# THE POWER TO DEFINE. OBSTETRIC VIOLENCE: BETWEEN TENSIONS, DEBATES AND THE ROMANIAN CASE STUDY

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## Abstract

*In April 2024, at the request of the FEMM Committee, the European Parliament announced the launch of the study "Obstetric and Gynaecological Violence in the EU - Prevalence, Legal Frameworks, and Educational Guidelines for Prevention and Elimination." In May 2024, the European Commission also announced the launch of a commissioned study on obstetric violence, "Obstetric Violence in the European Union: Situational Analysis and Policy Recommendations." In September 2024, the Association of Independent Midwives announced the release of the first research report on obstetric violence in Romania. We are talking about a growing interest in bringing to the public and formal agenda issues related to the quality of care that women receive in interactions with the medical system, especially in relation to the topic of reproductive health. In this paper, I aim first to discuss the controversial aspects of defining and classifying inappropriate, abusive, or violent interactions, particularly in relation to obstetric health. I will attempt to answer the question, "What is obstetric violence, and who has the authority to define this term?" The answer to this question is crucial, as it will impact how obstetric violence can be integrated into a solidified legal framework. Secondly, I will analyze the Romanian case, briefly reviewing the quantitative research results conducted in collaboration with the Association of Independent Midwives, as well as examining how the debates, controversies, and potential pathways toward a legal framework are developing about the complex issues encapsulated by the concept of obstetric violence.*

**Keywords:** *obstetric violence, definitions, controversies, Romania.*

## 1. Introduction

In September 2024, after approximately nine months of work alongside a research team consisting of two sociologists with solid experience and myself (with a background in political science and expertise in gender equality and gender-based violence), we presented the findings of the first descriptive cross-sectional study about obstetric violence done in Romania. The primary objective of this research was to identify Romanian women's perceptions of their experiences with care during pregnancy, childbirth, and the postpartum period in clinics and hospitals over the past five years (2018–2023). I accepted this challenge solely because it aimed to capture women's perceptions regarding childbirth experiences and because I would be working with a research team well-versed in quantitative methods and gender studies. Moreover, since a significant part of my research interest has always focused on domestic and gender-based violence, I thought my expertise would be beneficial in carrying out this study.

The entire research team understood from the beginning the complexity and interdisciplinary nature of the subject being

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investigated. Throughout the research, data collection, and analysis phases, we made continuous efforts to seek feedback, comments, and revisions from medical professionals and other practitioners in the field of obstetric medicine. We were committed to a transparent and ethical approach to data collection and presentation, clearly acknowledging the study's limitations. At the same time, we adopted a clear theoretical perspective aligned with our expertise in gender studies, which influenced our choice of the definition of obstetric violence used in the study, as well as the analysis and interpretation of the collected data. This perspective was especially influential when it came to designing potential solutions or interventions to reduce the phenomenon investigated.

These considerations were crucial for several reasons. Upon reviewing the relevant literature, we realized, on the one hand, that there is still no universally accepted definition of obstetric violence—one that could provide us with a clearly defined concept that is easier to investigate, integrate into comparative analyses, and transfer into a coherent legal framework. On the other hand, we recognized that the concept is fraught with controversies and tensions, as well as dynamics that deserve in-depth investigation. These dynamics involve the power to define a concept, particularly one whose definition necessarily carries legal implications and legitimizes demands for policies that states must adopt and implement.

Building on this experience, my aim in this paper is to anchor the research findings regarding Romanian women's perceptions of their experiences with pregnancy, childbirth, and postpartum care in Romanian clinics and hospitals within a deeper analysis of the debates and controversies surrounding the definition of a form of violence that women experience[1]. As we saw, this form of violence is gaining increasing attention not only from citizens and non-governmental organizations but also from states and the EU.

