

melhor para mim no momento do parto e em cada fase da gestação com profissionais de fora e com isso me senti segura de pedir que fosse respeitado as minhas escolhas.

- Sentiu-se pressionada ou forçada a aceitar alguma intervenção médica? - me senti pressionada em 2 situações específicas: quando eu estava de 41 semana e pedi um procedimento de descolamento da membrana e eles colocaram em mim muita pressão de que minha bolsa poderia estourar, de que eu deveria induzir meu parto. Eu pedi para eles monitorarem meu bebê, checarem o coração e tudo como ele estava e se estivesse bem eu me sentia segura de não induzir e fazer o procedimento. Foi tudo bem, não aconteceu nada do que eles me pressionaram falando que iria acontecer, eu fui para minha casa e no outro dia minha bebê veio naturalmente sem nenhuma intervenção e nem indução. - Outra situação foi durante o meu parto, eu disse várias vezes que não queria um gás de relaxamento e eles insistiam muito até colocavam na minha mão para eu usar. Meu esposo interviu e disse pra me respeitarem se eu não quisesse.

- Se sentiu desconfortável em algum momento em relação ao atendimento, em relação a estrutura do hospital? Em geral médico e midwife's foram bem humanos, principalmente as durante o trabalho de parto e logo após ter o bebê o cuidado e atendimento foram maravilhosos. Porém durante a gestação, em uma das consultas eu tive muita dúvidas sobre um exame específico e fui tirar as dúvidas com uma midwife que estava me atendendo, ela se irritou, perguntou minha nacionalidade e quando eu respondi ela disse que mulheres do meu país eram assim mesmo, que perguntavam demais. Foi péssima essa experiência em específico.

- Teve alguma dificuldade para ter contato com seu filho? - nenhum! Ao contrário, eles fazem muita questão de entregar o bebê nas nossas mãos para gente ficar com ele assim que nasce. Equipe de parto e cuidados pós parto são muito bons.

- Houve alguma situação em que você se sentiu desrespeitada, desvalorizada ou violentada? - me senti desrespeitado por essa midwife que não tirou minhas dúvidas, que ainda por cima falou isso a meu respeito e de outras mulheres da minha nacionalidade. Foi desrespeitoso. E sim, mulheres do meu país levam a saúde muito a sério, somos bem informadas e buscamos um cuidado preventivo em relação a saúde. Tenho orgulho disso, pois é uma forma excelente de não cairmos no sistema hospitalar e aceitar tudo o que nos é proposto sem conhecimento.

Narrative 3

- Você se sentiu respeitada e informada sobre os procedimentos realizados? Sim, me senti respeitada. Todos os procedimentos que iriam realizar primeiramente avisavam o que seria

realizado.

- Teve liberdade para tomar decisões sobre seu próprio corpo? Não, depois de muito tempo tentando procedimento normal e sem sucesso, acredito que deveriam ter optado pela cesária.
- Sentiu-se pressionada ou forçada a aceitar alguma intervenção médica? Não tive escolha de optar pela cesária, mesmo depois de muito tempo aguardando dilatação.
- Se sentiu desconfortável em algum momento em relação ao atendimento, em relação a estrutura do hospital? Não, o atendimento pelos profissionais foi ótimo, percebemos que eles estavam seguindo protocolo. A estrutura do hospital era ótima.
- Teve alguma dificuldade para ter contato com seu filho? Não, elas realizaram os procedimentos que precisava ser feito e assim que foi possível ele retornou para quarto.
- Houve alguma situação em que você se sentiu desrespeitada, desvalorizada ou violentada? Não. Porém, o processo todo foi um tanto assustador pelo fato de saber que estavam tentando parto normal mesmo não havendo evolução na dilatação. Na sequência tive complicações devido ao parto normal e tive que ser submetida a uma cirurgia. Portanto, o parto que deveria ser “normal” não teve nada de normal.

Narrative 4

Olá, boa tarde! Tive dois partos. Ambos tentei parto de via normal, mas por fim, não evoluíram e foram para a cesárea. Meus médicos foram respeitosos na medida do possível! Mas na época da primeira gestação, era atípica, pois estávamos iniciando uma pandemia COVID! Meu esposo não conseguiu entrar comigo no sala de parto! Fiquei sem acompanhante! E tanto no primeiro quando no segundo partos, o médico foi tendencioso à cesárea! E também, após tentar parto normal nas duas situações, poderia ter induzido, mas a forma como ele me explicou sobre o balão, ficou sem condições! Morri de medo! Hoje, após minha cunhada ter o parto normal, me explicou como funcionava. Teria dado certo talvez partos normais! Ele explicou mas foi técnico e fiquei assustada. No geral foi ótimo!

