Controversies in Defining and Recognizing Obstetric Violence in Europe and Romania

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Abstract

Obstetric violence remains an insufficiently documented and researched issue on the European continent (especially in Romania), despite its growing visibility and extensive documentation in Latin America, particularly in countries such as Argentina, Brazil, Mexico, Panama, Venezuela, Paraguay, Suriname, and Uruguay. In Romania, the concept is largely unknown to the general public and insufficiently explored in academic research. To date, only one study, conducted by the Association of Independent Midwives in 2024, has examined obstetric violence in Romania, collecting through an opinion poll the experiences of women who gave birth in Romanian hospitals between 2018 and 2023. Recently, several Romanian organizations have initiated projects aimed at raising awareness and addressing the effects of gender base violence(including abortion, obstetric violence, femicide). Feminist organizations have staged protests in response to cases of obstetric violence that have caused public outrage. The protests have highlighted systemic deficiencies in the healthcare system. In Europe, only a few regions, such as Catalonia, Portugal and Valencia, have adopted legislation that explicitly addresses obstetric violence, while others, including Spain as a whole, refer to it only indirectly in their legal frameworks. There have also been countries that have attempted to legislate against obstetric violence, including Croatia, France, Italy, Lithuania, Luxembourg. The purpose of this article is to examine how obstetric violence is addressed in Romania, compared to other European Union member states. Using content analysis as the main research method, this article analyzes existing legislation, reports, and various opinions on obstetric violence (opinions of specialists in the health, legal, and academic fields). A major limitation of this research was the lack of Romanian resources related to this topic. This limitation is caused by the general neglect of the subject in national discourse. By tracing the evolution of the concept of obstetric violence in the European Union and examining existing sources in Romania, this article aims to contribute to the ongoing discussion about forms of gender-based institutional violence in healthcare and to promote awareness of obstetric violence as a public health and human rights issue.

Keywords: obstetric violence, reproductive rights, informed consent, gender-based violence

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Understanding the Concept: Definitions, Professional Views, and Critiques

From a terminological point of view, the term obstetric violence is used in Latin America, in the academic field and in feminist research. A synthesized definition of obstetric violence can be found in the article "A concept analysis of obstetric violence in the United States of America" by Lorraine Garcia (2020). According to this definition: *"Obstetric violence is abuse or mistreatment by a health care provider of a female who is engaged in fertility treatment, preconception care, pregnant, birthing, or postpartum; or the performance of any invasive or surgical procedure during the full span of the childbearing continuum without informed consent, that is coerced, or in violation of refusal. It is a sex-specific form of violence against women (VAW) that is a violation of human rights"* (Garcia, 2020).

As for the WHO, it intentionally avoids using this term. The WHO prefers to use the phrase "disrespect and abuse during childbirth" instead of obstetric violence. This means that the WHO does not recognize inappropriate treatment of women as an explicit form of violence. The WHO's choice is not coincidental. Among medical professionals, there is a reluctance regarding the use of the term "obstetrical violence." The reluctance of medical staff is caused because they believe the term "obstetric violence" can lead to violence against obstetricians.

According to a 2014 document, WHO defined the expression of "disrespect and abuse during childbirth" as: "Reports of disrespectful and abusive treatment during childbirth in child care centers have included physical treatment and physical abuse, profound humiliation and verbal abuse, coercion or unconventional medical procedures (including sterilization), lack of privacy, failure to obtain full informed consent, refusal to administer pain medication, rough treatment gross violations of privacy, refusal of admission to health care facilities, neglect of women during childbirth to suffer life-threatening and preventable complications, and detention of women and their newborns in facilities after birth due to inability to pay" (WHO, 2014).

According to the article written by Sylvie Lévesque and Audrey Ferron-Parayre (2021), the WHO definition of forms of abuse of women during childbirth is flawed in two ways. First, the definition sees violence as a public health problem: "a phenomenon that has harmful effects on the health of populations that are exposed to it" (Lévesque & Ferron-Parayre, p. 1012). Forms of violence could be viewed as other activities that produce harmful effects on health such as malnutrition, alcohol consumption, tobacco use, etc. Secondly, the WHO definition does not prioritize violence that occurs in the medical system, as a result the definition could be considered outdated in the current conception of forms of violence in various contexts. The authors believe that the WHO definition was never intended to be applied in the context where the abuses were carried out by medical professionals. One of the authors faced reluctance from medical professionals when she presented a study about obstetric violence at a medical conference in Dublin.

The effects of obstetric violence can be divided into two categories: physical effects and psychological effects. Physical effects may include breastfeeding problems, episiotomy, incontinence (urinary and fecal), and unnecessary cesarean sections. The breastfeeding process can be affected by how labor went. In the case of a cesarean section, the patient experiences pain, and the breastfeeding process is unpleasant. If the patient suffers from post-traumatic stress, breastfeeding is impossible or even difficult. Psychological effects may include

postpartum depression, post-traumatic stress disorder, and anxiety. Worldwide, 15% of women suffer from postpartum depression. In the case of postpartum depression, the most terrible complications are suicide and infanticide. Post-traumatic stress syndrome is caused by poor care of the patient during childbirth. The effects of this syndrome are "impaired breastfeeding and rejection of the newborn by the mother" (Valiente et al., p. 75).