## 2. Defining Obstetric Violence – Tensions and Controversies.

At the outset, it's important to note that there is no widely accepted definition of obstetric violence, primarily due to controversies surrounding the conceptualization of the term. As we will see from the examples below, while the conceptualizations in most definitions are closely aligned, there are certain hesitations in labeling problematic aspects as violence. From my perspective, analyzing the arguments for and against using the term "violence" is closely tied to, on one hand, the responsibilities and legal implications associated with different definitions, and on the other, to the degree of understanding and awareness regarding the link between obstetric violence and gender-based violence. This includes viewing obstetric violence as a form of violence situated at the intersection of the healthcare system (in terms of access to health services), a set of sociocultural norms and often patriarchal rules (such as stereotypes, biases, and traditional gender roles), and the dominant or counter-dominant discourses on the place of the state and the market in providing healthcare services, reproductive health, as

[1] The violence, abuse, or inadequate treatment that women experience during pregnancy, childbirth, and postpartum are not new phenomena; they have always existed. However, they have only recently begun to enter the formal agenda in the EU, becoming a topic of public attention, research, and debate, particularly at the level of Latin America.

well as in naturalizing, pathologizing, and medicalizing women's bodies, especially concerning reproductive aspects[2].

Perhaps the best way to illustrate the hesitations in naming certain forms of abuse as violence is in how the World Health Organization (WHO) refers to the issue. In a report commissioned by the European Parliament, it's noted that WHO "conceptualizes" obstetric violence in terms of "any abuse, disrespect, and mistreatment in childbirth caused by healthcare professionals that results in violations of women's dignity (this can consist of outright physical abuse, humiliation caused by verbal abuse, lack of confidentiality, and neglect that results in unnecessary pain and avoidable complications)"[3], but without explicitly mentioning the term "obstetric violence."[4]

The study also presents two other definitions of obstetric violence. The one used by France's High Council for Equality between Women and Men (HCE), an independent governmental body, refers to the concept as the "most serious sexist acts that can occur in the context of gynecology and obstetrics follow-ups." This definition includes "sexist acts during gynecological and obstetrical follow-up—gestures, comments, practices, and behaviors performed or omitted by one or more healthcare staff members during gynecological and obstetrical follow-up, which are part of a history of gynecological and obstetric medicine driven by a desire to control women's bodies (sexuality and reproductive capacity). These acts can take various forms, from seemingly innocuous to the most serious, by caregivers—of all specialties, both women and men—who may not necessarily intend to be abusive."[5]

Another definition mentioned is the one used in Portugal, following a 2021 parliamentary resolution, which defines "obstetric violence" as any conduct directed at women, during labor, childbirth, or the postpartum period, carried out without their consent, which constitutes an act of physical or psychological violence that causes pain, harm, unnecessary suffering, or restricts their ability to choose and make decisions.[6]

Even though in Europe, no Member State has passed a national law directly addressing and defining obstetric violence, the European Commission report references several definitions operationalized in other legal contexts, including Italy, Germany, Spain, and France. For instance, Catalonia's Law No. 17/2020 explicitly addresses obstetric violence and the violation of sexual and reproductive rights as forms of gender-based violence, introducing the following definition in Article 4.d: "Obstetric violence and violation of sexual and reproductive rights consist of preventing or hindering access to truthful information necessary for autonomous and informed decision-making.

[2] Nisha Z. 2021, *The Medicalisation of the Female Body and Motherhood: Some Biological and Existential Reflections*, in "Asian bioethics review", no.14(1), p. 25–40 (https://doi.org/10.1007/s41649-021-00185); Vieira, E. M. 2003, *A medicalização do corpo feminino*, Rio de Janeiro: Fiocruz; Costa T., Navarro Stotz E., Grynszpan D. et al. 2007, *Naturalization and medicalization of the female body: social control through reproduction*, Interface (Botucatu), Vol. 3(se):0-0. DOI: 10.1590/S141432832007000100006.

[3] World Health Organisation. Statement on the Prevention and Elimination of Disrespect and Abuse during Facility-Based Childbirth, World Health Organization; Geneva, Switzerland: 2015.

[4] Silvia Brunello, Magali Gay-Berthomieu, Beth Smiles, Eneidia Bardho, Clémence Schantz et alii, *Obstetric and gynaecological violence in the EU - Prevalence, legal frameworks and educational guidelines for prevention and elimination* [Research Report] European Parliamentary Research Service. 2024. ⟨hal-04574789⟩, p. 14.

[5] Silvia Brunello, Magali Gay-Berthomieu, Beth Smiles, Eneidia Bardho, Clémence Schantz, *et alii*, *op. cit*., p. 14.