Narrative 5

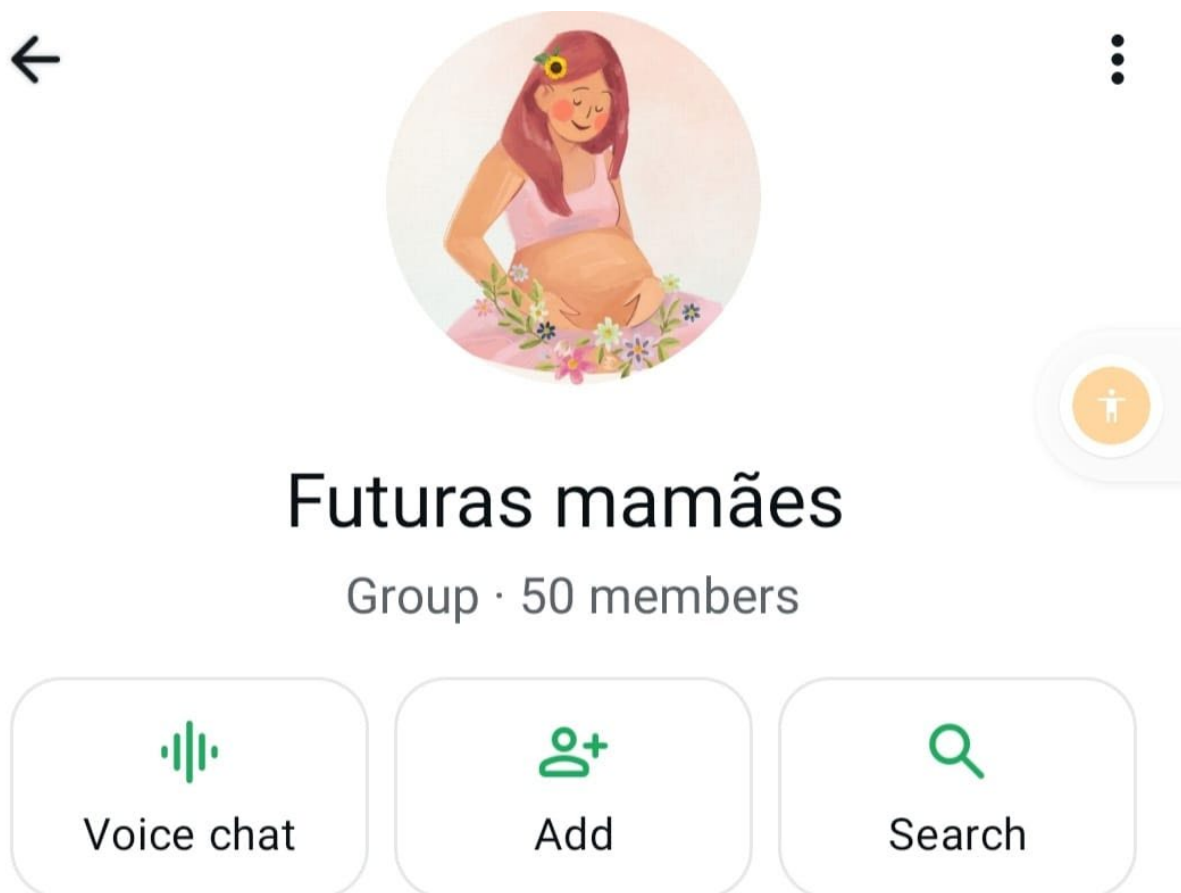
Já tem um tempo que tive meus filhos, diferença de dois anos de um para outro. Ambos foram cesárias. A escolha da cesária foi minha, o médico concordou, pois sempre tive muita cólica nos períodos das menstruações. Não queria sentir as dores do parto. A primeira, não lembro de ter algo a relatar, afinal era tudo novo, era a primeira vez. Tenho uma forte lembrança da segunda cesária, fui mais apreensiva, lembro-me que a bolsa rompeu, estava em casa, fomos

ao hospital, eu e meu marido. O médico foi avisado, a enfermeira me recebeu disse que ele estava a caminho, mas me colocou numa maca, fiquei no corredor, meu marido não pode ficar junto, lembro da minha barriga enorme, não podia me virar, me lembro que tive medo de cair, a maca era alta e estreita, estava de barriga para cima, não me mexi de medo de cair, me deixaram sozinha. Fiquei agarrada segurando a lateral da cama e passou um certo tempo, até que o médico veio. Só daí iniciaram os procedimentos, fiz laqueadura também e, fiquei três dias hospitalizada.

Narrative 6

Sim, tive informação, mas eu queria muito o parto humanizado que não tinha na cidade, nas duas gestações houve insistência para que fosse realizada cesárea. Não tive muita liberdade, mas a decisão médica se mostrou mais acertada, pois na primeira gestação a bebê nasceu roxa. Sim. Estrutura ruim, enfermeira, enquanto me auxiliava a caminhar pra sala de cesárea, após horas em trabalho de parto, com fraqueza e muita dor constante, como eu gemia alto de dor, ela mandou eu ficar quieta, que estava fazendo drama, exagerando, me senti ofendida. Quando perdi uma gestação, nesse mesmo hospital, não me aplicaram a medicação corretamente, via vaginal, não usavam luvas e pegavam remédio com a mão pra me entregar pra eu tomar, foi terrível a experiência da curetagem com a equipe hospitalar e o tratamento como um todo. Falei pro médico quando engravidei que não queria esse hospital novamente, ele concordou, quando eu fui fazer o parto, disse que tinha que ser lá, me senti enganada e desrespeitada, por ter sido categórica que não gostaria de retornar lá. Não tive dificuldade pra ver minhas filhas. Sim, tiveram essas situações com relação ao local do parto, forma do parto (mas nesse caso a insistência médica se mostrou adequada), tratamento e orientação da equipe de enfermeiras e parteiras enquanto tentava o normal (situação acima relatado sobre silenciar), as manobras que me foram orientadas a fazer pro bebê ‘descer’ me deixaram com sequelas na época (tais como hemorróidas, dor na coluna, distensão de músculo), principalmente a forma que fui tratada pela equipe de enfermagem enquanto era medicada quando perdi o bebê, a falta de higiene e estrutura hospitalar antiga, aparentemente suja, muita ferrugem nos móveis.

9. Appendix 3



Se tornar mãe é algo muito especial e que traz algumas inseguranças, ainda mais se vamos ter bebê em outro país com a cultura tão diferente da nossa. Esse grupo foi idealizado para trocas de experiências entre mães, futuras mães e para aquelas que planejam ter bebê aqui na Suécia 🧒👩