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LIVED EXPERIENCE OF OBSTETRIC VIOLENCE IN ROMANIA: BIRTH, WOUNDED FLESH, AND THE POLITICS OF CONTROL

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Abstract: This article investigates obstetric violence in Romania as a systemic form of disciplining the female body within the context of medicalised childbirth. Through a phenomenological analysis of lived experience, based on 30 semi-structured interviews with women who gave birth in public and private institutions between 2019 and 2024, the research explores how obstetric abuse is experienced, narrated, and at times rationalised. The findings reveal a complex typology of obstetric violence—from non-consensual medical interventions and verbal abuse to subtle forms of abandonment, institutional silence, and symbolic expropriation. Birth emerges as an ambivalent space where the woman's body is both hyper-visible and stripped of agency, reduced to an object of medical expertise. Obstetric violence is not an anomaly, but a recurring expression of how the biomedical system governs femininity, pain, and bodily autonomy. The implications of these findings underscore the need for institutional reforms in maternity care, including the adoption of consent-based practices, relational forms of support, and respectful communication. Applications include improved training for medical personnel, the development of patient-centred care protocols, and the creation of accountability mechanisms that address the structural dimensions of mistreatment.

Keywords: obstetric violence, lived experience, phenomenology, femininity, bodily discipline, Romania.

Résumé : Cet article examine la violence obstétricale en Roumanie comme une forme systémique de discipline exercée sur le corps féminin dans le contexte de l'accouchement médicalisé. À travers une analyse phénoménologique de l'expérience vécue, fondée sur 30 entretiens semi-directifs menés auprès de femmes ayant accouché dans des établissements publics et privés entre 2019 et 2024, la recherche explore comment les abus obstétricaux sont vécus, racontés et parfois rationalisés. Les résultats mettent en évidence une typologie complexe de la violence obstétricale — allant d'interventions médicales non consenties et de violences verbales à des formes plus subtiles d'abandon, de silence institutionnel et d'expropriation symbolique. L'accouchement apparaît comme un espace ambivalent où le corps de la femme est à la fois hyper-visible et privé d'agentivité, réduit à un objet de savoir médical. La violence obstétricale n'est pas une anomalie, mais une expression récurrente de la manière dont le système biomédical régule la féminité, la douleur et l'autonomie corporelle. Les implications de ces résultats soulignent la nécessité de réformes institutionnelles dans les soins maternels, y compris des pratiques fondées sur le consentement, des formes de soutien relationnel et une communication respectueuse. Les

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applications incluent une meilleure formation du personnel médical, l'élaboration de protocoles de soins centrés sur la patiente, ainsi que la création de mécanismes de responsabilité visant les dimensions structurelles des mauvais traitements.

Mots-clés : violence obstétricale, expérience vécue, phénoménologie, féminité, discipline corporelle, Roumanie.

Rezumat: Acest articol investighează violența obstetrică din România ca formă sistemică de disciplinare a corpului feminin în contextul nașterii medicalizate. Printr-o analiză fenomenologică a experienței trăite, bazată pe 30 de interviuri semi-structurate cu femei care au născut în instituții publice și private între 2019 și 2024, cercetarea explorează modurile în care abuzul obstetric este trăit, narativizat și raționalizat. Rezultatele relevă o tipologie complexă a violenței obstetrice – de la intervenții medicale fără consimțământ și violență verbală, până la forme subtile de abandon, tăcere instituțională și expropriere simbolică. Nașterea apare ca un spațiu ambivalent în care corpul femeii este simultan hipervizibil și lipsit de agenție, redus la obiect de expertiză medicală. Violența obstetrică nu este un accident, ci o expresie recurentă a modului în care sistemul biomedical reglează feminitatea, durerea și autonomia corporală. Implicațiile acestor rezultate indică necesitatea unor reforme instituționale în îngrijirea maternă, incluzând practici bazate pe consimțământ, forme relaționale de sprijin și o comunicare respectuoasă. Aplicațiile vizează îmbunătățirea formării personalului medical, elaborarea unor protocoale de îngrijire centrate pe pacientă și crearea unor mecanisme de responsabilizare care să abordeze dimensiunile structurale ale abuzului.

Cuvinte-cheie: violență obstetrică, experiență trăită, fenomenologie, feminitate, disciplinare corporală, România.