[6] *Ibidem*

This can affect different areas of physical and mental health, including sexual and reproductive health, and may hinder women's decisions regarding their sexual practices, reproductive choices, and conditions of childbirth as per specific legislation. It includes forced sterilization, forced pregnancy, impeded access to legal abortion, restricted access to contraceptives, STI and HIV prevention methods, assisted reproduction, as well as gynecological and obstetric practices that do not respect a woman's choices, body, health, and emotional processes of the woman."[7]. Similar definitions are present in the case of Italy and Germany[8]

The literature on the legal framework for obstetric violence cites **Venezuela** as the "pioneer country in constructing the term and its legal definition in 2007." This definition considers obstetric violence to be "any behavior, action, or omission triggered by a team of healthcare professionals, directly or indirectly, in a public or private setting, characterized by the domination of a woman's body and her reproductive processes, manifesting as dehumanized care, medicalization abuse, and pathologizing reproductive physiological processes, resulting in the loss of a woman's autonomy and capacity for free decision-making, negatively impacting her quality of life and well-being."[9]

Without aiming to provide an exhaustive overview of the various definitions of obstetric violence, I believe that, after reviewing these definitions, it becomes apparent that they have a high capacity to capture and describe the phenomenon. They are carefully formulated and, despite being produced in different contexts, by different organizations, at different times, they contain many of the same elements, clearly synthesized in the European Parliament's report published in April, which, in its attempt to outline a definition of the term, enumerates the core elements compiled from previous studies. Thus, in this report, obstetric violence is identified as:

- "Psychological, physical, and sexual abuse during obstetric and gynecological consultations—this includes humiliating behaviors such as denying privacy; physical abuse; coercion, such as restricting movement or denying choice of birth position; non-consensual vaginal or rectal penetration for medical examinations; discrimination/neglect/failure to be treated with dignity during pregnancy and gynecological consultations, infantilization, verbal abuse through inappropriate comments, ridicule, or raised voices.
- Forced medical procedures or procedures performed without consent—including forced contraception, forced sterilization, forced abortion, any medical act/examination performed without explicit consent.
- Non-medically necessary (harmful) procedures—such as routine labor induction, routine cesarean sections, routine episiotomies, non-evidence-based medical practices like Hamilton's maneuver and

[7] Silvia Brunello, Magali Gay-Berthomieu, Beth Smiles, Eneidia Bardho, Clémence Schantz, et al.. Obstetric and gynaecological violence in the EU, *op. cit*, p. 15.

[8] Patrizia Quattrocchi, 2024, *Obstetric violence in the European Union: Situational analysis and policy recommendations*, Directorate-General for Justice and Consumers Directorate D — Equality and Non-Discrimination Unit D.3 Gender Equality, pp. 27-28.

[9] Ferrão A.C., Sim-Sim M., Almeida V.S., Zangão M.O., *Analysis of the Concept of Obstetric Violence: Scoping Review Protocol*, *J. Pers. Med.* 2022, *12*, 1090. https://doi.org/10.3390/jpm12071090, p. 3 *apud* Pérez D'Gregorio R., *Obstetric violence: A new legal term introduced in Venezuela*, in Int. J. Gynaecol. Obstet. 2010, 111, 201–202.

fundal pressure.

- Refusal or delay of care—including delay or refusal of pain management during procedures, delay or refusal of abortion care, withholding of information, denial of contact, and refusal to allow a birth companion."[10]

In this context, a natural question arises: what are the controversies and tensions that make it difficult to adopt a unified definition and consequently direct efforts toward building an adequate legal framework? Various studies highlight, first and foremost, the reluctance of healthcare professionals to use the term "violence," with many preferring terms like "abuse," "disrespect," and "mistreatment in childbirth."[11] In a 2023 study on the perceptions of obstetrics physicians regarding "obstetric violence," of the 506 participants, 374 (73.9%) considered the term obstetric violence harmful to professional practice[12]. Another critique from healthcare professionals is that the term "violence" itself can be seen as an unfair accusation against medical staff.[13] Leila Katz dismantles this controversy, calling it "unreasonable," as the adjective "obstetric" is not exclusively associated with the medical doctor.[14]