When it comes to using the terms "obstetric" and "gynecological violence," the greatest reluctance is found among medical professionals. In many EU member states, medical professionals are opposed to using the word violence for several reasons. The first reason is that the use of the term violence refers strictly to individual malpractice, and that these forms of violence are not systemic. Obstetricians and gynecologists believe that the use of the term violence leads to the interpretation of acts of mistreatment as intentional.

A 2024 study commissioned by the European Parliament's Committee on Women's Rights and Gender Equality (FEMM) outlined the reactions of doctors in several EU countries to the use of the term obstetric violence. In Italy, following an online survey on obstetric violence, representatives of the Association of Obstetricians and Gynecologists in Italian Hospitals issued a press release regarding the accuracy of the study. They considered that the use of the term "obstetric violence" was damaging to the medical profession. *"Indeed, the words 'obstetric violence,' at the moment of communication, already become in themselves and in their immediacy, a tool for damaging the reputation of healthcare professionals, transcending into a blatant attack and aggression on the moral sphere of others"* (Colombo, 2017, p. 1). In France, medical staff initially refused to use the term "obstetric violence" and did not participate in the working groups. In the Netherlands, medical professionals prefer to use the term used by the WHO: "disrespect and abuse" or "maltreatment," and when the term "obstetric violence" is used, they react defensively.

In an advisory opinion issued by the Council of Obstetrics and Gynecology of the Portuguese Medical Association, it is believed that the use of the term "obstetric violence" alarms patients and causes them to lose trust in medical staff who are working hard to provide them with the best possible treatment. The institution emphasizes that, "in Portugal, these crimes or ethical violations are already provided for in the Penal Code and the Code of Ethics, as mentioned in the draft law in question, and penalties can include imprisonment, with temporary or permanent disqualification from practicing the profession" (Ordem dos Medicos, 2021, p. 2).

In Spain, in 2021, obstetrics and gynecology associations denied the existence of the problem caused by obstetric violence in several statements. These statements were in response to roundtable discussions organized by the Ministry of Equality. The Ministry of Equality wanted to create a law to combat forms of obstetric violence. Between September and October, the Ministry of Health held meetings with civil society, medical experts, and various activists. Several obstetrics and gynecology associations have reacted negatively to obstetric violence. Among them is the Spanish Association of Obstetrics and Gynecology. The association released a statement titled *"Obstetric violence: an illegal, immoral, and scientifically unacceptable concept"* (S.E.G.O., n.d.). As a result, in March 2023, the legislative initiative on obstetric violence did not include the term "obstetric violence." Instead, it was preferred that the term be used indirectly.

An article published in 2024 by the *American Journal of Obstetrics and Gynecology* mentions that in Latin America and the Caribbean, the term obstetric violence is misused. The authors mention that national legislation includes interventions aimed at easing the birth process and saving the lives of the mother and baby under the category of obstetric violence. These interventions include "induction of labor, cesarean section, episiotomy, and even the supine position during delivery, among others" (Chervenak et al., 2024, p. 3). For the authors of this study, obstetric violence refers strictly to disrespectful treatment by medical staff during childbirth. This article also mentions that the principle of autonomy over one's own body is misunderstood. They mention that the principle of autonomy over one's own body is misunderstood when it refers strictly to the patient's personal preference (ignoring the obstetrician's suggestion).

A 2023 study, based on a press release from the Spanish Society of Obstetrics and Gynecology, states that the use of the term obstetric violence without knowledge of its meaning can affect the relationship between patients and doctors. The same study also found that 354 obstetricians believe that the term obstetric violence has a negative effect (73.9% of the total number of participants). The Spanish Society of Gynecology and Obstetrics recently issued an official statement on the internet on this subject: "We consider the term 'obstetric violence' to be inappropriate, biased, and unfair because of its malicious legal meaning, as an intention to cause harm, to injure, to use force, or to threaten, which is criminally liable and which we must reject entirely" (Terribile & Filho, 2023, p. 252).

An article published in 2020 in the Brazilian Journal of Maternal and Child Health presented another critique of the concept. Some obstetricians believe that the use of the term obstetric violence in turn brings violence upon obstetricians. As a result of this opinion, there was an attempt by the Minister of Health to remove the term from public documents. What obstetricians forget is that this term does not only refer to abuse committed by them. Obstetric violence as a concept represents a form of systemic violence. Violence can be the result of systemic failures at different levels of care in health systems, so the expression cannot be understood as a synonym for "violence committed by the obstetrician" (Katz et al., 2020, p. 625).

