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The Fate of Obstetric Violence: A Phenomenological Study on the Urgency of Specific Regulation

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Abstract

Maternal healthcare services may involve practices that affect women's autonomy, dignity, and rights, while obstetric violence remains insufficiently recognized within the Indonesian legal framework. This research aims to understand women's experiences in maternal health care and to analyze the urgency of establishing specific regulations regarding obstetric violence, with a focus on Palu City and Sigi Regency, Central Sulawesi. This study employs a qualitative approach combining phenomenological and socio-legal designs. Data were collected through online in-depth interviews and pre-interview questionnaires involving women who had accessed maternal healthcare services and healthcare professionals selected through purposive sampling. Data were analyzed thematically to identify patterns of experience, power relations, and potentially harmful practices, which were then examined within the applicable legal framework. The findings indicate that women experience limited decision-making autonomy, disrespectful communication, and inadequate health information. These experiences reveal a gap between legal principles protecting patient rights and actual healthcare practices. The findings further demonstrate that obstetric violence is influenced not only by individual actions but also by paternalistic healthcare structures. Therefore, specific regulations recognizing obstetric violence are urgently needed to strengthen legal protection, promote women's autonomy and dignity, and encourage more empathetic, respectful, and rights-based maternal healthcare practices.

Keywords

Maternal Healthcare, Obstetric Violence, Patient Autonomy, Socio-Legal, Women's Rights.

1. Introduction

Maternal health services aim to ensure the safety and well-being of mothers and babies during pregnancy, childbirth, and the postpartum period. However, quality maternity care extends beyond clinical outcomes to include women's dignity, autonomy, participation in decision-making, and freedom from mistreatment. Women's autonomy is associated with better utilization of maternal health services (Rizkianti et al., 2020). Women's childbirth experiences are also shaped by the psychological, social, and relational dimensions of becoming a mother (Mercer, 2004). This perspective has strengthened Respectful Maternity Care (RMC), which emphasizes dignity, respect, information, informed consent, privacy, non-discrimination, and freedom from coercion (Jolivet et al., 2021). Evidence from Ethiopia shows that provider training, supportive supervision, and structural improvements can reduce mistreatment during childbirth, as demonstrated by Asefa et al. (2020). The technocratic model of birth, however, may position women's bodies primarily as objects of medical intervention, potentially limiting their autonomy (Davis-Floyd, 1993).

Within this context, obstetric violence describes practices that undermine women's dignity, bodily integrity, autonomy, and reproductive decision-making, including dehumanized care and abusive interventions (Perrotte et al., 2020; Molla et al., 2022). Global evidence identifies physical and verbal abuse, non-consensual care, and lack of informed consent as forms of mistreatment during childbirth (Bohren et al., 2015). Verbal abuse, denial of companionship, and disrespectful treatment may also become normalized in routine maternity care (Okedo-Alex et al., 2021; Amathullah et al., 2023). Obstetric violence therefore cannot be understood solely as individual misconduct. It may also reflect unequal power relations, institutional routines, and hierarchical professional structures (Sadler et al., 2016). It has been linked to broader structural inequalities within health systems (Sen et al., 2018). A global scoping review found that interventions addressing communication, privacy, informed participation, and provider behavior can reduce obstetric violence (Yalley et al., 2024). The Indonesian context makes this issue particularly relevant. Recent multicenter evidence indicates that respectful maternity care has not yet been fully realized in Indonesia, where medical interventions such as cesarean delivery and episiotomy remain important factors shaping women's experiences of maternity care (Al Farizi et al., 2025). This finding aligns with earlier Indonesian evidence showing the importance of women's autonomy in maternal healthcare utilization (Rizkianti et al., 2020).

From a legal perspective, Indonesia provides several forms of protection for patients and women through health, medical practice, and violence-related legislation. Law Number 17 of 2023 concerning Health recognizes patients' rights to information, safe and quality healthcare, and humane treatment (Haryanto et al., 2025). Law Number 29 of 2004 concerning Medical Practice establishes professional obligations and recognizes patient consent in medical practice. Law Number 12 of 2022 concerning Sexual Violence Crimes provides a broader framework for protecting victims of violence (Muhammad et al., 2025). Nevertheless, these provisions do not explicitly establish obstetric violence as a distinct legal category. International human rights scholarship has emphasized that mistreatment during childbirth may implicate women's dignity, bodily integrity, equality, and informed consent (Khosla et al., 2016). Emerging legal perspectives further recognize obstetric violence as a human-rights concern requiring effective protection and remedies (Pickles, 2025).