Another element brought up is the correlation of the term violence with a certain intentionality in harmful acts, which can have serious implications for professionals since intentionality in cases of violence is automatically linked to criminal law. Additionally, there is the argument that the use of the term violence refers strictly to individual malpractice, suggesting that these forms of violence are not actually systemic[15] and should be investigated on a case-by-case basis, without assigning such a broad scope to the phenomenon. We now have a clearer picture of the tensions surrounding the definition of obstetric violence and the alternative terminology used. Associating violence with intentionality and thus with responsibility and possible punishments helps us understand, from a new perspective, the lack of consensus on this issue. The distinction between individual intentionality in obstetric violence and "mistreatment that occurs as a form of structural violence, explained by the precarious conditions of health systems and the working conditions of professionals, with the potential to reduce

[10] Silvia Brunello, Magali Gay-Berthomieu, Beth Smiles, Eneidia Bardho, Clémence Schantz *et alii*., *op. cit*., pp. 13-14.

[11] Ferrão, A.C.; Sim-Sim, M.; Almeida, V.S.; Zangão, M.O., *op. cit*., p. 3, *apud* Sen, G.; Reddy, B.; Iyer, A. *Beyond measurement: The drivers of disrespect and abuse in obstetric care*, in Reprod. Health Matters 2018, 26, 6–18. [CrossRef].

[12] Terribile DC, Sartorao Filho CI, *Perceptions of the Brazilian obstetrics physicians about the term obstetric violence: a cross-sectional study*, Rev Assoc Med Bras (1992). 2023 Mar 3;69(2):252-256. doi: 10.1590/1806-9282.20220945. PMID: 36888765; PMCID: PMC9983464.

[13] Zanardo GLP, Uribe MC, Nadal AHRD, Habigzang LF, *Violência Obstétrica no Brasil: uma revisão narrativa*, Psicol Soc. 2017; 29: e155043.

[14] Katz, Leila et alii, *Who is afraid of obstetric violence?*, in Revista Brasileira de Saúde Materno Infantil 20 (2020): 623-626. 10.1590/1806-93042020000200017, pag 625.

[15] Silvia Brunello, Magali Gay-Berthomieu, Beth Smiles, Eneidia Bardho, Clémence Schantz *et alii*, *op. cit*., p. 81, *apud* Ayres-de-Campos D., Louwen F., Vivilaki V.,Benedetto C., Modi N., Wielgos M., Tudose M. P., Timonen S., Reyns M., Yli B., Stenback P., Nunes I., Yurtsal B., Vayssière C., Roth G. E., Jonsson M., Bakker P., Lopriore E., Verlohren S. Jacobsson B., European Association of Perinatal Medicine (EAPM), European Board and College of Obstetricians and Gynaecologists.

their ability to ensure the best possible care for women"[16] becomes important.

However, while terms like "disrespect and mistreatment"[17] reflect relevant differences from "violence," when it comes to the distinction between "abuse" and "violence," the differences are often imperceptible, and the two terms are frequently used interchangeably. Preference for such terminology is partly supported by the idea that "violence" is too harsh a term, which may antagonize professionals who play a fundamental role in addressing the phenomenon, as seen in WHO's strategy[18]. However, if we analyze how these alternative terms are defined, we realize that the scope is essentially the same, and there are reasons to believe that there is a deliberate softening of language, intended to avoid offending those that are harming. But in a world where women are the basic victims of different forms of domination and abuse, it is also worth questioning the legitimacy of calls for softer terminology, particularly when these calls primarily come from those accused of engaging in harmful behaviors. While substantial debates on how we define obstetric violence are necessary and should involve all relevant stakeholders, this question remains valid.

Leila Katz also brings up an element that seems to have been overlooked by obstetric professionals, but which is largely part of the solution to the tensions outlined above: understanding obstetric violence as gender-based violence and, therefore, directly linked to structural and systemic factors. Katz also notes that "violence can result from systemic failures at various levels of care in health systems, so the term should not be understood as synonymous with 'violence committed by the obstetrician."[19]. Recognizing, therefore, obstetric violence as a reality does not mean blaming any specific professional category. This violence is not only direct but also structural, reflecting the patriarchal norms prevailing in society and healthcare practices. Thus, even professionals who intend to care are situated in a care context that not only normalizes but constructs discursive rhetoric lacking a scientific basis to refuse recognition of practices that are actually violent.[20]