Another study suggests that using the term "obstetric violence" is harmful to both doctors and patients. The authors of the study say that using the term "obstetric violence" does not encourage change in the field of obstetrics. The authors of the study claim that the WHO definition of violence is outdated. Lapperman and Swarts have questioned the way feminist literature has analyzed obstetric violence. From the authors' perspective, it should be viewed as follows: "The question in this paradigm is not who is good and who is bad, but how different types of relational engagements and interventions can lead to different outcomes in terms of well-being, in this case, of mothers and infants" (Lappeman & Swartz, 2021, p. 991).

Their study focused on the experiences of women in a delivery room in South Africa. According to the authors, the delivery room was predominantly quiet, with even the babies not crying much. The authors also noted that the women who participated in the study were not accompanied by their partners, which is contrary to the recommendations made in the specialized literature. The women refused to bring their partners into the delivery room, even when the medical staff recommended it.

In the article "Emerging human rights standards on obstetric violence and abuse during childbirth", Camila Pickles offers a legal perspective on the evolution of the concept of obstetric violence. The term obstetric violence has evolved from "safe motherhood" to the point where the emphasis is now on respectful care. "Safe motherhood" emerged in 1987 as a United Nations initiative. The concept emphasized reducing infant and maternal mortality, with a focus on developing areas. Due to the relevance of the topic, several human rights organizations clarified the international human rights that apply to this concept. These included: the right to life and the right to the highest possible standard of health. In its early stages, the concept of safe motherhood focused on ensuring that medical facilities were adequately equipped and that medical personnel were well trained by the government.

However, following a decision by the Committee on the Elimination of Discrimination Against Women (CEDAW), a more comprehensive version of Safe Motherhood was sought. In the case of Alyne de Silva Pimentel v. Brazil, a Brazilian woman of African descent died as a result of inadequate treatment and complications in a local health facility and hospital. The Committee found that the woman's right to life, right to health, and right to non-discrimination had been violated. The Committee also noted that Alyne's right to medical care had been violated. The CEDAW decision in the case of Alyne da Silva Pimentel v Brazil demonstrated that the young woman's death was caused by inadequate care. The Committee also emphasized that Alyne da Silva's experience highlighted the systemic discrimination faced by "marginalized women on the basis of race, ethnicity, and socioeconomic status" (Pickles, 2025, p. 509).

In another article by Camilla Pickles, she offers a feminist-legal perspective on how the term obstetric violence may be affected by an overly broad definition. The author recommends limiting the concept of obstetric violence to women who give birth and that this violence occurs during prenatal, intrapartum, and postpartum care. This does not deny the connection that obstetric violence may have with other forms of violence occurring in reproductive health. The author explains how obstetrics has historically been considered an exclusively male specialty. Due to issues of racism, sexism, and colonialism, women and indigenous people have been excluded from the field of healthcare. According to the author, the biomedical perspective focuses on a highly medical and interventionist approach and excludes the social aspect. The social aspect is the part that includes women's experiences and feelings about childbirth.

The author explained that there are two perspectives in the literature. Perspective A is more restrictive and refers exclusively to forms of violence caused intentionally. Perspective B(1) refers to obstetric violence as disrespect and inappropriate treatment during childbirth. This perspective is not very clear on what exactly constitutes inappropriate treatment or disrespect, as it does not include any criteria for fulfillment. Perspective B(2) is much more comprehensive. Like perspective B(1), this perspective attempts to broaden the definition of obstetric violence. Obstetric violence is viewed as a form of systemic violence that affects women, especially those from disadvantaged backgrounds. This comprehensive perspective can be beneficial for activism, but it raises legal issues. Countries in Latin America and the Caribbean have recognized obstetric violence as gender-based violence, but they focus on the individual actions of doctors rather than institutional problems.

Another issue is how certain jurisprudences interpret obstetric violence. In addition, violence against women, trans women, and non-binary women may differ *"in different*

geopolitical contexts, with the nature and the extent of violence correlating with different people's social status, race and sexual orientation/identity" (Pickles, 2024, p. 629). Pickles suggested that obstetric violence should be understood as a violation of physical and psychological integrity during labor and/or birth. This perspective could encourage reforms and view obstetric violence as a *"continuum of violence"* (ibid., p. 644). This would allow for the recognition of forms of obstetric violence and links to other forms of reproductive violence.

The article "A critique of the conceptualization and criminalization of obstetric violence in international human rights frameworks" (2024) offers a legal perspective on how countries have adopted legislation criminalizing obstetric violence and how international organizations approach this concept. In Latin American countries, laws combating obstetric violence have been adopted as a result of advocacy by feminist movements. Although the laws have their own particularities, they have one thing in common: they classify "obstetric violence as a form of gender-based violence against women" (Barbosa et al., 2024, p. 7). Efforts to criminalize obstetric violence are diminished in some countries by the existence of criminal laws that already cover offenses such as bodily harm, abuse of power, and endangering the patient. International human rights organizations have been influenced by how Latin American countries have treated the concept. Although there is no international treaty that explicitly mentions obstetric violence, the bodies that interpret treaties have called on states to take action against this form of violence (Neither the *Belém do Pará Convention* nor the *Istanbul Convention* include the concept).

