



Commentary

Beyond the term “obstetric violence”: A conceptual architecture for obstetric gynaecological violence and perinatal care violence

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ABSTRACT

Over the past two decades, “obstetric violence” has become a central concept in research, policy and law on reproductive health care. Debate has focused almost entirely on whether “violence” is the appropriate word, while “obstetric” has gone largely unexamined. This article argues that “violence” is justified, but that “obstetric violence” is conceptually insufficient: it confines the phenomenon to the moment of birth, frames as relational what is structural and institutional, and names one clinical specialty within a field of care that involves several. The field uses at least four overlapping labels - obstetric violence, obstetric and gynaecological violence, mistreatment and disrespect, and abuse - with no account of how they relate, making the phenomenon difficult to define and measure. Using four criteria — construct validity, operationalisability, socio-legal usability, and professional acceptability — the article proposes a two-level framework. Obstetric gynaecological violence is proposed as the macro-category, covering violations of physical and psychological integrity occurring within reproductive health care across the reproductive life course. Perinatal care violence is proposed as its subcategory for pregnancy, labour and birth, and the six weeks following birth. Both terms name a context and a phase of care rather than a profession, and neither displaces the term codified in existing legislation.

Statement of Significance

Problem or Issue	Terms for violence in reproductive health care proliferate without any account of how they relate, making the phenomenon hard to delimit and to measure.
What is Already Known	Debate has focused on whether “violence” is the right word, and one recent proposal narrows “obstetric violence” to antenatal, intrapartum and postnatal care.
What this Paper Adds	An explicit two-level architecture: obstetric gynaecological violence as macro-category and perinatal care violence as its perinatal subcategory, each named by context and phase of care rather than by specialty.

Introduction

Over the past two decades, obstetric violence has become a central concept across psychology, midwifery, obstetrics, public health, sociology and law (Bohren et al., 2015; Castro and Frías, 2020; Sando et al., 2017). Emerging from Latin American movements for humanised childbirth, it was first codified in Venezuelan legislation in 2007 (Ley Orgánica sobre el Derecho de las Mujeres a una Vida Libre de

Violencia, 2007) and subsequently in Argentina and several Mexican states. It refers to mistreatment and abuse experienced by women in health care during the reproductive period: physical, verbal and psychological abuse, denigration, lack of privacy, forced positions, and routine procedures performed without clinical indication or informed consent. These practices violate dignity, autonomy and self-determination and have been documented in health systems at every income level (Fraser et al., 2025; Martínez-Galiano et al., 2021).

The concept later gained international recognition through a 2019 report by the United Nations Special Rapporteur on violence against women (Šimonović, 2019), the Council of Europe’s Resolution 2306 (Council of Europe, 2019), and a 2024 European Parliament study (European Parliament, 2024). The World Health Organization has instead preferred “disrespect and abuse” or “mistreatment” (World Health Organization, 2014, 2018), making terminology an institutional as well as a semantic issue.

The term remains controversial, particularly in medical and gynaecological settings, where it is perceived as accusatory and professionally stigmatising; some authors prefer “mistreatment during childbirth” or “disrespect and abuse” (Ferrão et al., 2025). Lappeman and Swartz

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(2021) argue that it includes unintentional behaviours - silence, poor communication, and lack of emotional support - better described as inadequate care. Chadwick (2023) replies that milder terms minimise women's accounts and perpetuate a form of epistemic injustice. Sadler et al. (2016) defend the term because it allows the phenomenon to be understood as structural rather than merely interpersonal.

Beyond this debate, this paper asks a further question: is "obstetric" adequate? Obstetric violence, obstetric and gynaecological violence, mistreatment, and disrespect and abuse overlap without a clear hierarchy or boundary. Pickles (2024) captures the consequence: "obstetric violence" can denote almost any violation in reproductive health care, weakening measurement and socio-legal application. Although "violence" is appropriate, as argued below, "obstetric violence" remains analytically insufficient: it is commonly associated with birth, frames as relational what is structural, and names one specialty within multidisciplinary care. This contribution therefore organises terms already in use into two levels. "Obstetric gynaecological violence" as the overarching category, already used in French scholarship and European institutional documents (Oliveras-Medina et al., 2025); and "Perinatal care violence", already the object of an instrument endorsed by the National College of French Midwives (Sauvegrain et al., 2025), which designates violations during pregnancy, birth and early postnatal care.

Four criteria are used to assess the proposal: (i) construct validity: does the category capture what women themselves describe? (ii) operationalisability: can it be measured with existing or foreseeable instruments? (iii) socio-legal usability: can it be translated into norms and subjected to scrutiny? (iv) professional acceptability: can it be used clinically without incriminating individual professionals?

This article addresses women because its theoretical framework is that of gender-based violence and because the empirical literature draws predominantly on women. It is not intended to exclude trans and non-binary people who give birth, whose inclusion is rightly made explicit in more recent definitions (Pickles, 2024); the framework also applies to them unchanged.