This creates an important normative gap. Practices such as coercive decision-making, degrading communication, inadequate information, disregard for patient preferences, and non-consensual interventions may undermine women's autonomy

and dignity without necessarily fitting conventional categories of legal violations. The absence of explicit recognition may therefore lead to women's experiences being treated primarily as matters of professional ethics or service quality rather than as practices requiring specific legal recognition and accountability (Pellegrino, 2002).

Therefore, the issue is not simply whether Indonesia has legal provisions protecting patients, but whether its existing legal framework is sufficiently responsive to the lived, relational, and embodied dimensions of women's experiences in maternal healthcare. The growing international recognition of obstetric violence as a human-rights concern strengthens the argument for examining whether specific legal recognition is necessary within the Indonesian context. Based on these premises, this research aims to understand women's experiences in maternal health care and to analyze the urgency of establishing specific regulations regarding obstetric violence, with a focus on Palu City and Sigi Regency, Central Sulawesi.

2. Methods

This research employs a qualitative approach with phenomenological and socio-legal designs. The phenomenological approach helps understand women's subjective experiences in maternal health care, particularly how they interpret interactions, medical procedures, and relationships with healthcare professionals. Meanwhile, the socio-legal approach analyzes how the law positions these experiences, including identifying gaps between actual practices and prevailing legal norms. The legal analysis draws on relevant legal materials concerning maternal healthcare, patient rights, women's rights, and healthcare services in Indonesia, complemented by secondary legal literature and comparative legal materials from selected countries. These materials were analyzed to assess the extent to which existing legal frameworks recognize women's experiences and provide protection against practices that may constitute obstetric violence.

The research locations were selected in Palu City and Sigi Regency based on the social context and access to maternal health services in these areas, including post-disaster dynamics that have influenced the healthcare system and women's vulnerabilities. The research subjects consisted of two main groups: women who have accessed pregnancy, childbirth, or postpartum services, and healthcare professionals providing maternal services (doctors, midwives, and nurses). The selection of respondents was conducted using purposive sampling, taking into account experiences relevant to the research focus.

Data collection was carried out through online in-depth interviews, which provided a safe and flexible space for respondents to recount their experiences. In addition, a pre-interview questionnaire was utilized to explore initial understandings and the patterns of practice developing among healthcare professionals. The research procedures included the stages of respondent identification and selection, completion of the initial questionnaire, execution of the interviews, as well as the data transcription and verification process. Data analysis was conducted thematically by identifying patterns of experience, forms of power relations, and indications of practices that potentially harm women. The results of the analysis were then linked to the applicable legal framework to identify normative gaps and their implications for the protection of women's rights in maternal health care.

3. Results

3.1. Women's Experiences in Maternal Healthcare

The results of this study indicate that women's experiences in maternal health care cannot be separated from the unequal configuration of power relations between healthcare professionals and patients (Sadler et al., 2016). All patient respondents (12 individuals) revealed experiencing pressure during the medical decision-making

process, both in the context of normal delivery and *cesarean* sections (C-sections). This pressure is not always present in the form of direct instructions or explicit coercion, but rather through situations perceived as urgent, rushed, and leaving no room for patients to understand, question, or negotiate the available options.

In this experience, the woman's body is placed in a paradoxical condition: on one hand, it becomes the center of medical intervention, yet on the other, it loses authority over itself (Davis-Floyd, 1993). Patients not only experience physical pain but also face limitations in articulating their will, as they are situated in a relationship that structurally positions them as the party who "must follow" the directives of the healthcare professionals. The medical knowledge monopolized by healthcare workers further solidifies the patient's subordinate position, meaning that the decisions made are often not reflections of free choice, but rather responses to previously constructed situations.

