

Erasmus Mundus Master's Degree in Women's and Gender Studies

OBSTETRIC VIOLENCE:

Medicalization, authority abuse and sexism within Spanish obstetric assistance.

A new name for old issues?

MASTER THESIS

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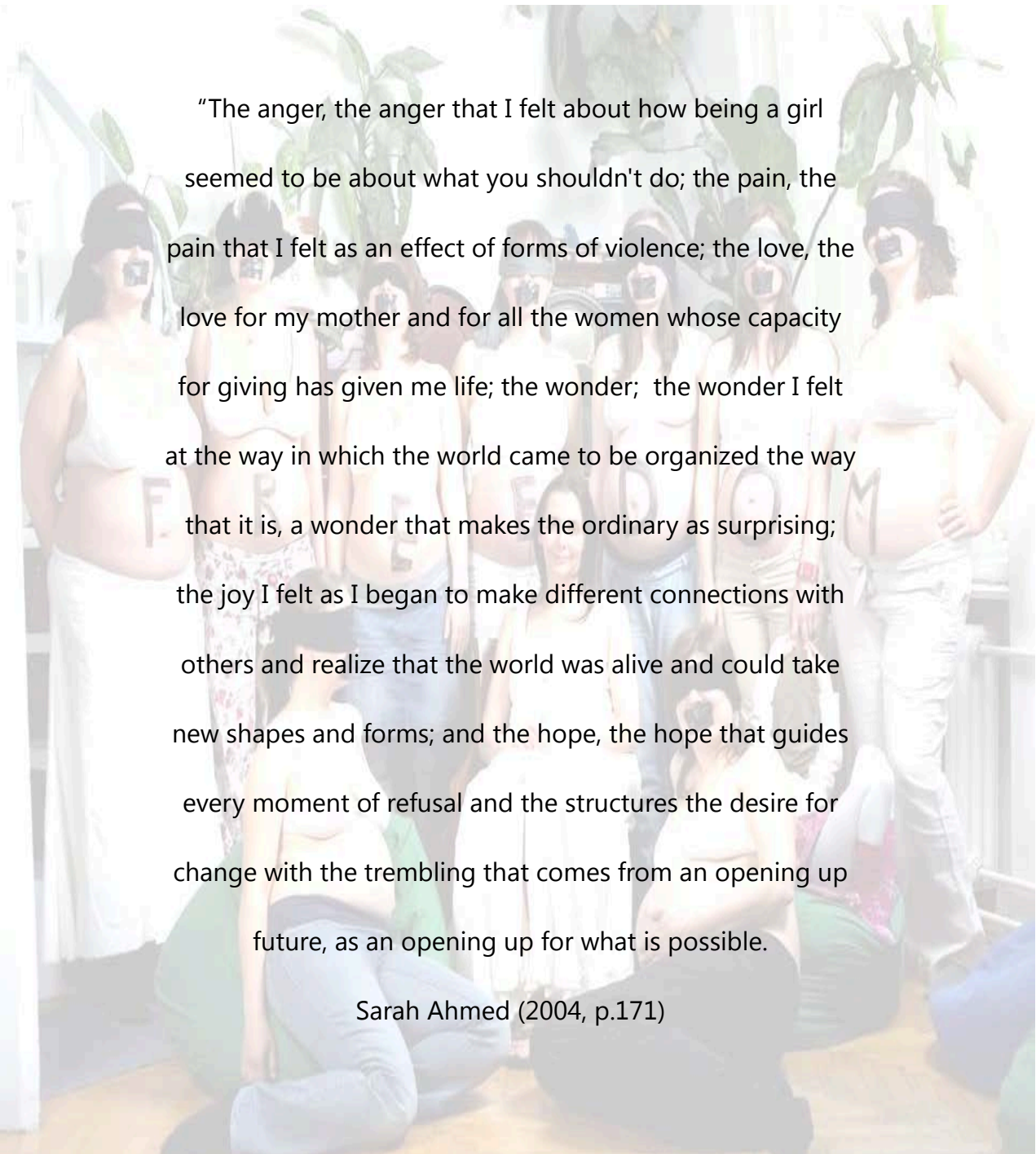
They made possible this thesis.

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all the friends who took me away from my computer and made me smile during these months.

my parents, who I owe all.

A group of pregnant women are gathered in a room. Some women have their mouths taped shut with black tape. Others have large letters painted on their abdomens. The women are dressed in casual, light-colored clothing. The room has large potted plants in the background and a wooden floor. The overall atmosphere is one of protest or activism.

"The anger, the anger that I felt about how being a girl seemed to be about what you shouldn't do; the pain, the pain that I felt as an effect of forms of violence; the love, the love for my mother and for all the women whose capacity for giving has given me life; the wonder; the wonder I felt at the way in which the world came to be organized the way that it is, a wonder that makes the ordinary as surprising; the joy I felt as I began to make different connections with others and realize that the world was alive and could take new shapes and forms; and the hope, the hope that guides every moment of refusal and the structures the desire for change with the trembling that comes from an opening up future, as an opening up for what is possible.

Sarah Ahmed (2004, p.171)

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Abstract:

Recently, Spain witnessed the emergence and widespread of the concept of 'obstetric violence'. Some legal texts appeared in Latin-America (Venezuela 2007, Mexico 2007-2014, Argentina 2009), activists and scholars define the concept of 'obstetric violence' as a kind of gender-based violence exercised by healthcare personnel on women and fetuses/children during pregnancy and childbirth. This takes place in form of dehumanized treatments, medicalization and pathologizing of women's reproductive processes through the appropriation of their bodies, reproductive capacities and sexuality. Harmful practices that have been reported in case files include: the denial of information about the procedures employed during the labor process, humiliations and miscarrying attitudes, excessive rates of cesarean birth, routine medical practices that do not have proven advantages for women and fetuses/children's welfare (enemas, episiotomies, sedatives, supine position as mandatory, or practices that have been proven risky as the Kristeller's method):

The reports made under the label of obstetric violence generally express severe misgiving about the medicalizing approach, professional authoritarianism and sexist attitudes towards pregnant women within the current healthcare system. Through the case of Spain this research aims to understand what are the possibilities of the concept of 'obstetric violence' to raise awareness about the patriarchal, medicalizing and authoritarian practices that seem to take place within the field of obstetrics, since the concept has begun to be used within different movements related to respected childbirth claims in the country. The research departs from the work done by the biopolitical and feminist approaches to healthcare, the issues addressed by women's health movements, the sexual and reproductive rights advocacy and respected childbirth's statements in the Western context, with special emphasis in the context of Spain.