1. Introduction

Obstetric violence is increasingly being recognised at an international level as a form of structural and symbolic violence embedded in the functioning of biomedical systems, especially in those marked by rigid hierarchies, paternalistic authority, and power relations that reproduce gender inequalities. Defined as "the appropriation of the body and reproductive processes of women by health personnel" (World Health Organisation, 2014), obstetric violence highlights the relational dimension and the power imbalance involved in medical interventions on the birthing body. Because it entails medical interventions on women's bodies without consent, often performed in ways that violate sexual integrity and erase agency, obstetric violence functions as a form of gender-based violence (Rusu, Nogueira & Topa, 2025). It is directed at specifically gendered bodies, operating through systems that naturalise subordination and silence. Far from being exceptional, this violence is often normalised: concealed by institutional logic, routinised through clinical procedures, and legitimised in the name of safety and professional authority (Annborn & Finnbogadóttir, 2022; Sadler et al., 2016). Although recent research has begun to outline obstetric violence more clearly as a systemic issue, most approaches focus either on legal and institutional aspects or on prevalence and public policy. Less attention has been paid to how this violence is lived, signified, and contested by women from within the experience of

childbirth. This research contributes to this field by placing lived experience at the centre of epistemological and political reflection, proposing a phenomenological analysis of feminine embodiment in obstetric contexts.

In this article, I explore obstetric violence as a phenomenon situated at the intersection of standardised medical intervention and cultural regimes of moralising the female body. By centring the narratives of birthing subjects, I analyse how childbirth in the Romanian healthcare system functions as a two-dimensional space – both physical and symbolic – of reinforcing control and discipline, elements specific to a patriarchal understanding of female bodily autonomy. I documented the *lived experiences* of 30 women, diverse in socio-demographic terms, who gave birth in medicalised spaces (public or private) in Romania over the past five years. Initially, the research aim was to identify the primary forms of obstetric violence experienced by these women and to understand the mechanisms through which such practices are reproduced and rendered normal. The focus was structural, as I was trained in a school of thought where miniature framings and immediate experiences are considered valuable only insofar as they can tell a coherent story about broader social structures. During the interviews, however, a type of knowledge emerged that structural explanations often suffocate: *suffering*. Even though it has a systemic origin, suffering is individual, bodily, and immediate. Thus, the goal of this research is not only descriptive, aimed at identifying patterns of abuse, but also interpretive: I propose a phenomenological and critical reading of how obstetric violence is embodied, narrated, justified, or contested in social contexts marked by gender hierarchies and medical paternalism.

Obstetric violence should not be understood merely as an expression of excessive medicalisation, but as an intersection between an institutional context and a cultural-moral one that normalises pain, submission, and silence as expressions of "proper" femininity. To decipher the structural context in which obstetric violence emerges, it is not enough to refer to the medicalisation of childbirth – that alchemy through which a profoundly bodily, relational, and transformative experience is transmuted into a sequence of standardised, quantifiable, and depersonalised procedures. The clinical redefinition of childbirth reactivates a regime of authority that reproduces gender hierarchies, in which the woman's body becomes both a site of medical intervention and an object of patriarchal normative control. Childbirth is understood as a moment of feminine duty, sacrifice, and conformity to social expectations of "good motherhood." In this register, the birthing body is not only medicalised but also moralised. Managing pain through non-assertion of space and vocal absence, along with the uncritical acceptance of medical interventions, even when perceived as abusive or mutilating, are valued as signs of maternal responsibility. Conversely, asserting autonomy and expressing suffering are perceived as transgressions of the implicit expectations surrounding how women are expected to behave in society. The birthing woman's "amplified," open, unpredictable, and visceral body is perceived as deviant from hegemonic norms of domesticated, silent, and controlled femininity (Cohen

Shabot, 2016). In this sense, childbirth becomes a scenario for reinscribing these norms: a moment in which female corporeality is "brought back to order," reintegrated into the socially acceptable limits of compliant femininity, even at the cost of suppressing the woman's subjective experience (Young, 2005).

2. Framing Obstetric Violence: Critical Perspectives

The topic of obstetric violence has gained discursive traction in recent years (Freedman & Kruk, 2014; Jewkes & Penn-Kekana, 2015; Ferrão et al., 2022). The explicit definition of this type of violence by the World Health Organisation (WHO) in 2014 represents a pivotal moment in the recognition of institutional forms of abuse and mistreatment that women may face during childbirth. While this definition represents an important and valuable step, it frames obstetric violence as a moral failure in the delivery of care, rather than as a constitutive feature of biomedical power. By presenting obstetric violence as a deviation from the normative standard of medical care, the WHO (2014) reproduces a functionalist understanding of medicine as a social institution. This perspective ultimately fails to interrogate the epistemological violence that underpins clinical authority.