However, MESECVI, which analyzes the progress of states in implementing the Belém do Pará Convention, mentioned obstetric violence in its 2012 report. It also recommended that states criminalize it. "*For all these reasons, the Committee reiterates its Recommendation to the States that they not only adopt provisions to criminalize obstetric violence, but also respect what constitutes a natural process before, during and after childbirth, without arbitrary or excessive medicalization"* (MESECVI, 2014, p. 63).

The CEDAW convention does not include the term obstetric violence either. However, the commission has used the term in its recommendations. It should be noted that its recommendations vary from case to case. In the case of Bulgaria, CEDAW made a recommendation on Obstetric Violence in its Concluding Observations on Bulgaria's eighth periodic report. The recommendation appears in paragraph 34 (a): "*Criminalize obstetric violence and other forms of violence during delivery and ensure adequate and accessible standards of care in all maternity wings of hospitals*" (CEDAW, 2020, p. 11). The inclusion of sexual and reproductive rights in the mandatory school curriculum is another CEDAW recommendation. This should be inclusive and adapted to the age of the students. In the case of N.A.E. v. Spain, CEDAW upheld the victim's complaint for violations of articles 2 (b), (c), (d) and (f), 3, 5 and 12 of the Convention on the Elimination of All Forms of Discrimination against Women. The Commission recommended that the victim be awarded compensation. CEDAW also recommended to "*conduct research into obstetric violence in the State party in order to shed light on the situation and thus provide guidance for public policies to combat such violence*" (CEDAW, 2022, p. 17). Another recommendation is professional training in women's reproductive rights for obstetricians and other medical workers. The latest CEDAW recommendation aims to provide easy avenues of appeal for victims of obstetric violence and train legal personnel on women's reproductive rights.

In the special report by rapporteur Dubravka Šimonović and presented to the UN Human Rights Council, "A *human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence*" uses the term obstetric violence rather than violence against women during childbirth. However, it does not include the criminalization of this offense among its recommendations, focusing instead on the creation of public policies to combat the issue. A legal criticism of the criminalization of obstetric violence is that criminal law focuses more on punishing the guilty rather than on training doctors to prevent further cases of violence.

As an alternative, the special report includes a series of legislative and policy recommendations to reduce obstetric violence. These include civil law measures such as compensation claims against medical facilities and medical professionals, and administrative law measures (disciplinary complaints). One of these recommendations includes cooperation between medical professionals, NGOs, and feminist movements. *"States should establish constructive cooperation between health institutions and professional associations on the one hand, and women's non-governmental organizations, feminist movements, and independent human rights institutions dealing with reproductive and obstetric care on the other"* (Šimonović, 2019, p. 21).

The European Context

In the case of obstetric violence, there are only a few regions on the European continent that currently have the concept introduced into legislation (the Region of Catalonia, the Canary Islands and Portugal). However, in recent years, the subject has begun to be known through various articles and debates. The international Roses Revolution movement began in Europe. This movement started in 2011 in Spain and is a form of fighting against obstetric violence. The movement was created by Jesusa Ricoy, and the campaign logo was created by the creative agency Cuatro Tuercas. "Initially, it was created in response to the incredibly offensive cartoons that the Spanish Society of Obstetricians and Gynecologists published in their medical journal, in which they humiliated their own patients, their conditions, and their births" (Ricoy, n.d.). This movement proclaimed November 25 as the day against obstetric violence (it was also known as the day against all forms of violence against women).

On November 25, women who have been victims of obstetric violence lay a pink rose at the medical facility where the assault took place. In a 2019 session of the European Union Parliament, a definition of the concepts of obstetric violence and gynecological violence was adopted. According to this definition, "Obstetric and gynecological violence is a form of violence that has long been hidden and is still too often ignored. In the privacy of a medical consultation or childbirth, women are victims of practices that are violent or can be perceived as such. These include inappropriate or non-consensual acts such as episiotomies and vaginal palpation performed without consent, pressure on the uterine fundus, or painful interventions without anesthesia. Sexist behavior during medical consultations has also been reported" (Council of Europe, 2019).

The COVID-19 pandemic has had a significant impact on obstetric violence. Specifically, it has exacerbated certain forms of obstetric violence (lack of autonomy over one's own body, inadequate care). The pandemic has also led to an increase in unnecessary interventions (episiotomies, induced caesarean sections). For example, in France during the

pandemic, women were not allowed to be accompanied, in addition to sanitary measures (wearing a mask). This creates a state of insecurity and loneliness for the future mother. In Portugal, a study was published on neonatal care during the pandemic. A total of 1,845 women were surveyed as part of this study. "Of the 1,845 women who responded to the questionnaire, 66.2% had restrictions imposed on them regarding the presence of a companion of their choice due to COVID-19 restrictions" (Brunello et al., 2024, p. 37).

In April 2024, a report on obstetric and gynecological violence was released by the European Parliament. This article analyzed how these two forms of violence operate in the 27 EU member states. According to this study, there is currently no EU member state that has adopted a legislative proposal to combat obstetric and gynecological violence. Moreover, these forms of violence are not recognized as a violation of women's rights. "Even if there is no legislation yet, women can seek compensation based on the current civil and criminal code" (ibid., p. 10).