In this context, informed consent loses its substantive meaning as a form of agreement based on complete understanding and free will (Khosla et al., 2016). The patient's consent becomes problematic because it forms in a situation that does not fully allow for autonomy. Phenomenologically, this experience demonstrates that women are not fully present as subjects in the childbirth process, but rather as objects undergoing a medical process controlled by others. This condition raises fundamental questions regarding the implementation of the principle of autonomy in healthcare services. Although patients' rights are formally recognized in various regulations, practices in the field demonstrate that this recognition has not been fully realized in the form of egalitarian relations. Thus, the erosion of autonomy is not solely a matter of individual practice, but also a consequence of a service structure that remains deeply paternalistic (Perrotte et al., 2020).

Table 1. Power Relations and Decision-Making in Maternal Care

No.	Findings	Context of Experience	Description
1	Pressure in decision-making	12/12 patients	Occurred during normal delivery and C-sections under rushed conditions
2	Poor communication	12/12 patients	Healthcare workers tended to dominate the direction of decisions
3	Minimal space for patient reflection	12/12 patients	Patients lacked time and information to consider options

Based on Table 1, these findings indicate that the decision-making process in maternal care does not occur in a neutral space, but rather in a situation constructed by unequal power relations. Patients may experience limitations in articulating their preferences, meaning that decisions made may not fully reflect their autonomy. This suggests that informed consent has not yet been fully implemented as a dialogical process, but may instead function primarily as an administrative formality that legitimizes medical decisions (Vogels-Broeke et al., 2023).

All patient respondents reported experiences of disrespectful communication, such as being yelled at, belittled, or subjected to statements that dismissed their experiences of pain. Statements such as "it does not hurt" or "do not complain too much" do not merely reflect a lack of empathy; they also reflect power relations that position the patient's experience as something that can be negated by medical authority (Okedo-Alex et al., 2021). From a phenomenological perspective, this experience cannot be reduced simply to "poor communication." Rather, it is an experience that shapes the patient's perception of herself in the childbirth situation. The patient not only feels pain but also experiences the delegitimization of that experience, which ultimately reinforces a sense of powerlessness and dependency.

However, the primary issue is not only the existence of these practices but how the service system normalizes them. Findings from healthcare professionals indicate

that not a single respondent was familiar with the term obstetric violence. Even after being provided with an explanation, degrading communication practices towards patients were still understood as an "ordinary" part of work dynamics (Amathullah et al., 2023). This situation reflects a process of normalization in which violent behavior is no longer perceived or recognized as violence. Verbal violence may therefore remain unnoticed, not because it is absent, but because it is not perceived as problematic. This suggests inadequate internalization of ethical standards within healthcare practices. Consequently, violence in maternal healthcare should be understood not merely as an isolated occurrence, but as a practice that may be embedded within an unreflective service culture (Sadler et al., 2016).

Table 2. Normalization of Communication and Verbal Violence

No.	Findings	Context of Experience	Description
1	Degrading communication	12/12 patients	Patients were yelled at, and their experiences of pain were belittled
2	Delegitimization of patient experience	12/12 patients	Pain and patient needs were unacknowledged
3	Ignorance of the OV concept	6/6 healthcare workers	Practices were considered ordinary

Table 2 shows that disrespectful communication practices demonstrate that violence in care is not always explicit but may be embedded in everyday practices. Patients may experience the delegitimization of their own bodily experiences, particularly when their concerns and perceptions are disregarded. This condition reflects a failure to uphold the principle of respect for patient dignity and indicates limited conceptual awareness of Obstetric Violence (OV) (Adinew et al., 2021).

This study found that the majority of respondents did not receive adequate information regarding their postpartum conditions, neither for themselves nor for their babies. The absence of education regarding postpartum danger signs, mental health issues such as postpartum depression, and postpartum contraception indicates that healthcare services effectively cease at the point of completing the medical procedure (Minckas et al., 2021). From a phenomenological perspective, the absence of this information creates an experience of discontinuity of care, leaving patients without a framework of understand and navigate their postpartum state. The childbirth experience does not end at the health facility but continues into daily life, which is unsupported by adequate information. This leaves patients to confront health risks without sufficient knowledge (Sebayang et al., 2022).