"Violence" and the structural nature of the phenomenon

The World Health Organization (2002) defines violence as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that results in, or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation." Power, here, extends beyond individual intent to institutions. Limiting violence to intentional acts risks obscuring normalised, widespread, and well-documented routines (Chadwick, 2023): protocols applied without consent, coercive decision-making, time and staffing pressures, verbal humiliation or neglect. These may occur without overt physical force or malicious intent and are sustained by the organisation of health systems (Sadler et al., 2016).

The definition also emphasises psychological and physical harm, both already documented: postpartum depression and post-traumatic stress disorder (Kohan et al., 2025; Martínez-Vázquez et al., 2022); perineal and vaginal pain, dyspareunia and urinary incontinence (Bohren et al., 2015). Women and representatives of patient organisations have also explicitly endorsed the term (Sauvegrain et al., 2025).

The temporal dimension

"Obstetric violence" directs attention to pregnancy and birth, although some definitions extend across the reproductive life course (Chadwick, 2023; Sadler et al., 2016). Research and measurement nevertheless concentrate on childbirth and the immediate postnatal period (Bohren et al., 2015). Fertility treatment, miscarriage, termination of pregnancy and gynaecological consultations remain comparatively underexamined, although negative experiences are documented (Bellhouse et al., 2019; Hodson and Bewley, 2019). A category that

excludes experiences women recognise as harm has limited construct validity.

This mismatch also affects measurement: instruments based mainly on intrapartum items generate estimates about childbirth that may be interpreted as applying to reproductive health care generally (Sando et al., 2017). A clearer temporal boundary would align prevalence claims with what was measured.

Multiple specialties beyond obstetrics

Mistreatment, abuse and violence are not attributable to obstetric practice alone. They arise across the continuum of reproductive care, involving gynaecology, prenatal medicine, anaesthesiology, neonatology and postnatal care (Bohren et al., 2015; Sadler et al., 2016). The problem is sharper in some languages: in English "obstetric" describes a branch of medicine, whereas in Italian *ostetrica* ("midwife") and *ostetricia* ("obstetrics") overlap, so the term points almost exclusively at midwives.

Resistance to the concept within medicine is usually described as resistance to the word "violence" (Ferrão et al., 2025; Reyes-Amargant et al., 2025), but the disciplinary label carries a significant cost of its own. It leads professionals in that specialty to feel accused, and leads those in adjacent specialties — anaesthetists, neonatologists, nurses and support staff — to conclude that the problem does not concern them. Both reactions are inconsistent with a structural account. A useful term should include all relevant settings without attributing an institutional problem to one group.

Towards a broader conceptual framework

Taken together, these limitations show that the term is asked to do two incompatible jobs: to identify practices concentrated around childbirth and to cover violence throughout reproductive health care. Pickles (2024) offers the most developed response: violence is defined as a violation of physical or psychological integrity, including overt harm and dehumanising objectification, and obstetric violence is limited to prenatal, intrapartum, and postnatal care. Other reproductive violations are linked through Kelly's (1988) continuum of violence. The present conceptual framework retains this substantive definition and the need for boundaries but adds a superordinate category and revises the perinatal label. Kelly's (1988) continuum explains how normalised and overt violations are connected, whereas measurement requires categorical boundaries; the two approaches are therefore complementary.

Obstetric gynaecological violence (OGV) is therefore proposed as the macro-category: the abuse, coercion, neglect and disrespect women experience within health systems across their reproductive life, whether or not a pregnancy is involved. Three conditions must be met: a violation of physical and/or psychological integrity in the sense defined by Pickles (2024); occurrence within reproductive health care; and the person receiving care as the subject of the violation. The third condition also marks the boundary of the category, and a category that cannot specify what it excludes cannot be measured. This excludes violence against professionals, adverse outcomes or errors without a violation of integrity, and intimate partner violence during pregnancy. These may share causes or contexts but belong to different constructs.

A label naming two clinical specialties might seem to reproduce the problem described above. It does not: the composite term refers to a context of care - the settings, protocols and institutional arrangements through which reproductive health care is provided - rather than to the professional groups working within them. It is also used by the Council of Europe (2019), the European Parliament (2024), and recent empirical research (Oliveras-Medina et al., 2025).

Within this macro-category, violations occurring during pregnancy, childbirth and the postpartum period are termed perinatal care violence (PCV). This phase is clinically distinct, characterised by vulnerability, intensive and time-dependent interventions and power asymmetries; it

is also the phase most studied and measured (Bohren et al., 2015; Sauvegrain et al., 2025). Yet it has often been treated as representative of reproductive health care as a whole. The reference to "care" is essential. "Perinatal violence" and "perinatal intimate partner violence" already refer to violence occurring during the perinatal period. Perinatal care violence is violence instead arises from care provided during this period. Because "perinatal" varies across fields, the proposed boundary follows the World Health Organization's postnatal period: pregnancy, labour and birth, and six weeks after birth (World Health Organization, 2022). Later violations remain within obstetric gynaecological violence rather than disappearing from the framework.