One of the most common forms of abuse is prohibiting the partner from accompanying his partner during prenatal check-ups, labor, and the postpartum period. This was seen in most European countries during the COVID-19 pandemic. According to a 2021 study in Portugal by Dulce Morgado Neves and Catarina Barata, women who tested positive for COVID-19 weren't allowed to breastfeed their babies or even touch them. In fact, "women have reported discriminatory attitudes by health personnel in the face of the slightest suspicion they might be COVID-19 positive" (Barata et al., 2020, p. 2).

A similar situation occurred in Italy. A sociological study conducted by Brenda Benaglia and Daniela Canzini showed that of the 49 respondents (29 from the Bologna region and the remaining 20 from other regions), 20% of respondents from Bologna and 30% of respondents from other regions were unable to be accompanied by their partner due to Covid-19. Following a letter from the association *Voci di Nascita* (in English: *Voice of Birth*), "the most restrictive measures were corrected: starting on April 27, partners could be present from the beginning of active labor until after birth" (Benaglia & Canzini, 2021, p. 4).

According to the Report on Obstetric and Gynecological Violence published by the European Parliament, all member states have a document on patients' rights with minor differences between Member States. "*Furthermore, different degrees and forms of physical violence are covered by criminal law with slight differences from one MS to another*" (Brunello et al., 2024, p. 54). An example of this would be a doctor performing a cesarean section after an episiotomy without using anesthesia, in which case this act could be considered a form of torture. Another example is if a doctor performs a "husband stitch," he could be accused of genital mutilation. On the other hand, these actions are not considered crimes if the perpetrator presents an objective reason to justify them or if there is legislation in place. These actions are criminally punishable if they are not performed as required by law.

Legal framework on obstetric violence

Currently, in Europe, only the autonomous regions of Catalonia, Valencia, the Canary Islands and Portugal have adopted legislation on obstetric violence. In Catalonia, obstetric violence is mentioned in the "law on women's right to the eradication of gender-based violence" (Law 17/2020, adopted on December 22). This law includes elements related to both obstetric violence and reproductive and sexual health rights. A bonus of this law is the inclusion of

women with disabilities and lesbian women (who receive inadequate care from medical staff). In the case of women with disabilities, there is a popular belief that they do not have a sex life.

Under this law, obstetric violence appears in Article 3, letter d. According to Article 3, "Obstetric violence and the violation of sexual and reproductive rights consist of preventing or impeding access to accurate information necessary for autonomous and informed decision-making. It can affect different areas of physical and mental health, including sexual and reproductive health, and can prevent or make it difficult for women to make decisions about their sexual practices and preferences, as well as about their reproduction and the conditions under which it takes place in the long term, in accordance with the assumptions contained in the applicable sectoral legislation. It includes forced sterilization, forced pregnancy, prevention of abortion in legally established cases, and difficulty in accessing contraceptive methods, methods of preventing sexually transmitted infections and HIV, and assisted reproduction methods, as well as gynecological and obstetric practices that do not respect women's decisions, bodies, health, and emotional processes" (Portal Jurídic De Catalunya, 2022).

In the case of the Valencian Community, obstetric violence was introduced into health law in 2021. The provisions on obstetric violence appear in Chapter III, Article 59 ("Health care in the field of women's sexual and reproductive health" (Valencia Ministry of Health, 2021, p. 42). According to this article, combating obstetric violence is mentioned in accordance with the recommendations made by the WHO. This article also mentions provisions such as receiving appropriate training on childbirth and the postpartum period, informing women about all procedures. The article also includes the right to be accompanied by a person, facilitation of direct contact with the child, receiving advice on breastfeeding, and information on the benefits of breastfeeding, etc.

In the case of the Canary Islands, a legislative proposal on obstetric violence was initiated in 2022. This legislative initiative was proposed by the socialist group in parliament. As a result, the Canary Islands made several proposals to the Spanish government: "(I.) To introduce the concept of obstetric violence as an additional element in healthcare requests in all hospitals in the Canary Islands. (II.) Ensure effective training for health professionals, leading to safe practices during childbirth and throughout pregnancy, and early detection of cases of obstetric violence. (III.) Create protocols that are not invasive, risky, or painful, and ensure that births are treated with humanity and respect. (IV.). Promote research related to obstetric violence and implement interventions that strengthen women's autonomy" (Parlamento de Canarias, 2022, p. 7).

In the case of Portugal, obstetric violence was regulated by Law 33 of 2025. The law includes a definition of obstetric violence, prevention measures (including training sessions for medical staff and transparency regarding medical procedures), and sanctions for medical staff who treated patients disrespectfully or used harmful practices against them. The law published in Diário da República defines obstetric violence in Article 2. According to this article, "Obstetric violence is the physical and verbal action exerted by healthcare professionals on the body and procedures in the reproductive area of women or other pregnant individuals, which is expressed in dehumanized treatment, abuse of medicalization, or pathologization of natural processes, disrespecting the protection regime in preconception, medically assisted procreation, pregnancy, childbirth, birth, and the postpartum period provided for in section II of chapter III of Law No. 15/2014, of March 21 (Diário da República, 2025).