This neglect also highlights a reduction of the meaning of maternal health care, narrowing it down strictly to a clinical process. Patients' preferences, such as requests for early initiation of breastfeeding, are not always accommodated, demonstrating that even non-clinical aspects are not fully respected (Heera et al., 2024). This condition reflects a failure to fulfill the patient's right to information. This right pertains not only to the medical procedures performed but also encompasses a comprehensive understanding of the experienced health condition. Thus, the withholding of information can be understood as a form of subtle or structural harm, as it does not produce immediate, visible impacts, but carries long-term consequences for the patient's well-being (Mira-Catalá et al., 2024).

Table 3 shows that the withholding of information indicates that maternal healthcare remains largely focused on clinical procedures. Patients may experience uncertainty during the postpartum period because they do not receive adequate information. Limited information can also restrict patients' ability to understand their health condition and participate in decisions concerning their care. This situation reflects the inadequate fulfillment of the patient's right to information, which is essential for informed decision-making and continuity of care. Adequate

information and continuous maternal healthcare are important to ensure that women remain informed and involved throughout the care process (Andriani et al., 2021).

Table 3. The Withholding of Information and Patient Education

No.	Findings	Context of Experience	Description
1	No postpartum education	9/12 patients	No information was provided on danger signs for mothers and babies
2	Minimal contraception education	11/12 patients	No postpartum family planning education was provided
3	No mental health education	12/12 patients	No information was provided on baby blues or postpartum depression
4	Refusal of Early Initiation of Breastfeeding (IMD)	3/12 patients	Patient preferences were not accommodated

The study's findings show that the maternal health service experience is not neutral but is shaped by the patient's background and condition. In the case of a sexual violence survivor experiencing an unplanned pregnancy, the denial of abortion services illustrates that the personal moral considerations of healthcare professionals can intervene in professional decisions (Cunha et al., 2023). From a phenomenological perspective, this experience relates not only to access to services but also to how the patient is positioned within the service relationship. The patient is not treated as a subject requiring protection, but rather as an object of moral judgment. This creates an experience that is not only medical but existential, wherein the patient must confront stigma in a setting that ought to provide support.

Findings regarding victim-blaming indicate that the patient's experience is interpreted through social norms internalized by the healthcare workers. Furthermore, the case of a patient with hyperemesis gravidarum who was perceived as being careless about her pregnancy demonstrates how medical conditions can be subjectively interpreted, thereby affecting the quality of care provided (Li et al., 2025). This condition reveals a violation of the principle of non-discrimination in healthcare services. Services that should be based on medical needs and patient rights are instead influenced by bias and social constructs. Consequently, the patient's experience is shaped not only by their medical condition but also by how healthcare professionals interpret the patient (Hameed et al., 2021).

Table 4. Bias and Stigma in Healthcare Services

No.	Findings	Context of Experience	Description
1	Denial of abortion	2 cases	Underage sexual violence survivors with unplanned pregnancies were denied abortion services on moral grounds.
2	Victim blaming	Some healthcare workers	Patients were held responsible or considered contributors to their conditions.
3	Stigma regarding medical conditions	1 case	A mother with hyperemesis gravidarum was perceived as not caring for herself or her fetus.

According to Table 4, these findings indicate that healthcare services are not entirely neutral but may be shaped by social bias and prevailing social constructs. Patients may experience stigma in situations where they should receive protection, respect, and equal treatment. Such experiences can undermine patients' sense of dignity and trust in healthcare providers. This condition reflects a failure to uphold

the principle of non-discrimination and indicates that personal biases and moral judgments may influence professional decision-making. Evidence shows that implicit and explicit provider biases can contribute to differential treatment and disparities in person-centred maternity care (Afulani et al., 2021).

3.2. Legal Gaps and Regulatory Urgency

The findings of this study indicate that the practices experienced by patients possess characteristics that can substantively be categorized as obstetric violence. However, they lack explicit recognition within the legal framework in Indonesia. As a result, women's experiences in maternal health care tend not to be articulated as rights violations, but are reduced merely to issues of ethics or service quality. From a normative perspective, this condition highlights a gap between empirical experience and legal construction. The law has not been fully capable of capturing the subjective, relational, and contextual dimensions of the experience where violent practices precisely and most frequently occur (Garcia et al., 2024).