Therefore, when studying the "microphysics of obstetric power" (Chadwick, 2018), it is important to avoid the epistemological trap of locating the source of violence in the "malevolent" intentions of individual medical staff. Obstetric, gynaecological, or neonatal violence emerges at the intersection of medical socialisation within a paternalistic and violent professional culture, one in which the patient is entirely subordinated to medical authority, intertwined with the reality of an underfunded, understaffed, and technologically strained healthcare system. To this, we must add the political and administrative levels that deliberately neglect the public healthcare sector while encouraging hybrid public-private entrepreneurial models.

Obstetric violence is not simply a deviation from an ideal standard of care; it is a systemic outcome of how modern obstetrics is structured to govern femininity. Drawing on Foucault's (1973) theories of biopolitics and discipline, we can understand the hospital not as a straightforward site of healing, but as a heterotopia – a space in which the body, regardless of gender or pathology, is extracted from its everyday context, stripped of subjectivity, and reduced to a procedural object of medical knowledge (Palaga, 2021). The medical gaze fragments the body into parts, symptoms, and metrics, erasing its social embeddedness (Lock & Scheper-Hughes, 1987). In obstetrics, this fragmentation becomes total: the labouring body ceases to be a fluid subject and is transformed into a clinical case (Duden, 1993; Martin, 2001). According to clinical discourse, childbirth is not enacted by the woman as an active subject, but rather treated as a procedure, as she is submitted to the expert supervision of medical knowledge.

The regulation of femininity extends beyond behaviour to include the very terms through which presence is allowed. In Western societies, women are socialised to minimise their presence – spatially, vocally, and emotionally (Young, 2005; Cohen Shabot, 2016). A "well-behaved" woman is discreet, manageable, and

quiet. The birthing body, however, defies all these expectations of feminine decorum: it is expansive, noisy, unpredictable, and openly challenges both the medical imperative of control and the patriarchal ideal of restrained, decorative femininity. Obstetric violence thus operates as a disciplinary apparatus that reacts to the expressive and agentic female body. When a woman screams, questions instructions, or demands information, she transgresses not only the internal logic of medical rationality but also the deeply embedded norms of passive femininity. The institutional response to this "disruptive" femininity is coercive: verbal humiliation, non-consensual procedures, and the systematic dismissal of requests. These mechanisms serve as technologies of re-feminisation, re-domesticating the unruly birthing body and repositioning the subject within socially acceptable and medically manageable forms (Davis-Floyd, 2003; Briggs, 2002; Roberts, 1997).

Recent studies across diverse healthcare systems confirm that obstetric violence is neither incidental nor restricted to under-resourced settings. In Spain, a national online survey conducted in 2019 with over 899 women found that 67.4% (606 of the women) had undergone unjustified medical interventions during childbirth (Martínez-Galiano et al., 2021). In Poland, a 2018 cross-sectional national study, based on self-reported data from 8.378 respondents, found that 81% of respondents experienced violence or abuse from medical staff on at least one occasion (Baranowska et al., 2019). In the United States, a 2022 national online survey carried out by the Centers for Disease Control and Prevention (CDC) revealed that 20% of birthing women felt coerced into medical decisions (CDC, 2023).

In Romania, a 2024 national survey conducted by the Association of Independent Midwives (Asociația Moașelor Independente) on 5.623 women showed that obstetric violence was most frequently reported in vaginal births, where 29.6% of women said they had endured one or more distinct forms of mistreatment. A striking 83.6% of respondents reported being denied the option to have a partner or support person present during labour and birth, suggesting a significant disregard for relational and emotional support in maternity care (Neaga, Grünberg & Radu, 2024). Additionally, 76.1% of women indicated that they were forced into specific birthing positions, reflecting a broader institutional tendency to prioritise medical control over bodily autonomy (idem). More than half (56.0%) experienced postnatal separation from their newborns, a practice known to affect bonding and breastfeeding negatively. Alarmingly, 45.3% of women reported being subjected to the Kristeller manoeuvre (fundal pressure with the elbow), a controversial and often painful intervention associated with increased risks (ibidem). Although the phenomenon is widespread, only 16.2% of women explicitly identified themselves as victims of obstetric violence, pointing to a high level of normalisation and low awareness of patients' rights (Neaga, Grünberg & Radu, 2024).