Keywords: obstetric violence, gender, childbirth movements, reproductive rights, medicalization.

Resumen:

Recientemente, en el Estado español ha empezado a emplearse el concepto de 'violencia obstétrica'. Algunas leyes aparecidas en Latinoamérica (Venezuela 2007, México 2007-2014, Argentina 2009), activistas y académicxs definen el concepto 'violencia obstétrica' como un tipo de violencia basada en género ejercida por el personal de salud hacia las mujeres y fetos/niños durante el embarazo y parto. Ésta tiene lugar en forma de malos tratos, medicalización y patologización de los procesos reproductivos de las mujeres mediante la apropiación de sus cuerpos, capacidades reproductivas y sexualidad. Algunas de las prácticas denunciadas son la negación de información acerca de los procedimientos empleados durante la atención al parto, humillaciones y actitudes despectivas, excesivos porcentajes de partos por cesárea, prácticas médicas estandarizadas sin una mejora probada para el bienestar de las mujeres (enemas, episiotomias, la administración de sedantes, la obligatoriedad de la posición supina durante el parto, o prácticas de riesgo como la maniobra de Kristeller).

Las denuncias hechas bajo la etiqueta de violencia obstétrica generalmente conllevan críticas hacia el modelo medicalizador de atención al parto, el exceso de autoritarismo en la praxis médica y actitudes sexistas en el sistema de salud. A través del caso del Estado español esta investigación busca entender qué posibilidades puede brindar el concepto de 'violencia obstétrica' para concienciar sobre las prácticas patriarcales, medicalizadoras y autoritarias que parecen tener lugar en el campo de la obstetricia. Todo ello teniendo en cuenta como distintos movimientos del estado relacionados con las demandas sobre partos respetados han empezado a usar el concepto. La investigación parte de los aportes hechos desde la crítica biopolítica y feminista al sistema de salud, la denuncia de los movimientos de la salud de las mujeres, el activismo por los derechos sexuales y reproductivos y los movimientos por los partos respetados en el contexto de occidente, con un énfasis especial en el caso del Estado español.

Palabras clave: violencia obstétrica, género, parto respetado, derechos reproductivos, medicalización

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INTRODUCTION:

“The revolution of birth remains pending. Birth is something that concerns all of us: we are all born, and many of us encounter birth again when laboring our own children. In this sense child is ours. The discourse on motherhood has many hidden places, that have been very little studied, analyzed or criticized”.

Stella Villaranea and Francisca Fernández
(2001, p.212)

In recent years three countries have adopted legal regulations against obstetric violence. Venezuela was the first country to employ the term 'obstetric violence' in 2007 within its “Organic Law on the Right of Women to a Life Free of Violence” (2007), followed by Argentina in 2009 and the Mexican states of Durango, Veracruz, Guanajuato and Chiapas, in 2007, 2008, 2010 and 2012, respectively. In April 2014 Mexico's national Senate also approved modifications to current legal texts on violence against women by including obstetric violence as a punishable practice¹.

¹References and extended information about these legal texts can be find in p.51 of this document.

According to these legal texts obstetric violence is a kind of gender violence which implies: "...the appropriation of the body and reproductive processes of women by health personnel, which is expressed as dehumanized treatment, an abuse of medication, and to convert the natural processes into pathological ones, bringing with it loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting the quality of life of women." (translation by Pérez, 2010, p. 201).

Obstetric violence includes a wide range of possible violent practices to which women are subjected when they give birth in hospital settings. Some of the most common practices reported include:

- a) denying information about procedures employed during the labor process.
- b) procedures that embarrass and neglect women's needs
- c) unnecessary performance of cesarean sections.
- d) routine medical practices that do not have proven advantages for women and fetuses/children's welfare: enemas, episiotomies², sedatives, supine position as mandatory, or practices that have been proven risky (the Kristeller's method³).

In the last decade activists for respected childbirth and scholars in different parts of the world started to use the concept 'obstetric violence' to stress the implicit violence some of these

² Surgical section on the perineum and vagina's walls made during the delivery to enlarge the delivery canal. It is done under local anesthesia.

³ Maneuver done during the delivery, which consists of pushing on the top of the uterus while the woman has a contraction. It is usually performed when the childbirth process seems to take too long. It has several potentially risky effects, such as uterine rupture, perineum damage, haematomes on the abdomen, and traumas to the child's body.

birthing practices entail. However, movements for respected childbirth, women's rights and reproductive health have paid attention to childbirth assistance issues since the nineteen-sixties (Burt, 1978). Some of their early achievements during the nineteen-eighties included various international conventions about Sexual and Reproductive Health and Rights (SRHR) and the WHO's recommendations about *Appropriate Technology for Birth* (1985^a). The fact that today Venezuela, Argentina and Mexico include forms of obstetric violence as legally punishable offenses reveals that some birthing practices are still generating important tensions within different areas of Latin-America. But as a case study on Spain – the main task of this thesis - will show, these issues stretch beyond the borders of the South American continent. Within Europe Spanish women have reported numerous negative experiences with childbirth assistance, which several activist organizations have classified as cases of obstetric violence.

Focusing my attention on Spain, this thesis aims to explore why and how Spanish childbirth activists use the concept of 'obstetric violence' and what it adds to their previous strategies to combat these issues. My starting hypothesis is that the issues reported by childbirth movements have their roots in a complex set of power relations, where gender and knowledge hierarchies play an important role. The result is a negative impact on childbirth assistance primarily from medicalization, abuses of authority and sexism.