The law provides as preventive measures, the existence of notions of respectful care of patients in the curriculum of medical universities. Another measure is the implementation of awareness campaigns regarding obstetric violence. This measure is closely linked to the implementation of the annual report on patient satisfaction with medical services. These attributions fall within the newly established Multi-Professional Commission for Rights in Pregnancy and Childbirth. According to Article 11, this commission is composed of 9 members. The president elected at the proposal of the government, 4 members representing patients elected following a vote by Parliament and 4 members elected by the State Secretariat for Health (including specialists in maternal health, child health, obstetrics and gynecology).

In some European countries, there have been attempts to pass laws that include obstetric violence. One such attempt took place in Italy in 2016. The proposal came from politician Adriano Zaccagnini of the Progressive Democratic Movement. The name of the proposed legislation was "Rules for the protection of the rights of women and newborns at birth and regulations for the promotion of physiological birth" (Paganelli, 2023). This law aimed to criminalize obstetric violence. This legislative proposal was linked to the *#bastatacere* (translation: *keep silent*) campaign. As part of this campaign, 3,000 experiences of obstetric violence were collected through an online questionnaire. The legislative proposal was not adopted. Other countries that have attempted to legislate on obstetric violence: Croatia (2014, 2018—both unsuccessful), France (2023, still under discussion), Portugal (2021, 2023)[1], Lithuania, and Luxembourg.

Poland, although there is no legislation on combating obstetric violence, there is a law on medical treatment during childbirth (August 16, 2018). This law was published in 2019 and covers the following: treating women with respect, giving the mom-to-be the information she needs, respecting the patient's consent, and asking for the patient's consent (for procedures and exams). On the other hand, this law is not yet applicable. There are many reasons for this, the main ones being the lack of knowledge of patients and doctors on this subject. "This, in addition to the fact that there is a lack of awareness of this type of violence, not only among healthcare professionals, but among victims too (and legal professionals), limits the application of these principles and renders the applicable legal framework less effective" (Brunello et al., 2024, p. 60).

As a result, there is no consensus at European level on a coherent definition of obstetric violence. This causes problems in terms of understanding and acceptance of the concept at both societal and professional levels (particularly among medical and legal professionals). For example, in Catalonia, obstetric violence was introduced into the law on women's rights to eradicate gender-based violence in the same paragraph as violence in reproductive health. This can be confusing, given that some forms of obstetric violence are not necessarily related to other forms of reproductive health violence. In the case of the Valencia region, obstetric violence is only mentioned in health legislation, without including a definition or specifying what acts can be considered obstetric violence. There have also been European countries that have had legislative proposals on obstetric violence, but these have been rejected (Italy,

[1] In the case of Portugal, it should be mentioned that a legislative initiative on combating obstetric violence was adopted in 2025.

Croatia, France, Lithuania, Luxembourg). Even though Poland has a law on providing respectful treatment during childbirth, this law is not well known among patients and doctors.

Reproductive Rights and Gender-Based Violence: The Case of Romania

As with many EU countries, Romania has not yet adopted legislation on obstetric violence. The subject of obstetric violence is not well-known in society. Currently, several associations are trying to raise awareness of this concept. In addition, the issue of obstetric violence is closely linked to other problems in the Romanian healthcare system. The main difficulty of the healthcare system is the lack of funding in the medical field. This issue is closely linked to the poor conditions of public hospitals. In 2023, many hospitals missed the opportunity to obtain non-reimbursable European funds. The funds from the PNRR amounted to 750 million euros. Currently, "Romania has 368 public hospitals and 167 private hospitals. Some of these public hospitals are very old (some are even over 100 years old)" (Spiridon-Drăgodan, 2023).

Another problem is bribery in Romanian hospitals. "Romania ranks first among European Union countries with the highest percentage of bribes in healthcare, namely 19%" (Tănasie, 2023). People choose to bribe doctors to ensure they have access to healthcare services. There are cases where, if a person does not give a bribe to the doctor, their treatment will be delayed. The bribery issue affects people from vulnerable backgrounds much more because, in most cases, they do not have the financial resources to pay doctors. According to the bribery map[2] (data from October 2025), the counties with the highest percentage of bribes were Buzău (8.85), Teleorman (8.54), followed by Harghita (8.5%) and Dâmbovița (8.27%). The counties with the lowest percentage of bribes were Bistrița Năsăud (2.03%), Maramureș (2.74%), and Cluj (3.07%). Another problem is the lack of medical staff. In this case, the unattractive salaries of doctors were the main cause of the problem. Many graduates of medical universities in our country prefer to work abroad for higher salaries.