It might be objected that abandoning the term constitutes precisely the epistemic injustice described by Chadwick (2023). That argument turns on the word "violence", which is retained in both proposed terms. What is not retained is "obstetric" - a technical qualifier introduced by legislators and researchers rather than the element at the center of women's accounts. Nor does the proposal seek to repeal existing law. "Obstetric violence" is codified in Venezuelan, Argentinian and Mexican legislation and used by the United Nations Special Rapporteur (Simonović, 2019), and will continue to refer to what those instruments designate; what they define as obstetric violence is, in the terms proposed here, perinatal care violence. Explicit boundaries strengthen application to cases without invalidating established terminology.

The framework therefore answers a question the field has left implicit: how its terms relate. Perinatal care violence is a subcategory of obstetric gynaecological violence, distinguished by phase of care and not by severity; both are forms of gender-based violence produced by health care institutions, and both name settings rather than professionals. Table 1 sets out how each performs against the four criteria.

Implications for practice and policy

The proposed distinction may clarify which forms of violence a woman of reproductive age may experience within the health system, and which of them occur around labour and birth. Naming where violence occurs rather than which professionals are to blame, and treating it as an institutional phenomenon, could reduce defensiveness and support communication between midwives, physicians, psychologists, anaesthetists and neonatologists. It could also help direct policy at the conditions that enable it, including staff shortages, professional hierarchies and protocol-driven care.

Engagement of public in research

This conceptual analysis involved no primary data, so formal public involvement in its design was not applicable. It draws, however, on research involving women and patient organisations (Sauvegrain et al., 2025), and stakeholder validation of the proposed terminology is a necessary next step.

Limitations and future research

This is a conceptual and normative analysis, not a systematic review. Its literature is predominantly European and Latin American, with African and Asian contexts—where "disrespect" and "mistreatment" often predominate—underrepresented (Ferrão et al., 2025). The linguistic argument derives from Italian and may not apply where professional and disciplinary terms clearly differ. The four criteria were drawn from the debate itself rather than from an established method of concept analysis (Rodgers, 1989).

Finally, the two proposed terms have not been validated with women and other recipients of reproductive health care, health professionals, policy makers or legal stakeholders. Work of this kind has begun for violence in perinatal care (Sauvegrain et al., 2025); no equivalent exists for the macro-category. The framework should therefore be read as a theoretically grounded proposal requiring further exploration, not as a

Table 1

Evaluation of "obstetric violence" and of the proposed framework against the four criteria.

Criterion	"Obstetric violence"	Obstetric gynaecological violence (OGV) / perinatal care violence (PCV)
(i) Construct validity Does the category capture what women themselves describe?	Captures intrapartum experience well. Excludes accounts women give of fertility treatment, gestational loss, abortion care and routine gynaecological consultations.	OGV restores those accounts to the category; PCV retains the descriptive precision of the intrapartum phase.
(ii) Operationalisability Can it be measured with existing or foreseeable instruments?	Validated instruments are built from intrapartum items and administered to women who have recently given birth, so estimates describe birth but are read as describing reproductive health care.	PCV names what existing instruments already measure, so current estimates remain valid under a correct label; OGV identifies the areas for which instruments still have to be developed.
(iii) Socio-legal usability Can it be translated into norms and subjected to scrutiny?	Codified in Venezuelan, Argentinian and Mexican legislation and adopted by the United Nations Special Rapporteur, but increasingly used without conceptual limits, which weakens its application to cases.	The analytical vocabulary coexists with the codified one without displacing it; specified boundaries make each category applicable to cases and open to scrutiny.
(iv) Professional acceptability Can it be used in clinical settings without incriminating individual professionals?	Names a clinical specialty. Professionals within it read the term as an accusation; those in adjacent specialties conclude that the problem does not concern them.	Both terms name a context and a phase of care rather than a profession, while retaining the word "violence" and its political force. A context-of-care label has institutional precedent in a national midwifery body.

Note. Criteria (i) and (ii) are argued from published evidence. Criterion (iii) is argued conceptually: that the substitution preserves socio-legal force remains an empirical proposition to be tested. For criterion (iv), the adoption of a context-of-care label by a national midwifery body provides institutional precedent, but the claim that such a label reduces professional defensiveness has not been tested directly.

definitive taxonomy.

Conclusion

The language used to describe a phenomenon is never neutral: it shapes how the phenomenon is defined, interpreted, institutionally recognised and studied. "Obstetric violence" has done important scientific and social work in bringing abuse and mistreatment to light, but it has also become the object of a controversy that risks diverting attention from the phenomenon itself and hindering communication between professionals, pushing the woman and her experience into the background once again. The framework proposed here distinguishes a macro-category, obstetric gynaecological violence, from a subcategory, perinatal care violence, limited to pregnancy, childbirth and the six weeks following birth. Greater terminological precision is a necessary condition for targeted prevention, accurate measurement and structural change.

Ethical statement

Not applicable. This article is a conceptual and normative analysis and did not involve human or animal research; no ethical approval was therefore required.

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Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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