My first chapter is dedicated to explaining methodological decisions in order to make clear my motivations and procedures regarding the current research. The second chapter follows with my theoretical framework, where I explain various aspects that I consider essential to understanding and framing current childbirth issues. This includes a brief introduction to the concept of 'gender' and its impact on the field of medicine, a basic summary of the concepts of 'biopower' and

'authoritative knowledge' in the field of obstetrics, some historical reflections on the shift from midwives to physicians in childbirth assistance and an outline of some tensions that have arisen between opposite sides in debates about childbirth (e.g. 'natural childbirth' versus 'techno-medicalized childbirth').

The third chapter consists of a legal and institutional review of the concept of 'obstetric violence'. The aim of this chapter is to frame some of the pioneering and influential changes in the governmental attention to childbirth assistance, which highly influences childbirth activism strategies. I will focus my attention on the WHO's recommendations in *Appropriate Technology for Birth* from 1985 and the apparition of the Sexual and Reproductive Health and Rights approach in the 1990s. I end this chapter with an analysis of the obstetric legal texts adopted during the last decade in Venezuela, Argentina and Mexico.

The fourth chapter is based on the case of study of Spanish childbirth activism. Within this part I present the main concerns of current childbirth activists, combining data and reports about today's obstetric assistance in the country and the reflections made by childbirth activists I interviewed. I pay special attention to the recent introduction of the concept of 'obstetric violence' to the activist narrative of some Spanish organizations.

The thesis ends with some conclusions regarding the future possibilities for the concept of 'obstetric violence' in raising awareness about current issues in pregnancy and childbirth assistance.

CHAPTER 1:

Methodology

"...we are the embodied others, who are not allowed to not to have a body, a finite point of view and so [we have] an inevitably disqualifying and polluting bias in any discussion".

Donna Haraway, 1988, p.575

1.1. From where do I speak? Motivation and objectives.

An analysis of 'obstetric violence' is highly relevant to critiques of the Western approach to health care, medical authoritarianism and sexism in contemporary society. Through a case study on Spain that focuses on the concept's strategic usage by different activist groups and strategies that current activism employs around this concept, my aim is to provide a well-founded study on (1) what obstetric violence is understood and (2) how 'obstetric violence' as a concept might be employed for future respected childbirth and feminist advocacy.

Persuaded by the feminist critique of a long tradition of research with an androcentric and ethnocentric bias, usually legitimated under the label of scientific, neutral and objective (Haraway, 1988, 1991, 1993 Harding, 1992, 1993, 1987, Schiebinger, 2000), I want to make explicit my social, ideological and vital point of departure, as they influenced my research methodology.

I will not pretend to avoid the fact that my education and life experiences within a specific social, economic and geographical context shaped my approach to the topic at hand. As Donna Haraway (1988) points out, the finite vision that our primate eyes allow is partial, embodied and locatable – “The moral is simple: only partial perspectives promises objective vision” (1988, p.583). Following the suggestions made by the concepts of 'feminist objectivity' or 'embodied objectivity' (1988), I will not try to be neutral or objective, but instead provide explicitly positioned though valid argument.

I focus my research on the specific case of Spanish obstetrics assistance and its critique due to the fact that I grew up in Catalonia and am therefore a concerned citizen and user of the system. Practical aspects also influenced this decision as, due to linguistic and cultural factors, framing the research within the borders of the Spanish state made it easier to access to information resources.

A fundamental experience that shapes my approach to the topic of obstetric violence is the fact that I have also been raised as part of a family that adopts some of the critiques and ideas of the naturopathy current of thought. I was born at home in the late eighties, a rare practice that was seen as backward and dangerous in Spain at that time. My parents' wish of a non-medicalized birth in a relaxed and intimate atmosphere brought them to the decision to give birth at home. They were also familiar with other's experiences of natural childbirth and had been influenced by

some groups that criticized the assistance provided within hospitals. Later in life I had the opportunity to attend the home childbirth of friends, who chose this option for similar reasons. This caused me to realize the viability of the non-interventionist childbirth approach as an alternative option to experience childbirth. During my life several routine visits to the doctor and two experiences of hospitalization led me to encounter some of the main problems this thesis outlines – reinforcing my criticism of current healthcare assistance. On two occasions I rejected surgery prescribed by a doctor that after a few days in the hospital was finally deemed unnecessary. If I would not have insisted on waiting for some further tests, right now I would probably be without my appendix and part of my cervix. These problems with medicalizations and professional authoritarianism caused me leave the many consultations with the feeling that my opinion about my own health was not important and that to ask questions about one's own health is an uncommon practice. Finally, too many comments during gynecological consultations about how being a woman means high doses of suffering and sacrifice led me to wonder – to what extent is healthcare assistance pervaded by social discourses based on gender prejudices? And to what extent do these prejudices affect the quality of the assistance provided?. These are the main experiences that brought me to begin my research on obstetric violence with the belief that there is a general tendency to medicalize in Spain, which may be caused by authoritarian and sexist attitudes in medicine. This does not mean that I do not appreciate the effort of many healthcare personnel to offer the best assistance they can, nor do I argue they are wholly responsible for the issues reported. More responsible users and changes to education or economic investments in the healthcare system are also key factors in making a difference in the quality of healthcare assistance.

The growing spread of the concept of 'obstetric violence' and its relation with one of my main topics of concern – gender inequality in current societies – definitely called my attention towards this issue. Since obstetric violence legal texts have showed up in the international sphere and childbirth activism in different parts of the world have started to introduce this concept in their advocacy, I decided to focus my attention on the effect these changes have had and will have on the struggles against medicalization, professional authoritarianism and sexism from which Spanish childbirth assistance seems to suffer. Hence, the main questions this research aims to answer through the Spanish case study is: **Why and how do current childbirth activists use 'obstetric violence' to report issues and what can the concept add to their previous strategies?** Taking into account that the main issues reported by childbirth activism are related to practices of medicalization, professional authoritarianism and sexism, there are three main topics this thesis aims to cover in order to answer the aforementioned questions:

- 1) The role of power relations in understanding current issues regarding medicalization, professional authoritarianism and sexism in modern western/westernized obstetric assistance (*chapter 2: Theoretical framework*).
- 2) The influence of pioneering institutional initiatives against medicalization, professional authoritarianism and sexism during childbirth assistance on obstetric violence legal texts and current childbirth activism (*chapter 3: Legal review*).
- 3) Matters of concern, strategies and usages of the concept of 'obstetric violence' by current Spanish childbirth activists (*chapter 4: Case study*).