The connection between obstetricians' reluctance to use the term "violence" and a limited understanding[21] of the structural/systemic nature of this type of violence is clearly highlighted in a study aimed at evaluating health sciences students' perceptions of obstetric violence and identifying possible changes after an educational intervention. Before presenting the study's results, the authors note that training on obstetric violence had a much higher participation rate than initially expected, and that the sample consisted primarily of women (89.7%). The

[16] Ferrão, A.C.; Sim-Sim, M.; Almeida, V.S.; Zangão, M.O., *op. cit.*, p. 4, *apud* Bohren, M.A.; Vogel, J.P.; Hunter, E.C.; Lutsiv, O.; Makh, S.K.; Souza, J.P.; Aguiar, C.; Saraiva Coneglian, F.; Diniz, A.L.; Tunçalp, Ö. et alii *The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review*, PLoS Med. 2015, 12, e1001847. [CrossRef].

[17] "the concept of mistreatment is broader by allowing us to separate the issue of individual intentionality in violence and link it within the scope of quality in health", Ferrão, A.C.; Sim-Sim, M.; Almeida, V.S.; Zangão, M.O. *op. cit.*, p. 11 *apud* Sen, G.; Reddy, B.; Iyer, A. *Beyond measurement: The drivers of disrespect and abuse in obstetric care*, Reprod. Health Matters.

[18] Ferrão, A.C.; Sim-Sim, M.; Almeida, V.S.; Zangão, M.O., *op. cit.*, p. 4.

[19] *Idem* p. 625.

[20] *Idem* p. 625.

[21] Which is completely understandable in patriarchal societies, in fact being the basis on which obstetrical and gynecological violence is perpetuated.

intervention consisted of an 8-hour seminar (including a theatrical performance on obstetric violence in the delivery room, a master class on legal aspects presented by a health law specialist, a roundtable with professionals from different fields sharing their experiences, and another roundtable where four volunteer mothers narrated their birth experiences). The study concluded that a formative activity aimed at raising awareness and reflecting on obstetric violence helps students recognize this type of violence and identify it; women in the study perceived all points raised on the OV scale as having higher OV; a normalization of this type of violence was observed according to the students' year of study (with a lower perception of OV among more advanced students); and a normalization of these obstetric practices based on personal experience with pregnancies and births (with a decreased perception of OV after having been pregnant or given birth)[22].

Similarly, the European Parliament report emphasizes that obstetric and gynecological violence should not be equated with medical malpractice or negligence due to its structural nature, which must be addressed comprehensively, showing how it impacts women's human rights, equality, health, and reproductive autonomy[23].

Finally, these debates could be solved by considering the importance of the perspective of women and all those affected by this form of violence. Increasingly, research highlights the traumatic experiences of women related to sexual and reproductive health, including various forms of obstetric violence to which they are subjected[24]. Ethical considerations are also critical when discussing obstetric violence. Based on these premises, a study using qualitative methodology, in which 24 midwives participated in three focus groups, revealed that obstetric violence infringes on the basic principles of bioethics (American principles of non-maleficence, beneficence, autonomy, and justice, as well as European principles of vulnerability, integrity, and dignity), as it involves four major categories of ethical issues: the maleficence of forgetting my vulnerability, beneficence requires respect for my integrity and dignity, my autonomy is being removed from me, and a problem of social justice towards us, women. The study also emphasizes that it is not as important to focus on whether it is called violence or not; the critical issue is that women have such negative experiences during childbirth, and measures must be taken to improve the quality of obstetric care[25].

## 3. Obstetric Violence in Romania – A Case Study

### *a) The Experience of Giving Birth in Romanian Hospitals.*

As noted at the beginning of this article, in September 2024, together with Laura Grunberg and Crina Radu, and with the support of the Association of Independent Midwives, we published the

[22] Mena-Tudela D, González-Chordá VM, Soriano-Vidal FJ et alii, *Changes in health sciences students' perception of obstetric violence after an educational intervention*, Nurse Education Today. 2020 Feb;88:104364. DOI: 10.1016/j.nedt.2020.104364. PMID: 32120084.

[23] Silvia Brunello, Magali Gay-Berthomieu, Beth Smiles, Eneidia Bardho, Clémence Schantz *et alii, op. cit.*, pp. 81.

[24] *Ibidem*, pp. 21.