3. Methodological Design

The research is informed by a phenomenological methodology, which focuses on capturing and interpreting the lived, embodied experience of childbirth

from the perspective of the individual. Drawing on feminist phenomenology (Young, 2005; Cohen Shabot, 2016), this approach views the body not merely as a biological object but as a site of meaning, power, and social inscription. Phenomenology enables a shift from viewing obstetric violence as a set of discrete events to understanding it as an experience of violation felt through the flesh, narrated through memory, and shaped by social and institutional structures. This framework foregrounds the affective, relational, and temporal dimensions of the birthing experience, with particular attention to how violence is named or not named, justified or resisted.

The research raises three key questions: *(1) How do women in Romania articulate and make sense of their experiences of obstetric violence during medicalised childbirth?; (2) What institutional, discursive, and affective mechanisms contribute to the normalisation, invisibilisation, or justification of these forms of violence?* and *(3) In what ways do women resist, internalise, or reconfigure these experiences over time in their personal and social narratives?*. Building on these questions, the research aims to fulfil three core objectives: first, to document and categorise the diverse forms of obstetric violence as narrated by women who have given birth in both public and private medical institutions in Romania; second, to explore the socio-cultural and clinical logics through which these practices are legitimised and rendered routine; and third, to develop a phenomenological interpretation of how obstetric violence is embodied, silenced, or contested in contexts marked by gendered hierarchies and medical paternalism. This dual focus on structural critique and subjective experience enables a more nuanced understanding of how violence is both systemically produced and intimately experienced.

The empirical investigation was based on 30 in-depth, semi-structured face-to-face interviews conducted between May 2022 and July 2024. Each interview lasted approximately 90 minutes. The interview guide was designed to foster a broad discussion on reproductive health and to allow participants to reconstruct their experiences of pregnancy and childbirth in their own words. It is important to mention that my interest in this subject is not grounded in an autoethnographic approach. My personal trajectory has not been shaped by the experience of motherhood, but rather by a reaction to the banality of obstetric violence that I encountered during my professional training as a nurse. It was during my clinical internship in obstetrics and gynaecology that I first came into contact with a routinised form of violence, embedded in clinical protocols and everyday doctor-patient interactions.

The structure of the interview guide was not centred on obstetric violence, but was instead situated within a narrative account of perinatal reproductive health, childbirth, and the postnatal period. The research instrument contained four analytical dimensions: reproductive sexual hygiene, medical planning of pregnancy, the experience of birth medicalisation, and the postnatal period, focusing on the retrospective evaluation of how reproductive health experiences were felt, interpreted, and re-evaluated over time. Moreover, the concept of "obstetric violence" was deliberately excluded from the interview in order to avoid

providing participants with a predefined conceptual framework of expression, and to allow for spontaneous articulations of discomfort, confusion, or abuse when such emerged.

Participant recruitment was conducted using the "snowball" method (Babbie, 2010), beginning with my personal and professional network and gradually expanding through informal recommendations. The inclusion criteria were as follows: (1) a recent (not before 2019) childbirth experience in a medicalised setting in Romania; (2) direct, embodied access to the experience of childbirth (only individuals who had themselves given birth were included, not partners, or medical professionals), and (3) contextual and experiential diversity – although not a formal exclusion criterion, I sought variation in terms of type of medical facility (public, private, university-affiliated), type of birth (spontaneous, induced, cesarean), parity (primiparous versus multiparous), and medical history (including high-risk pregnancies and premature births).

In the following section, I present the socio-demographic data of the interviewees in tabular form to offer a general overview of the diversity of profiles included in the research. The selected information does not aim for statistical representativeness but rather to contextualise the narrated experiences, in line with the qualitative approach centred on subjectivity (Iluț, 1997).

Table 1. Socio-Demographic, Obstetric, and Clinical Characteristics of Participants (n = 30)

Category	Subcategory	Number of participants (n = 30)
age	19–25 years	4
	26–35 years	18
	36+ years	8
place of residence	urban	22
	rural	8
education level	secondary education	9
	higher education	21
occupational status	public sector	10
	private sector	8
	unemployed	4
	student	3
	maternity leave	5
type of medical facility	public	20
	private	10
birth experience	primiparous	18
	multiparous	12
number of births	1 birth	18
	2 births	9
	3 + births	3
type of birth	spontaneous vaginal birth	9
	induced vaginal birth	8
	emergency C-section	5
	scheduled C-section	8

Category	Subcategory	Number of participants (n = 30)
relevant medical history	high-risk pregnancy	9
	premature birth	4
	no complications	17
obstetric violence (≥1 form)	YES	27
	NO	3

Out of the 30 women interviewed, 20 gave birth in public hospitals and 10 in private clinics. Eighteen participants became mothers for the first time, while twelve had at least one previous birth. Regarding the type of delivery, 12 participants gave birth naturally (spontaneous vaginal deliveries), 6 underwent induction, and twelve had cesarean sections (five scheduled, seven emergency). Nine participants were classified as having high-risk pregnancies, and four experienced premature births. I also considered the clinical setting (public or private) in order to explore how institutional culture affects medical discourse and practices.