1.2. Methods and research decisions:

The main methods I used in this research are (1) a theoretical review of relevant literature, (2) a discourse analysis of legal texts and policy interventions and (3) oral interviews. Thus, the information sources I have employed can be classified in three categories: (a) relevant theoretical approaches to the topic of childbirth from the fields of anthropology, sociology, history and critical theories as feminism and biopower, (b) legal and institutional texts around childbirth assistance and (c) diverse material provided by childbirth activists. Organized under these three categories this section provides explanations for my choices regarding the use of these information sources:

a) theoretical and anthropological works on reproduction, historical approaches to the field of medicine and reflections on concepts as 'gender' and 'biopower'.

The theoretical framework takes a multidisciplinary perspective with the aim to integrate disciplines such as anthropology, sociology, history and critical theories to understand feminism and biopower. In other words, it has the aim to do justice to the complexity that the obstetric violence phenomenon entails. Some information about the physiology of childbirth and some medical performances also appear in this part in order to understand the health consequences of obstetric violence. Even though I attempt to present a wide framework where different disciplines are combined, I would like to make explicit that a complete understanding of childbirth as a cultural event is behind the scope of this thesis. The contributions from the anthropology of birth compiled in the book *Childbirth and Authoritative Knowledge* (1997), edited by Robbie E. Davis-

Floyd and Carolin F. Sargent, was the main literature that inspired this approach. Since the 1970s anthropological studies in the field of reproduction stressed the fact "that birth is almost never simply a biological act; on the contrary, as Brigitte Jordan has written, 'birth is everywhere socially marked and shaped'" (1997, p.1). As more women entered in anthropology, a field that was traditionally biased towards men, more attention was given to the study of childbirth practices (p.2). Special attention to the influence of gender hierarchies is also in the background of this thesis since it has been a mistaken aspect of the traditional androcentric research. In order to correct this deficiency and keeping in mind the idea that gender is one of the main powers that shape social relations and power distribution, this thesis applies the gender perspective⁴.

b) legal texts regarding the usage of obstetric violence in Argentina, Venezuela and Mexico and institutional documents as: WHO's recommendations, human rights consensus and Spanish national guidelines and data collections regarding childbirth assistance.

Since the concept of 'obstetric violence' became internationally widespread after the inclusion of the term in legal texts of the states of Venezuela (2007), Argentina (2009) and Mexico (2007-2014), an important section of the thesis is dedicated to the legal review of obstetric violence regulations. It aims to show the potential impact of their way of defining 'obstetric violence'. I read these texts paying special attention to what extent they take into account gender issues, how they understand childbirth according to the debate between "natural childbirth" and "techno-medicalized childbirth", and how the practices penalized are described to distinguish their use of

⁴ More information regarding this topic is provided in the first section of the theoretical framework (p. 21).

terms such as 'medicalization', 'authority abuse' and 'denigrating or dehumanized practices'. Finally the approach to these legal regulations is combined with examples of the main issues concerning obstetric violence that these countries have to face. The goal of this research choice is to briefly frame these legal texts in concrete examples, as well as offer some reference points for looking at the Spanish case study. Nonetheless, it is not my aim to provide an exhaustive explanation of the situation of healthcare assistance in these three countries as it is outside the limits of my research.

A review of previous international institutional documents such as WHO's recommendations (1985a) regarding childbirth assistance and human rights consensus in line with obstetric violence regulations is also offered due to the importance they have for pioneering changes in governmental attention to childbirth assistance's issues. I read WHO's recommendations as one of the first institutionally legitimated sources against medicalization of childbirth. It also reveals the role played by knowledge hierarchies in this field. Regarding the human rights consensus, I chose them as a way to illustrate how the growing approach offered by Sexual and Reproductive Health and Rights presents an important standpoint for considering the interrelations between health care assistance, human rights and gender issues – which obstetric violence paradigmatically shows.

In order to know the specific state of the issue in the Spanish context I read institutional documents and data collections. The most relevant one is the *Strategy for Assistance at Normal Childbirth in the National Health System (Ministerio de Sanidad y Consumo, 2007)*, which became the first institutional document with the aim of facing the issues pointed out by activists and WHO's recommendations about childbirth assistance. In this document I paid special attention

to the arguments given for the necessity of improving childbirth assistance.

c) Written and audiovisual sources spread by Spanish activism and oral interviews carried to activists of four Spanish initiatives for the respected childbirth and against obstetric violence.

The information provided by the on-line platforms of activism in blogs, press articles, documentaries and e-mail lists were important information sources because one of their main goals is to promote access to information for users of obstetrics units. Data, reports and testimonies of women users of Spanish obstetric units that I found on activist websites helped me to build a general picture of the current tensions of obstetrics assistance in Spain. Due to the relevant amount of information, legal reports and data collections spread by the organization for respected childbirth, *El Parto es Nuestro*, its website has been one of the main activist platforms I used.

Interviews with childbirth activists have been another important information referent. I carried out a total of four interviews, the results of which are shown throughout chapter 4. The people targeted for interviews were members of the main activist organizations in the field of respected childbirth that work in Spain. I selected three main organizations located in Spain: *El Parto es Nuestro*, *Dona a Llum* and *Plataforma pro Derechos de Nacimiento* and an on-line platform against obstetric violence: *La Revolución de las Rosas /Roses Revolution*. The last one was chosen for being the first movement that specifically works under the term of 'obstetric violence' in the Spanish state, even though its founder lives in the UK.