[25] Martín-Badia J, Obregón-Gutiérrez N, Goberna-Tricas J. *Obstetric Violence as an Infringement on Basic Bioethical Principles. Reflections Inspired by Focus Groups with Midwives*, Int J Environ Res Public Health. 2021 Nov 29;18(23):12553. doi: 10.3390/ijerph182312553. PMID: 34886279; PMCID: PMC8656655.

first quantitative study in Romania aimed at identifying Romanian women's perceptions of the care they received during pregnancy, childbirth, and the postnatal period in Romanian clinics and hospitals over the past five years (2018-2023). The approach explicitly chosen and adopted in the report was to refer to this phenomenon as obstetric violence, and we received no fewer than 5,623 valid responses to the survey we conducted. Here, I will present only a small part of the research findings, to place them within a broader presentation of the current situation regarding obstetric violence in Romania[26].

Hyper-medicalization as Obstetric Violence? Caesarean sections outnumber natural births in both public and especially private hospitals, significantly exceeding any reasonable recommendations in the field. Just over one-third of women reported giving birth naturally. For pre-scheduled caesarean sections, 33.7% of women in the sample reported this mode of birth. Adding another 12.5% who underwent a caesarean section without entering labor, the number of caesareans open to critical analysis increases. In total, 70.4% of births in private hospitals were caesarean sections, while in public hospitals, caesarean sections accounted for 60.1% of all births. The WHO is currently reserved about setting an ideal caesarean rate but still refers to the 1985 WHO recommendation that the ideal caesarean section rate should be between 10-15%[27]. In 2014, following a second expert meeting organized by the WHO, the main conclusions were that "every effort should be made to provide caesarean sections to women in need, rather than striving to achieve a specific rate," and that "at the population level, caesarean section rates higher than 10% are not associated with reductions in maternal and newborn mortality rates."[28] In 2024, a joint statement by the European Association of Perinatal Medicine and the European Midwives Association recommended a caesarean delivery rate at the country level of 15-20%[29].

Although I am not qualified to validate or invalidate the data presented above, I want to draw attention to the significant differences in recommendations regarding the utility of caesarean sections compared to the much higher rates reported in our research, which points to a hypothesis of birth hyper-medicalization. It's also worth noting that out of the 1,894 women who had a scheduled caesarean section over the past five years, nearly 3/4 stated that they chose caesarean section based on their obstetrician's recommendation, and about 1/4 said the choice was theirs[30].

The most frequently used recommendation by gynecologists for

[26] For more details, the full report is accessible at: https://moasele.ro/wp-content/uploads/2024/09/Raport-privind-violenta-obstetrica_AMI_septembrie_2024.pdf.

[27] WHO Statement on Caesarean Section Rates, accessible at chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://iris.who.int/bitstream/handle/10665/161442/WHO_RHR_15.02_eng.pdf?sequence=1.

[27] WHO statement on caesarean section rates. 14 April 2015. https://www.who.int/publications/i/item/WHO-RHR-15.02.

[28] *Idem*.

[29] EUROPEAN ASSOCIATION OF PERINATAL MEDICINE (EAPM) EUROPEAN MIDWIVES ASSOCIATION (EMA) Joint position statement: Caesarean delivery rates at a country level should be in the 15-20 % range Ayres-de-Campos, Diogo et al. European Journal of Obstetrics and Gynecology and Reproductive Biology, Volume 294, 76 – 78.

[30] D. Neaga, L. Grunberg, C. Radu, *Experiența nașterii în spitalele din România. Raport de cercetare privind violența obstetrică*, Asociația Moașelor Independente, 2024, p. 13.

caesarean birth (Q15) is based on a history of prior caesareans (32% said this was the reason their doctor recommended it). Other common reasons include cephalopelvic disproportion (large baby/small pelvis): 17.7%; nuchal cord (cord around the neck): 18.8%, and abnormal presentation (other than anterior occiput): 11.5%; maternal myopia: 11.6%. Other less frequent reasons include thrombophilia, the mother's age, and overdue pregnancy. For women, the main reason cited by nearly 2/3 (60%) for choosing cesarean birth was fear of pain. Other reasons included hearing traumatic stories about natural birth (around 50%), or the belief that cesarean birth is safer for themselves (30%) or for the baby (22%)[31].