On the other hand, healthcare professionals' concerns regarding potential criminalization suggest that drafting regulations cannot be approached simplistically. Regulations must balance patient protection with the realities of healthcare practice. Nevertheless, the absence of regulation reinforces the invisibility of women's experiences, allowing harmful practices to persist without clear accountability mechanisms (Bernardini & Dal Monico, 2024). Thus, the urgency of establishing specific regulations regarding obstetric violence lies not only in the aspect of legal protection but also in the imperative to recognize women's experiences as a legitimate component of the legal system. This recognition is an essential first step in shifting healthcare services from a paternalistic approach to one grounded in respect for women's autonomy, dignity, and lived experiences (Sjoholm, 2024).

Table 5. Normative Gaps and Regulatory Challenges

No.	Findings	Context of Experience	Description
1	No understanding of obstetric violence	6/6 healthcare workers	The concept is unrecognized in daily medical practice
2	No specific regulation	Indonesia	No explicit recognition of obstetric violence
3	Fear of criminalization	Some healthcare workers	Resistance towards regulation

According to Table 5, the gap between empirical experiences and the existing legal framework indicates that some forms of violence experienced by patients have not been adequately accommodated within the legal system. Patients' experiences may therefore remain insufficiently recognized when legal provisions focus primarily on conventional forms of healthcare violations. This can make patients' experiences less visible within formal legal protection mechanisms. The condition highlights the need for clearer legal recognition of obstetric violence and more effective mechanisms for addressing violations in maternal healthcare. At the same time, regulatory development should balance patient protection with legal certainty and professional accountability for healthcare providers (Pickles, 2024).

Table 6. Comparison of Obstetric Violence Legal Frameworks

No.	Country	Legal System	Status	Description
1	Indonesia	Civil Law	Not explicit	Protection is scattered across the Health Law and patient rights.
2	Thailand	Civil Law	Not explicit	No specific regulation on obstetric violence; approach based on professional ethics and patient rights.
3	Netherlands	Civil Law	Implicit	Regulated through laws on patient rights and medical liability.
4	Venezuela	Civil Law	Explicit	Explicitly recognizes obstetric violence in law as a form of violence against women.

Based on Table 6, the comparison shows that legal recognition of obstetric violence varies with each country's legal framework. Indonesia remains at an implicit stage, whereas Venezuela explicitly recognizes obstetric violence as a form of violence against women. This difference shows that specific legal recognition can provide a clearer basis for protecting women's autonomy, dignity, and reproductive rights. It also demonstrates the feasibility of developing a more specific legal framework for obstetric violence in Indonesia, while considering the national legal context (Pickles, 2024).

4. Conclusion

This study concludes that women's experiences in maternal healthcare are shaped not only by clinical procedures but also by unequal power relations, disrespectful communication, inadequate information, and paternalistic service structures. These conditions limit women's decision-making autonomy and undermine their dignity and bodily integrity. The findings further reveal a normative gap between existing patient-rights principles and actual healthcare practices, particularly because obstetric violence has not been explicitly recognized within the Indonesian legal framework. Consequently, experiences such as coercion, degrading communication, and inadequate information tend to be treated as ethical or service-quality issues rather than as forms of violence requiring specific legal recognition.

The findings imply that improving maternal healthcare requires more than technical improvements. Specific legal regulation on obstetric violence is needed to provide clearer recognition, protection, and accountability while maintaining legal certainty for healthcare professionals. This regulatory development should be accompanied by strengthening healthcare workers' understanding of obstetric violence, informed consent, empathetic communication, adequate information provision, and respect for women's autonomy.

This study has several limitations. The research was conducted only in Palu City and Sigi Regency, and the qualitative design with purposive sampling limits the generalizability of the findings to other regions and healthcare settings. In addition, the use of online interviews may have limited direct observation of healthcare interactions and contextual conditions. Future research should examine obstetric violence across broader geographical and institutional settings, involve larger and more diverse participant groups, and explore healthcare providers' perspectives more deeply. Further socio-legal research is also needed to develop a specific regulatory framework that balances women's rights and protection with professional responsibilities and legal certainty for healthcare providers.

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