El Parto es Nuestro and *Plataforma pro Derechos de Nacimiento* are national organizations which work in different areas of the state. *Dona a Llum* only works within the area of Catalonia and *La Revolución de las Rosas/Roses Revolution* started as a way to report issues in Spain, but they are now internationally orientate. In fact, other later initiatives have been launched under the same name in other countries such as Italy, France and Australia.⁵

I found these initiatives through internet research and I contacted them via e-mail, explaining the topic of the research and my interest in their point of view. They were willing to do an interview without any problem and the total of people interviewed were 5. All the people interviewed were women who experienced childbirth and 4 of them reported experiences described as disrespectful including unnecessary medical performances. Two interviews could be carried face to face and two were conducted via phone due to the fact that their representatives were located out of the area of Catalonia. All of them took place during the months of March and April 2014. The first one was conducted by phone to Jesusa Ricoy, founder of *La Revolución de las Rosas/Roses Revolution*. She defines herself as a matriactivist and she works as antenatal teacher for the British organization, National Childbirth Trust, a charity that supports parents in need of help with early childcare. The interview had the duration of 60 minutes. The second interview took place in Barcelona, where I could talk with Ángeles Hinojosa, director of the *Plataforma pro Derechos de Nacimiento*. She works as podal reflexologist, specialized in children, and she carries several workshops based on the rebirthing therapy. The duration of the interview was also one hour. The third interview was also done in Barcelona with two representatives of *Dona a Llum*: Silvia

⁵ Detailed information about each initiative can be found in the fourth chapter (p.74)

Salvador, a psychologist, and Judith Reyes, a graduate of pre-primary education. Both are part of *Dona a Llum's* board of directors and the interview took 100 minutes. I previously met them during a session of support that the group organizes, where activists welcome people who want to share worries and doubts about childbirth. I attended one of the sessions, which took place in the civic center of Casa Sagnier, as a way to get to know the activities they are developing. During the one hour and a half session, four members of the organization were present along with one pregnant woman interested in their advice. All the members shared their childbirth experiences and the woman explained her worries and experiences during the sessions of birth preparation in the hospital. Some of the comments that arose during this session are included in the analysis of the interviews. The last interview was with Adela Recio, president of the organization *El Parto es Nuestro* and public servant in the Spanish National Institute of Statistics. The interview was conducted by phone and it had a duration of 35 minutes.

They were organized as semi-structured interviews. Shulamit Reinharz (1992) describes this method as:

“Semistructured or unstructured interviewing, the method given prominence in the opening quote, is a qualitative data-gathering technique. It differs from ethnography in not including long periods of researcher participation in the life of the interviewee and differs from survey research or structured interviewing by including free interaction between the researcher and interviewee. Survey research typically excludes, and interview research typically includes opportunities for clarification and discussion. Open-ended interview research explores people's views of reality and allows the researcher to generate theory. In this way complements quantitatively oriented, close-ended interview research that tries to test hypothesis. (pg.18)

This method fit my aim of undertaking flexible interviews which could cover my questions regarding the activists' points of view without restricting their concerns and expressions too much, or emphasizing some topics over others. Semi-structured interviews require that the interviewer prepares a guideline of questions to bring into the conversation, but allows the spontaneous apparition of them depending on the flow (Reinharz, 1992, p.18). Accordingly, I outlined the following topics:

- 1) Main problems detected in obstetric assistance.
- 2) Reasons for their prevalence. The role of gender.
- 3) Activist strategies.
- 4) Views about the role of professionals of obstetrics (changes, attitudes, main issues).
- 5) Obstetric violence: How did they hear about it? How do they define it? How is the concept useful? What do they think about making it legally punishable?
- 6) The use of technology during childbirth (issues, possibilities, etc.)
- 7) Description of the ideal childbirth assistance.

Depending on the direction the conversation took, I asked the questions in a different order. The interviews were recorded and I also took notes during the interviews and after them in order to have a structured summary of the information provided by the interviewee. Since the quality of the recording of the interviews conducted by phone was very low, those notes were very useful to complete my analysis of the interviews. An important decision I had to make regarding the interviews was the way to present the information collected from them. It is an important decision

that requires me to choose what I find important to highlight and what I keep unmentioned or less developed. I will explain the reasons of my selection:

Due to the large amount of information I registered and the quite similar opinions of the people interviewed, I decided to present the information by dividing it into in three sections:

- 1) main concerns about Spanish obstetric assistance.
- 2) activism strategies.
- 3) perceptions and uses of the concept of 'obstetric violence'.

Within these sections I present the information provided by the interviewee by paraphrasing and directly quoting the activists. I paraphrased mainly when the opinions of the different interviewees were similar and I did not find any reason to highlight the voice of one over the others. Paraphrasing is also a method to connect topics and create a narrative in the section in order "not to disrupt the coherence of informant's perspective" (Elliot Mishler in Devault and Gross, 2007, p.184). Regarding the direct quotes, I chose those that I found to be highly expressive or strong statements and I provided the original Spanish or Catalan translation in a footnote, as I felt they might lose some of their meaning through my interpretation.

CHAPTER 2

Theoretical framework: A platform to understand obstetric violence.

"For birth conditions can be terrible in places where we would not expect them to be. This is not because of a lack of economical, intellectual, scientific, or technological resources, but despite of all of them"

*Stella Villaranea and Francisca Fernández
(2001, p.212)*

In this chapter, I would like to offer some explanations which may aid in understanding why in Western countries, where welfare states are quite developed and no economic issues or a lack of technological innovation takes place, childbirth assistance is one of the fields of medicine that most negative reports occur⁶ – so much to the point that strong activism is specifically working to ensure the rights of obstetrics's users.

⁶According to data collected in a Spanish publication on biomedicine and law- *Biomedicina y Derecho Sanitario* (2010)- after Trauma and Orthopedic Surgery, Obstetrics and Gynecology was the second most defendant specialization of health care assistance in the area of Madrid between 2002 and 2007 (González Minguzea, 2010, p.268).