The interviewed women were informed about the broader aims of the study, their rights, and the procedures in place to protect their identity, anonymity, and data confidentiality. Verbal consent for audio recording was obtained. After recording, the interviews were transcribed using transcription software. The data were coded and analysed in two stages, without the use of specialised software. In the first stage, I conducted a thematic analysis to identify recurring patterns of obstetric violence, comparing the empirical data with the primary forms described in the literature. In the second stage, I applied a phenomenological lens, focusing on how the participants construct their narratives of labour, childbirth, and the immediate postnatal period (in the hospital). This analysis stage did not focus on the affective and performative textures of the women's discourse. Through this dual lens, which addresses both patterns and the lived experience of violence, I sought to produce a thick description (Geertz, 1973) that not only documents specific instances of obstetric abuse but also seeks to understand how this violence is embodied, silenced, internalised, or contested.

4. Results

Several key themes emerged (Figure 1) from the narratives of the women I interviewed, each tracing a particular mode through which obstetric violence is experienced, processed, or contested. One of the most recurrent was voicelessness – accounts in which participants were silenced, ignored, or mocked when attempting to express pain or ask questions. Closely tied to this was the disruption of bodily autonomy, as women described procedures performed without explanation, forewarning, or consent, reducing them to passive recipients of intervention. Some testimonies bore traces of symbolic violence through the use of derogatory language, comparisons with animals, or infantilising tones that undermined their status as adult, rational subjects. And yet, moments of resistance and reclamation also surfaced – instances where women challenged authority, refused procedures, or reasserted their agency. Finally, a subtler layer of experience

emerged in the form of ambiguity and rationalisation: many struggled to name what had happened to them, caught between recognising harm and justifying it as necessary, expected, or "how birth is."

These findings strongly resonate with recent international ethnographies (Chadwick, 2018; Pickles, 2023), demonstrating how violence is often normalised through repetition and silence. Frequently, women themselves interpret abuse not as a violation of bodily autonomy or the right to co-participation through consent, but as part of what is perceived to be the "natural" process of giving birth. This normalisation form operates as a discursive mechanism that obscures the birthing subject's agency and restricts – or entirely erases – the possibility of resistance. Therefore, contrary to the way the WHO (2014) frames obstetric violence as a breach of care standards, what is at stake is the reproduction of an ontological absence. This erasure is re-inscribed upon all bodies subjected to expert knowledge in the clinical space.

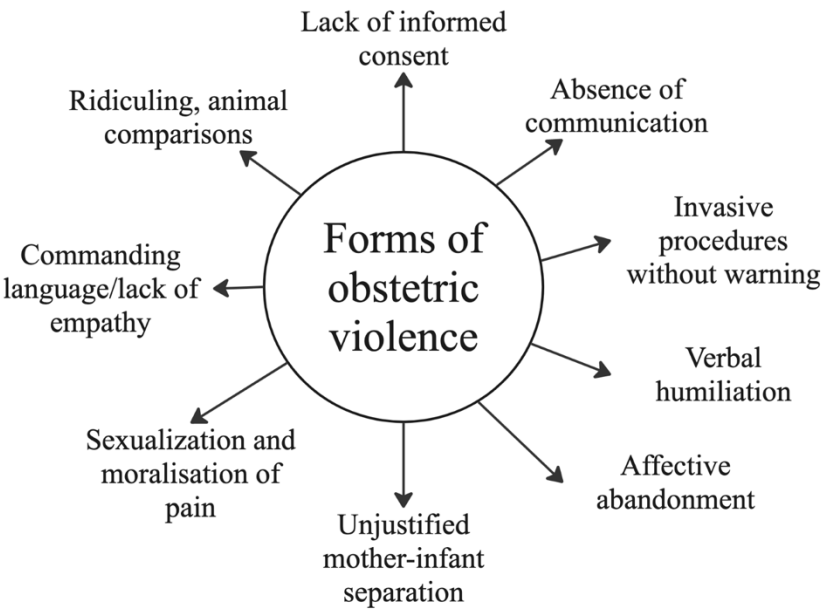

Figure 1. Typologies of Obstetric Violence: A Conceptual Mapping of Reported Practices. Source: author's elaboration based on interview data.