The report also highlights a greater probability of experiencing forms of obstetric violence during vaginal births. According to the data, women who gave birth vaginally reported encountering obstetric violence risks more frequently. On average, they identified approximately one-third of the 25 forms of violence identified in the study as applicable to this type of birth (29.6%)[32]. Vaginal birth is considered by women to involve the most exposure to forms of obstetric violence, which may explain the high number of caesarean sections, particularly scheduled caesareans. More specifically, the choice by the 525 women who opted for a scheduled caesarean was motivated primarily by fear of pain (59% of these) and traumatic stories about vaginal births (48.8%)[33].

Separation from the baby at birth remains one of the most traumatic experiences for laboring women, but in vaginal births, it ranks third, after being forced into a specific position (lithotomy position), a practice commonly encountered in both private and public hospitals. More than half of women who gave birth in private hospitals reported experiencing this. The Kristeller maneuver (applying pressure to the uterine fundus/pressing down on the abdomen), a procedure not recommended both in Romania and internationally, was identified as frequently practiced in both state hospitals (45.3%) and private ones (32.4%). Other frequently encountered experiences in public hospitals (over 30%) include non-consensual procedures, movement restrictions during labor, lack of information, inappropriate staff conversations, insufficient time for consultations, and food/water restrictions during labor, which also occurred in private hospitals[34].

***b) The Obstetricians' Response.*** The data published in this research report sparked critical reactions from the Obstetrics and Gynecology Commission and the Board of the Romanian Society of Obstetrics and Gynecology (SOGR), which sent a letter to the Association of Independent Midwives. The issues raised in the letter highlight that the debates and tensions mentioned earlier in this article are also very much current in Romania. The main criticisms of the report focused on: a) the epistemic authority of the researchers and, consequently, the study's validity, specifically pointing out that the authors do not come from the medical field, alongside critiques regarding methodological transparency; b) the contestation of the term "violence," citing a lack of consensus on terminology and an overly broad interpretation of obstetric violence; c) the argument that such studies might harm the doctor-patient relationship

[31] *Idem*, p. 14.
[32] *Idem*, p. 25.
[33] *Ibid*em
[34] *Idem*, p. 31.

and create unrealistic expectations and tension; d) the contestation of the relevance of the ideal caesarean rate of 10-15%, citing that it does not account for the increased age of first-time mothers, higher rates of chronic conditions, and infertility issues; e) the argument that current population, medical, and economic realities should be more considered in such studies, emphasizing that an entire medical body, which genuinely works in the interest of women, should not be blamed; f) the argument that pregnancy and childbirth are times of intense emotions that should be supported positively to provide women with confidence, support, and medical safety.

## 4. Conclusions/Discussion

Romania mirrors debates that have already emerged in other regions, indicating that the issue of obstetric violence is reaching both the public agenda and potentially the formal agenda as well. Bringing this form of gender-based violence to light will consequently require a unified definition, as well as the establishment of a legal framework to prevent and address this phenomenon. Naturally, I anticipate a challenging phase ahead, marked by intensified dialogue among various professionals. This phase should be accompanied by increased research on the topic, ultimately leading to a legal and policy framework aimed at minimizing obstetric and gynecological violence.

The success of this stage will certainly depend on how each relevant actor involved in the process recognizes that obstetric violence is a form of gender-based violence, thus having a structural/systemic nature. For this to happen, it is important to be aware of the need for an interdisciplinary approach to this issue. Obstetric and gynecological violence is a topic at the intersection of fields like anthropology, ethics & bioethics, sociology, political science & administration, law, medicine, and gender studies. Professionals from all these domains must be involved to define the problem comprehensively and to propose a coherent legal and policy framework as part of the solution.

Secondly, it is essential to gain a better understanding of how obstetric violence is configured in Romania, its causes and implications, and how various medical professionals and decision-makers perceive and respond to this issue. Equally important is to give a voice to the women affected by this type of violence—not only to bring their experiences to light but also to identify their needs and expectations about the healthcare system. Without questioning the epistemic authority of doctors, it must be emphasized, whenever necessary, that medical practice should never undermine patients' autonomy and dignity. In this regard, the voices and experiences of women cannot be ignored. Finally, we have reasons to believe that educational interventions integrating the topic of obstetric and gender-based violence into the curricula of medical professionals are essential in reducing tensions between professionals.

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