I argue that obstetric violence practices can only be understood as a result of an intersection of power relations related to gender, knowledge and class hierarchies in the struggles for the ownership of legitimate knowledge and the management of healthcare in the field of childbirth assistance. The tensions that these hierarchies create also pervade opposite narratives about what childbirth is and what the appropriate procedures to assist it are. These become highly important aspects for understanding the reasoning behind current debates about childbirth assistance. In light of these issues the five main topics of this theoretical framework are:

2.1.) The link between gender and obstetric violence.

2.2.) The role played by sexism and androcentrism in the field of medicine.

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2.1. The link between gender and obstetric violence:

Due to the varied use of the concept of 'gender' I would like to start this section by clarifying why and how I will employ this concept in my research on obstetric violence.

In societies ruled by patriarchal values, the control over women's reproduction and sexuality

becomes a crucial means of keeping women in subordinate positions. Many mechanisms to ensure the control over these aspects of women's lives have been developed. Taboos and moral discourses to restrict women's sexuality, the narrative of motherhood as a sacrifice, the general view of women as inferior and dependent, women's exclusion from economic resources and the explicit exercise of violence towards them are just a handful of examples. These views and attitudes towards women pervade the whole of society and are perpetuated by both men and women.

Obstetrics is the field of medicine carried out by midwives and obstetrician-gynecologists specialized in the assistance of pregnancy, childbirth and post-childbirth issues. The target users are women, fetuses and new-born children. Due to the direct relationship between obstetrics and women's sexuality and reproductive issues, the field's professionals become important agents in either limiting and abusing or liberating and respecting women's autonomy and agency regarding their bodies and their children. Therefore, since obstetric violence cases seem to be perpetrated by health care personnel, analyzing the impact that gender views play in obstetrics, and health care in general, becomes a crucial aspect in understanding the reasoning behind these harmful practices. Many reports about obstetric violence discuss the traditional and misogynistic attitudes that health care personnel, like other groups in society, have about women's sexuality and reproduction. Childbirth and motherhood has been seen during the last centuries as the main duty of women and an essential aspect that defines womanhood – a woman's gender role is greatly shaped by the experience or lack of experience with pregnancy, childbirth and motherhood. Traditional views of women as destined to be sacrificed to motherhood combined with the idea that women sexual pleasure has to pay a tribute – as for instance a painful

childbirth— maintains harmful practices and behaviors that negatively impacts the health of women, fetuses and children during the process of pregnancy and delivery (Chiaroti et al., 2003, p.27). Lines uttered by doctors “when you were fucking, you didn't scream. If you liked the sweetness now stand the bitterness” (my translation, Chiaroti et al., 2003, p.27) reported in Mexico or “I have to sew you up because otherwise your boyfriend is going to get angry with me” (Blog El parto es Nuestro, n.d.) after an episiotomy in Spain which caused a lot pain for the woman during her later sexual relationships, are examples of the role that gender issues play in obstetrics healthcare. Due to the importance of the concept of 'gender', and before going further with my research, I would like to briefly make explicit the understanding of gender with which I will work.

Gender, out of linguistic considerations, was first popularized in the field of medicine in 1965 when the psychiatrist Robert Stoller used the term to indicate the power of social and family education to define the identity of children with ambiguous genitals. He saw that when these individuals grew up, their bodies did not correspond to their assumed identity as boys or girls (Pujal, 2005, p.71). In the seventies Ann Oakley introduced the term to the social sciences as a way of studying the cultural and social implications of being labeled as a 'man' or a 'woman'. Soon feminism saw the usefulness of this concept to explain how sexual differences, and the meanings attributed to them, are crucial factors in organizing and distributing power in our societies. Gender, therefore, was seen as the changeable part of being women or men based on a set of biological differences defined by the current two-sex system (Laqueur,1990), which in western societies is defined by our genitals.

Under this point of view, gender was seen as the identity we build on an immutable biological sex (Fausto-Sterling, 2000). At that time it opened opportunities to change unfair gender relations and

gender roles defined by biological determinism. However, in the 1990s, authors such as Judith Butler (1990) and Fausto-Sterling (2000) began to question the existence of a clear distinction between sex and gender. They argue that it is our gender system that primarily places conditions on our perceptions about sexes, defining what is biological and what are the important sexual differences (Ortiz, 2006).

“As a result, gender is not to culture as sex is to nature; gender is also the discursive/cultural means by which “sexed nature” or “a natural sex” is produced and established as “prediscursive,” prior to culture, a politically neutral surface on which culture acts” (Butler,1990,p.7)

'Gender' therefore is not a concept used to talk about men and women as the only possible identities based on biological sexes, but to talk about the relationships and reality that the cultural distinction between men and women produce. This research will use the concept of 'gender' as a category of analysis to understand the implications that the label 'masculine' or 'feminine' has in the studied cases and to make clear the role played by the power relations our current gender system sustains.

Finally, I would like to add that, even though the postmodern critique problematizes the use of dual categories of man/woman (Butler, 1990 and Fausto-Sterling, 2000), I will use of these categories as powerful and working social identities, that in this specific field of study seems unquestioned by the people involved.

2.2. The role played by sexism and androcentrism in the field of medicine:

One of the main problems we find when we try to look at Western medicine through the lens of gender is the view of medicine as an objective and unified institution far from social and ideological influences. As this research aims to show, Western medicine, like all other fields of science, entails values which can benefit, but also can provoke, the exclusion and discrimination of certain people by preventing them from receiving the best possible medical. To look at medicine as a system affected by social and personal values, and political and economic influences is not meant to criticize the valuable work of physicians and medical personnel. Rather, it is a way of raising awareness about a system which is too often seen as an unquestionable authority, which blocks the changes that a constructive critique could bring (Davis-Floyd and Sargent, 1997; Illich, 1975; Jordan 1993; and Starr 1982).