4.1. Silencing the "Loud" Feminine Body

One of the most pervasive forms of obstetric violence reported by participants was verbal aggression, often dismissed as clinical normalcy or rationalised as disciplinary intervention. These were not incidental slips of language, but performative acts of control, directed at bodies perceived as unruly. The voice of the birthing woman, especially when expressing pain, fear, or the need

for information, was framed as a disturbance that needed to be silenced. Expressions such as *"Did you scream like that when you made the baby?"* (R, 31 years old, public hospital birth) or *"You liked the sex, didn't you? Then shut up and take it now"* (A, 33 years old, public hospital birth) were not only dehumanising but reinscribed pain as something deserved, a form of punishment for female desire, agency, or voice. Pain was not merely dismissed; it was moralised, rendered a sign of weakness, guilt, or failure.

Voice, far from being received as a sign of presence, is treated as something to be managed, corrected, or neutralised. During labour, sound emerges not only as a reaction, but also in the clinical settings in which the interviewees gave birth; these gestures were repeatedly repositioned as inappropriate: *"Shut up! I do not want to hear you screaming! You are bursting our eardrums. I did not come to work to listen to your yelling"* (C, 21 years old, public hospital birth). The voice that carries pain, uncertainty, or fear is not heard as communication, but as disturbance, as failure to comply with an unspoken rule that pain must be orderly and quiet.

The expressive "loud" labouring body becomes something to be punished, not witnessed. Pain is not only invalidated, but reframed as shameful, as if the very act of vocalising suffering were a sign of weakness or moral deficit: "*They told me I should keep quiet, that others suffer more and do not make a fuss like I do"* (L, 26 years old, public hospital birth); *"(...) they told me that this is a clinic, and not a circus and that I should refrain screaming"* (I, 34 years old, public hospital birth). In the clinical space, there is limited tolerance for rawness, for being undone or for asking aloud what is happening or begging for someone to stay: *"The supervising nurse said I was being dramatic, that I was embarrassing myself and that I needed to stop making a scene"* (F, 28 years old, private hospital birth). Even when expression takes the form of sobbing or breathless silence, the body is not met with reassurance, but with avoidance, delay, or irritation: *"I was rocking back and forth, crying with everything I had left. My legs were shaking, and all they* (the medical staff, n.n.) *told me to stay still and stop exaggerating, that other women give birth without making a scene. I just broke down crying (...) It felt like I was bothering them by existing"* (E, 37 years old, public hospital birth).

The experience of being spoken to without being addressed, of being present but not received, forms a layer of violence that does not leave bruises but accumulates inward. At the intersection of bodily intensity and institutional silence, meaning begins to fray: *"Maybe I was too sensitive. Maybe I really did exaggerate"* (F, 28 years old, private hospital birth); *"I started to think I was going mad, because I kept begging for help and nobody even looked at me"* (E, 37 years old, public hospital birth). The voice, having failed to bring someone closer, becomes heavy, then folds inward. Instead of asking again, the body withdraws, not because the pain has stopped, but because the invitation to speak has collapsed.

When voice is punished for existing, it becomes impossible to trust its own urgency. Nevertheless, where silencing leaves rupture, women speak of what could have been — not in abstract terms, but through the memory of those who stayed: *"I was lucky. The midwife who assisted me was a kind woman. She kept saying, 'Come*

on, mama, you are strong. Do not give up now.' Honestly, when you are in there and feel like you cannot go on, a kind word is worth more than any medicine. Some nurses were angels on earth. Others... it was like they were just there to get the job done. The midwife who helped me, God, that woman was like a mother to me. She held my hand, whispered that I should not panic, and explained everything. Without her, I would have fallen apart" (M, 27 years old, public hospital birth). What endures in memory is rarely the clinical intervention itself, but rather the hand that remained, the whisper that soothed, and the sense that someone chose to stay. In the space where violence has taught silence, care begins with the simple, radical act of addressing the person who is still there.

4.2. Medicalised Control and the Rupture of Bodily Agency

Obstetric violence is often experienced not as a singular rupture but as a gradual stripping away of agency, enacted through procedures that arrive without explanation, bodily incursions that take place without pause, and gestures that leave behind confusion rather than clarity. Narratives of care-as-command fill the space where dialogue should have been, and in that absence, what remains is the feeling of being acted upon, of being handled rather than held: *"I was put in a wheelchair and taken for what they said was the delivery of the placenta. But they raised me on the table, and I felt them doing something inside me. I asked, 'What are you doing?' and the answer was, 'We are doing a curettage.' They had not told me. Even today, no one has explained why. It does not even show up in my discharge papers"* (O, 36 years old, public hospital birth). In this clinical choreography, consent was neither withdrawn nor explicitly invited.