Obstetric violence is closely linked to access to reproductive health services. When it comes to reproductive health, vulnerable women in Romania have the most difficulty accessing reproductive health services. A 2025 study by the Roma feminist association E-Romnja analyzed the difficulty Roma women face in accessing reproductive health services and contraception. The study also showed that the public health system is designed for heterosexual couples from the dominant ethnic group (and with relatively good financial and social status). This excludes queer people, Roma people, people with low incomes, etc. The results of the research show that the most common problems faced by women are the poor development of medical infrastructure in some regions, the lack of medical personnel (felt in rural areas or small towns) and the inefficiency of transport services. "For some of the women interviewed, the lack of specialized personnel in the vicinity led to risky births in emergency situations or even the death of the newborn" (Obreja, 2025, p. 15). One of the biggest barriers identified by the E-romnja study is poverty. Because of poverty, women cannot benefit from public health services (even if they have health insurance) or private ones.

[2] Vana, Dragoș, Graphs.ro. "Noua Harta Șpăgii din Spitale. Dacă vi s-au solicitat bani sau alte tipuri de recompensații de către personalul medical, doriți să sesizați acest fapt?" (October 2025). https://www.graphs.ro/feed_auto_judet_harta.php?q=8&myfeed=2. Accessed: 5 December 2025.

In Romania, several organizations have initiatives against obstetric violence or that want to improve medical services. One of these associations is the Filia Center. In May 2021, the Filia Center launched the ACCESS Project – "Advocacy, Capacity Building, and Consolidation for Equality in Health and Safety". This project aimed to advocate for health and reproductive health rights in vulnerable communities. "Starting in May 2021, the Filia Center organized 24 informational events and mapped the problems faced by women in disadvantaged communities in the communes of Valea Mare Pravăț, Bughea de Jos, and Aninoasa in Argeș and Munteni-Buzău counties, and Ion Roată and Borănești in Ialomița county" (Active Citizens Fund, 2022).

Another initiative of the Filia Center is the project "Noi să fim sănătoase" (*Let us be healthy*). As part of this project, women are taught what to do when visiting a gynecologist, what the Pap test is, contraception methods, breast cancer prevention, health insurance, childbirth, etc. The Filia Center reminds us that women should be treated with respect by medical staff. It also says that, by law, "you have the right to the best medical care, without any discrimination" (Centrul Filia, n.d.). What's more, medical staff are required to answer every question. In addition, women have the right to refuse surgery. Any surgical procedure is performed with the patient's consent.

The VIF network also launched the Virginity is Untestable project in 2022. As part of this project, the VIF network started an online petition calling on the Ministry of Justice to ban virginity tests in hospitals. "The World Health Organization strongly condemns this practice and considers it barbaric, as it cannot prove a person's virginity and is, rather, a method of coercing women" (Declic, 2022). According to 2019 data from INML (the National Institute of Forensic Medicine), 2% of the procedures performed in the institution were virginity tests.

Another project of the Filia Center is Sănătate pentru Toate (in English: *Health for All*). Through this project, meetings are organized with various national organizations dealing with sexual and reproductive rights. These meetings focus on topics "such as access to contraception, screening for cervical and breast cancer, and sex education. Together, we will establish a common advocacy strategy and produce communication materials tailored to the beneficiaries of each organization" (Centrul Filia, n.d.).

In an interview for the publication Educație Privată (Private Education), Andrada Cilibiu, PR & Communications Coordinator at the FILIA Center, stated that "Obstetric violence is still a taboo subject in Romania—we don't talk about the suffering of women and girls in obstetrics-gynecology, about abusive practices, about the unequal power relationship between doctor and patient. Virginity tests are a form of obstetric violence, often directed against young women and adolescents. For ten years, international organizations have been fighting to eradicate these tests, drawing attention to the fact that it is an abusive practice that has no medical relevance" (Cibiliu, interviewed in Educație Privată, 2022).

The result of the campaign Virginity is Untestable was the elimination of the issuance of virginity certificates upon request by the INML on June 10, 2022. Nationally, virginity tests upon request were banned following a joint order issued by the Ministry of Justice and the Ministry of Health in May 2023. This means that virginity examinations can now only be carried out at the request of the authorities. According to the WHO, "Health professionals and their professional associations should be aware that virginity testing has no scientific merit and cannot determine past vaginal penetration. These examinations are not only a violation of the

human rights of women and girls, but in cases of rape, they can cause additional pain and mimic the initial act of sexual violence, leading to re-experiencing, re-traumatization, and re-victimization" (WHO, 2018).

During the 2023 Women's Safety March (organized by the VIF group), one of the protesters' demands was "Establishment of protocols for the prevention and management of gender-based violence in primary, secondary, and tertiary health services. Training for medical staff: doctors, residents, nurses, midwives, etc" (VIF, 2023) and "Introducing modules on obstetric violence (prevention, identification, intervention, inter-institutional collaboration) in medical and pharmacy universities and post-secondary health schools" (ibid.). The protesters also demanded that the right to have abortions in public hospitals be guaranteed.

Another association fighting for the rights of pregnant women is the Association of Independent Midwives. One of their projects is *Safe Motherhood - Safe, universal, free, accessible, non-discriminatory care services accessible, non-discriminatory care services provided with respect for all women who want to become mothers*. As part of this project, research was conducted on obstetric violence in Romania. The report, published in September 2024, was coordinated by Diana-Elena Neaga, Laura Grünberg, and Crina Radu.