Medicine is currently categorized by Western academia as one of the sub-disciplines of the Health Sciences, which apply science to improve human health. It shares with other groups of sciences (formal, physical, social...) a research method, known as the scientific method in order to achieve what we agree as reliable knowledge. 'Science' entails procedures such as "systematic observation, measurement, experiment, and the formulation, testing, and modification of hypotheses" (On-line Oxford Dictionary, 2014). However, while medicine aims to ground its practice in theory-driven, neutral, and evidence-based knowledge, it is, like many areas of science, highly gendered and shaped by the social positions and personal values of its professionals. The critique of science conceptualized as neutral and objective has been highly developed by feminist scholars (Haraway, 1988, 1991, 1993 Harding, 1992, 1993, 1987, Schiebinger, 2000). They argue that the 'objective' view of science legitimatizes scientific projects which perpetuate the existent social hegemony

that blocks and excludes all the sectors of the population except those in ruling positions –and this means, women, sexual minorities, lower class people and people discriminated by race. The history of the field of medicine turns out to be, among other things, a history embedded with androcentric views on human health. The first scientific approaches to the nature of the body made by Hippocrates and Aristotle, among other authors, strongly influenced the development of institutional medicine in the Middle Ages as well as in the Modern Era. In these early views of medicine, the female body was generally seen as a passive actor, the main function of which was to carry a baby (Valls-Llobet, 2009, p.56). Until the Renaissance in Western institutionalized medicine, created by and aimed at men, female genitals were seen as the inverted genitals of the male body. An isomorphism that emphasized the idea of a universal pattern based on the male body. Even though from the Renaissance onward male and female bodies were seen as different, this new vision did not challenged the idea that biological reproduction is the most important function of women (Schiebinger 1989; Laqueur, 1994 and Bolufer 1997 in Ortiz, 2002, p.35). In words of Teresa Ortiz, “the idea of the inferiority of women's bodies and the idea of a unique body, isomorphic, were the result of adding social expectations to nature representations. With it, science “naturalized” and legitimized dominant cultural practices [...]” (my translation, Ortiz, 2002, pp.34-35).

Androcentrism is still prevalent in medical science, as Emily Martin's article, “The egg and the sperm: how science has constructed a romance based on stereotypical male-female roles”(1991) famously argues. In this article she points out how the current scientific narrative is still applying gender roles when explaining reproductive processes: “The egg is seen as large and passive. It does not move or journey, but passively 'is transported', 'is swept', or even 'drifts' along the

fallopian tube. In utter contrast, sperm are small, 'streamlined' and invariably active. They 'deliver' their genes to the egg, 'activate the developmental program of the egg', and have a 'velocity' that is often remarked" (Martin,1991, p.489). In contrast to these descriptions, studies have shown how the mechanical force of the sperm is too weak to penetrate the egg without the adhesives molecules that both the sperm and egg have (p.490). This is just one example of science's permeability to cultural beliefs. As I will show in my research, the androcentric bias of medicine is one of the main sources of reinforcement for the pathologization and strict control of women's bodies and reproductive processes.

The next section provides further explanations about the influence of power relations in the field of healthcare though the concepts of 'biopower' and 'authoritative knowledge'.

2.3. Power relations in childbirth assistance based on the concepts of 'biopower' and 'authoritative knowledge':

As I argued in the previous section and as Foucault accurately stated: Medicine is not a "pure" universal field of knowledge, but shaped by and seen through the eyes of the historical moment, and the economic and political systems where it takes place (Foucault 1975). Since in contemporary Western societies science is conceived of as the discourse of truth, medicine and its professionals appear as one of the most important authorities of our time (Foucault,1996, p.87). This has consequences of vital importance because medical discourse has the institutional power and social legitimization to administrate and rule life. Institutional medicine assumes a privileged

position as a field of science by defining when sickness starts – what is healthy and not and what is considered normal and not (p.21). Medicine dictates which are the right and capable bodies and which are not.

'Biopower' as it has been formulated by Foucault, is a power mechanism applied by modern capitalist states as a way to control the multitudes (2007). Control is not exercised anymore by a sovereign individual with the power to kill his or her subjects, but by more or less recognizable powers of rule. Foucault argues that through diverse mechanisms of biopower, population control can be administrated as something rational and achieved by consensus. Just to name a few, it regulates health habits, reproductive practices, sexual behaviors and defines welfare. In this context hospitals have become, in Foucaultian lexicon, one of the most important "disciplinary institutions" from where biopower is administered (Foucault, 1975).

In the field of reproductive anthropology we find examples of the intimate relationship between disciplinary technologies and medicine. María Isabel Blázquez (2005), in her review of anthropological studies related to pregnancy, childbirth and postpartum, highlights the connection between capitalism and biomedical assistance developed by Menéndez (1978), Martín (1987), Tabet (1985) and Narotzky (1995). These authors argue that childbirth in hospital settings is regulated by industrial productivity standards. Women's bodies are treated as workers who have to be controlled and disciplined: There is strict division of labor and time is highly regulated. The final product, a healthy baby, is of the highest importance, but not the process of delivery. As Pujol argues, a high medical control of pregnancies happens especially in societies with low birthrates in order to ensure continuity of society and its workforce (in Blázquez, 2005, p.2001).

This situation provokes feelings of exploitation in some women, who feel they do not have any choice but to choose the rhythm and conditions of delivery imposed by hospital routines and policies (Tabet in Blázquez, 2005, p.11). Under this view, medicalization and technology can be seen as key factors in the control of biological reproduction, but also a way to reinforce discourses of motherhood and parenthood (Blázquez, 2005,p.4) which perpetuate the social order. Mothers have to stay obedient and submissive to medical controls and performances, while fathers remain excluded from contributing to the first opportunity of care-taking to be replaced by healthcare personnel.

The control of hegemonic medical discourse is maintained due to the social legitimization it achieved. Influencing factors to legitimate it are the economic and political structures which promote some discourses at the detriment of others. Sometimes by making the discourses accessible and attractive, and sometimes by obscuring and complicating them to target sectors of the population (Foucault, 1971).