The laboring body becomes a site of rehearsed interventions that rarely pause for creating a trust relation: "*They brought me up on the table again and again. They even brought five students to check me (...). Nobody asked if I was okay with that*" (D, 28 years old, public hospital birth). What is remembered is not the procedure itself, but the sensation of being open, exposed, turned into something that could be touched and observed without acknowledgement. Medical authority, rather than entering into communication, arrived as a sequence of actions without explanation. *"They told me nothing. I felt something cold and just heard, 'We need to cut you.' I had no time to process, to ask or to refuse"* (R, 31 years old, public hospital birth). The body, made visible through technique, was simultaneously erased as a subject of experience. It was measured, stitched, examined, but never addressed, while care is unfolded like a script where time moved forward but meaning did not accumulate: "*I woke up from the anaesthesia in unbearable pain. I was not even given a painkiller. For 48 hours, I was in agony, and no one came to check on me for hours in a row"* (I, 34 years old, public hospital birth).

The women did not speak of these events as isolated incidents. What unsettled them was often not the act itself, but the way it was carried out (the sequence of movements, the routine, the impersonal flow that stripped the moment of care or consent): *"I was left alone in the operating room after the C-section. The doctors left. Two nurses stayed behind, looking at me and wondering what to do,*

because they were not sure if they could move me by themselves. It was like I was a weight, not an actual person in need of care" (O, 36 years old, public hospital birth). What takes shape across these narratives is not simply the failure to inform, but the systematic erasure of the subject as someone who might refuse, who might say no, who might need time to understand what is being done. The rupture is not only physical, but temporal and moral, perceived as dislocations from one's own body in a moment that should have demanded presence and care. Where communication was absent, interpretation became impossible: *"I did not understand what was happening. Even though it was my second birth, the pain and the way I was treated made everything feel alien. I felt like I had to figure it out on my own"* (A, 33 years old, public hospital birth). The loss of control was not only about the procedures themselves, but about not knowing when something would be done, why it was needed, or whether anyone thought to ask what she wanted. What was fractured was not just trust in the system, but the coherence of the experience itself.

4.3. Abandonment as Affective and Temporal Violence

Abandonment is not defined by what is done, but by what is withheld. In the delivery room, abandonment emerges not through visible aggression, but through absence of words, of gestures or recognition. The experience of being left alone while in pain, of not being seen or responded to, does not appear as a moment of neutrality but as an active form of violence, one that stretches over time, alters bodily perception, and breaks continuity with the self.

Time, when unaccompanied, ceases to move coherently: *"I was left alone in the ward, shaking with cold and in shock. I did not understand what was happening to me. I felt like crying, but I was too exhausted to feel anything clearly"* (D, 28 years old, public hospital birth). This loss of orientation is not only disempowering; it fractures the birth experience from within. There is no indication of how long it will last, nor is anyone explaining what is happening or when someone will return. The absence of presence not only delays care, but it also corrodes meaning. "*I kept asking if it was normal to hurt that much, and the nurse just said, 'It is normal. You will manage.' She did not even look at me, I swear to God (…)"* (S, 31 years old, public hospital birth) The question was not met with reassurance or explanation, but with a flat imperative to endure. The denial of response is never simply a procedural matter. Still, it communicates that the person in pain is not someone who needs to be with. Still, someone who needs to be managed or ignored: "*I gave birth, and they left me in the room without saying anything. I did not know if I had torn, if everything was okay. Nobody told me anything. They just walked out"* (N, 29 years old, public hospital birth). The silence does not feel like an absence; instead, it gathers weight, becoming dense with fear, with shame, and with the unsettling realisation that the experience unfolding no longer belongs to the person living through it, but seems instead to be claimed and directed by others.

The feeling of being abandoned does not come from one moment, but from an entire atmosphere in which care seems to have withdrawn its gaze: *"I asked them to close the window after birth because I was trembling all over and sensitive to*

cold, but they said, 'That is how it has to be, for ventilation.' I lay there shaking for hours and got sick after two days" (L, 26 years old, public hospital birth). The refusal to respond to suffering is not about clinical justification. It is about the distance created when bodies are treated as tasks and subjects disappear behind them. Where care becomes impersonal, even mechanical, presence takes on the form of exposure without relation: "*They took the baby to another ward, and when I asked how he was doing, nobody told me anything. I waited all night for someone to bring him back. The next morning, a nurse told me, 'What, you got scared and left him with us?' as if I had abandoned him, when it was their decision"* (S, 31 years old, public hospital birth). What remains from this moment is not just silence, but how silence is followed by blame. The question is never whether the patient was left alone, but why she did not behave better in the face of being alone.