The questionnaire focused on women who gave birth at least once between 2018 and 2023 in Romania. The report analyzed the responses to a questionnaire completed by approximately 5,635 people (5,623 responses were validated). Of this number of respondents, the majority came from urban areas (75.5%), had higher education (73.1%), and had stable incomes (78.7%). Of the 5,623, 37.7% gave birth vaginally, 33.7% gave birth by scheduled C-section, 16.1% gave birth by emergency C-section (after labor started), and 12.5% gave birth by emergency C-section (without going into labor).

Regarding the choice of cesarean section, the doctor decided this in 72.3% of cases, while the respondents decided in 27.7% of cases. "The most popular reasons why respondents chose scheduled C-section delivery were the fear of pain (59.8%), traumatic stories about vaginal deliveries (48.8%), because they considered it safer for them (30.1%), the safety of the child (22.1%), and fear of vaginal changes/impairment of sexual life (11.2%)" (Neaga et al., 2024, p. 14). Regarding awareness of the term obstetric violence, 35.6% of respondents were familiar with it, 30.6% were unsure, 30% were unaware of the term, and the remaining 3.7% did not respond.

Women who gave birth vaginally in public hospitals (1,754) experienced the following forms of obstetric violence: lack of opportunity to have their partner or a close person present during labor and delivery (83.6%), being forced into a specific birthing position (76.1%), and separation of the baby from the mother after birth (56%). Women who gave birth vaginally in private hospitals (364) experienced the following forms of obstetric violence: imposition of a certain position during birth (50.8%), difficult access to free consultations during and after pregnancy (40.1%), and lack of access to free consultations during and after pregnancy (38.7%)

Regarding ethnic origin, the respondents' testimonies showed that Roma women are more vulnerable to obstetric violence. "When I gave birth, there were several other women in the delivery room, including a 16-year-old Roma girl. They scolded her like a child because she was screaming in pain, and because her family was calling her at one point, then they took her phone and turned it off" (ibid., p. 46).

Conclusions

In conclusion, obstetric violence is a form of gender-based violence that affects both the mother and/or the child. The effects of this form of violence can be difficult to detect for people unfamiliar with the concept, and they must be treated quickly to avoid repercussions for the mother's health. Following the legalization of obstetric violence in some Latin American countries, discussions on obstetric violence have begun to emerge in European countries. In some of these countries, the discussions have led to the adoption of legislation on obstetric violence (the regions of Catalonia and Valencia), while in others, these discussions have been unsuccessful. In Poland, there is a law regulating respectful care during childbirth, but the law is not applicable because both patients and doctors are unaware of it.

In Romania, following the wave of European discussions on obstetric violence, the concept has slowly begun to be discussed in the public sphere with the emergence of research in the field. In September 2024, the first research on this concept in Romania was published by the Association of Independent Midwives. At present, there is no legislative initiative or national policy on combating obstetric violence. The problems of the Romanian state are not limited to obstetric violence, but also include poor access to abortion services on demand and the way Roma and queer women are treated in Romanian hospitals. Although abortion on demand is regulated up to 14 weeks of pregnancy, women encounter obstacles to the procedure (these include financial obstacles, religious/moral obstacles, and/or infrastructure obstacles). To these obstacles we can add various legislative attempts by politicians to restrict access to abortion.

In order to combat obstetric violence, we need a series of measures. The first measure is to conduct more research on obstetric violence. As a direction for research, my suggestion is to conduct research on obstetric violence among doctors in Romania. Such research could show us doctors' opinions on the concept and possible suggestions for managing obstetric violence from the doctors' perspective.

The second measure is advocacy. For advocacy, public campaigns could be carried out to raise awareness of forms of obstetric violence among the general public. This campaign could be organized through a series of public events, informational materials, and advertisements on television and/or online. The third measure is the recommendation of policies that could combat obstetric violence. This could include professional training for doctors and nurses during their studies. We need to have medical protocols that focus on the safety and comfort of the mother and child. For doctors who are already practicing, training courses should be provided that emphasize respectful care for both the mother and the child. These training courses can be conducted by feminist organizations that are familiar with the concept of obstetric violence.

Another policy recommendation could also be to include obstetric violence in the definition of gender-based violence in the Law on Equal Opportunities and Treatment between Women and Men (Law 202/2002). The definition of gender-based violence appears in Article 4(1). According to Article 4(l), gender-based violence means: “domestic violence, sexual violence, female genital mutilation, forced marriage, forced abortion and forced sterilization, sexual harassment, human trafficking, and forced prostitution” (Romanian Parliament, n.d.). Therefore, obstetric violence can also be included in the examples of gender-based violence. Finally, the section on sanctions should include sanctions for this type of violence. The

sanctioning of this type of violence should be dealt with by the medical council (for disciplinary sanctions) and by the courts (for obtaining moral damages and for punishing medical staff from a legal point of view).

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