In these accounts, abandonment is not equivalent to a lack of resources. It is felt as a withdrawal of recognition, a disappearance of relation: "*I gave birth and I was so tired, I could not move. I was left to figure it all out on my own. Nobody came. I did not even know where the call button was"* (T, 41 years old, public hospital birth). Clinical space becomes a space of waiting, not for labour to end, but for someone to see that labour is not over just because the body has expelled the child. This form of violence operates not through action but through non-response, unfolding as a temporal dislocation, where moments that should have been contained, held, and accompanied are stretched out. It is in these stretched-out moments that women begin to question whether they have the right to ask for anything at all.

When there is no genuine sense of connection, when no one is truly present to see or hear what is unfolding, time begins to lose its rhythm. It no longer moves forward in a steady flow, but thickens and coagulates, making the experience of birth difficult to recount. This difficulty is not due to a lack of intensity; on the contrary, the sensations are vivid and often overwhelming. What becomes elusive is the meaning of those sensations, because meaning does not arise in isolation. It takes shape through the presence of another, through a response that confirms and reflects the experience. In the absence of that response, the pain does not become less real; instead, it becomes harder to place and harder to hold within a coherent narrative. What remains are fragments: moments, impressions, bodily memories that linger long after the hospital stay has ended, carried quietly in the body as unspoken traces of something that was never fully witnessed.

5. Conclusion

Obstetric violence is not an anomaly. It is a patterned, systemic expression of how institutional medicine governs the birthing body through language, silence, gesture, and withdrawal. This research seeks not only to trace the external manifestations of violence but also the internal labour that women undertake to make sense of what has been done to them, often without consent, recognition, or apology. The narratives gathered in this study are not uniform. Some are punctuated by moments of acute rupture: physical or verbal acts that clearly crossed a threshold of harm. Others reveal more ambiguous forms of violence:

abandonment, condescension or erasure. What binds them together is not the intensity of the act, but the structure of power beneath it, that renders women's voices optional, their bodies procedural, and their suffering tolerable within the metrics of institutional care.

Obstetric violence reveals a paradox at the heart of biomedical care: birth, in its raw, chaotic, expressive form, destabilises the norms of both medical rationality and patriarchal femininity. The labouring body bleeds, screams, and demands, while refusing containment, and precisely because of this excess, it is corrected, silenced, sutured and brought back into compliance. This shows that this form of abuse is not merely a failure of bedside manner or professional ethics, but the result of a deeper ontological framework, in which the labouring woman is positioned as both hyper-visible and radically absent. The body is monitored, measured, and corrected, while presence is reduced to function, and visibility does not ensure recognition. Subjectivity is stripped away, leaving only a clinical object to be managed within institutional logics.

This research does not offer closure. It offers testimony, trace, and refusal. The women who shared their stories did not all identify as victims: some resisted, some rationalised, and others endured. Their narratives reflect the ambivalent terrain of embodied power, where violence and care are often inseparable, harm is inflicted in the name of help, and survival requires both silence and speech. Future research could further explore the affective afterlife of obstetric violence: how women narrate, suppress, or reconfigure these experiences over time, and how such memories impact maternal identity, trust in healthcare, and intergenerational transmission of medical anxiety. Anthropology can contribute to this reimagination, not by standing outside of suffering but by walking alongside it, bearing witness to what has not been named, and insisting that what has been normalised must no longer be accepted.

What is needed is not merely further research, but a collective public reckoning with the systems and values that have allowed obstetric violence to persist and remain largely unspoken. The narratives gathered in this study do not merely require analysis or theorisation; they demand recognition, responsibility, and action. They highlight the urgent need for institutional accountability, structural transformation, and the development of care practices grounded in relational ethics, bodily autonomy, and human dignity. To address obstetric violence is to reconfigure not only the clinical management of birth, but the very ways in which care is imagined, authority is enacted, and voices are acknowledged. This is not simply a matter of improving communication or bedside manners. It is a matter of justice, of whose pain is allowed to be visible, whose suffering is allowed to matter, and whose experience is allowed to reshape the world of care.

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