In the field of history and sociology of medicine, I would like to introduce two authors: Paul Starr (1982) and Brigitte Jordan (1978), who are worthy of mention due to their work on the construction of the medical authority. In his book *The social transformation of American Medicine* (1982), Paul Starr defines authority as “the possession of some status, quality, or claim that compels trust or obedience” thanks to “two sources of effective control: legitimacy and dependence” (1982, p.9). In most contemporary Western countries biomedicine acts as the sole authoritative knowledge in the field of health. To gain control over medicine, physicians had to find authority over the presence of folk healers, midwives and non-western physicians. These healers used to be considered a source of medical care (Jordan 1997, p.57). Starr (1982, p.12)

argues that part of modern medicine's legitimacy comes from university training in the field, where physicians are organized and trained as a professional group. It provided them the sense of community that validated their competence and gave them strength to delegitimize other kinds of medical knowledge. At the beginning of 20th century, middle- and upper-class men dominated the world of physicians in the majority of European countries and their colonies. The control physicians sought to gain over the field of medicine in general, and in the field of obstetrics in particular, has had far reaching consequences for women giving birth (Jordan, 1997).

One of the reoccurring aspects the anthropologist Brigitte Jordan (1997) observed during hospital births, was that the majority of women believed that their experiences and bodily perceptions were not listened to until the attending doctor confirmed that their symptoms were "real". Even when some women expressed that they were ready to start the delivery, the process did not officially start until the physician gave consent. For example, the recurrent expression "she can push" addresses the rest of the medical team but not the woman herself who is in labor (Jordan 1997, p. 66). Jordan states "the power of authoritative knowledge is not that it is correct but that it counts" (p.58). Jordan also calls attention to the role of social interactions and the use of technology to reinforce the idea of there being only one authoritative knowledge. The ownership of the technology used in labor's processes "defines and displays who should be seen as possessing authoritative knowledge and consequently as holding legitimate decision-making power" (p. 65). She explains that technology has a social meaning that entails an expert status and an ownership power which makes a difference in the social interactions among people (p.65). In some cases the information provided by machines is used to legitimate women's complaints, or the opposite "to negate and to redefine the woman's experiences" (p.69). The descriptions Jordan

offers on the hierarchical social interactions between doctors and pregnant women and doctors and medical personnel are factors that reinforce the idea that the *only* authoritative knowledge lies in the hands of doctors (pg.71). In words of Jordan: "...in the labor room several different kinds of knowledge are actually present, but the only kind that counts is the knowledge delivered by the physician. This knowledge is communicated downward along the hierarchical structure of which the woman is the most distal member"(p.72). Nonetheless, the cultural authority that medicine gained means that, in many cases, the knowledge it provides is accepted as natural and only based on reason (p. 57). In this context sometimes the patient's knowledge is suppressed and delegitimized which has negative consequences on their welfare.

All these explanations about biopower and authoritative knowledge try to contribute an understanding of the broader reasons for the current role of medicine in Western societies. However, it is important to mention that users of the healthcare system are not always passive victims of it, but active subjects who sometimes know the weakness of the system and take advantage of it to achieve goals beyond health (Carr, 2010). In addition, doctors and users of healthcare make various efforts to change these dynamics of authoritarianism and professional lobbying. In the field of women's and reproductive health, some doctors and social and professional collectives work every day to challenge the stagnations of medicine, as I will show throughout this thesis.

2.4. The history of childbirth assistance: a gender and professional competition.

Physicians have not been the only members of society who owned the authority to assist childbirths. Before the 19th century women midwives were the most important practitioners that assisted childbirth in Europe and its colonies. They were important authorities on women's and children health and they usually played a relevant social role in their communities (Ortiz, 1996, p.113). As the compilation of studies about midwives in early modern Europe, edited by Hilary Marland (1993) points out: Midwives were a very heterogeneous collective. Their practices, working conditions, target users, status and social backgrounds greatly differed across Europe (1993, p.2). However a complex and diverse set of factors, changing depending on the geographical context, contributed to making a general change in the midwives hegemony starting to slowly "decline" during the 19th century (p.8).

This section aims to emphasize how this change benefited the emergent professional group of men physicians, who slowly had gained the authority in assisting childbirth that previously was owned by midwives (Green, 2008). During Middle Ages obstetric practice became a part of the male physicians' university training in Europe – "a social and intellectual transformation in the care of women's bodies" began (p.12). Women were excluded from the male dominated scientific community, which contributed to limiting their access to the legitimated intellectual knowledge. Midwives and experienced women were employed as intermediaries "to perform the visual and manual tasks that male physicians or surgeons could or would not do" (Green,2008, 74). It solved the moral issues of obstetric physicians who had to work in a field so close to women's sexuality, but put women in subordinate positions which had become the rule until few decades ago (2008, p.74). The increasing tendency of governmental institutions to require a degree provided by

education institutions to exercise healthcare assistance, favored in many cases the growth of physicians in childbirth assistance to the detriment of midwives. An example of this trend are the different licensing laws that appeared between the 13th and the 20th centuries in many European countries (Marland, 1993). In some cases they contributed to secure the role of midwives, as in Holland (Marland, 1993, 192-213), but in other cases these regulations put midwives in subordinate positions in relation to physicians. In Spain during the 16th century midwives, as other groups of practitioners, such as spicers and druggists, were not allowed to pass an exam to obtain the license to practice. For midwives this meant that they only could work under the approval of a physician (Ortiz, 1993, 98). However, as the compilation edited by Hilary Marland (1993) and Monica Green's work on pre-modern gynecology call attention to, the progression of the male monopoly in the field of childbirth assistance was slow and not easy. Many midwives did not act as passive victims of these events and they fought to keep and improve their role in childbirth assistance (Marland, 1993, 8). There were several women who challenged authorities to keep their right to work autonomously. One example is the case of Luisa Rosado⁷ in Spain in the 18th century (Ortiz, 1993, p. 105). Combining the fact that women were regarded as experts and authorities on women's healthcare for centuries and that men's irruption into a practice so close to women's sexuality entailed moral issues, were factors that caused people to be hesitant to accept the shift from midwives to physicians. Nonetheless, the Enlightenment brought the expansion of the university system and the medical profession as an authoritative field of science. Governmental control increased through licensing and thus denying access to traditional

⁷ Luisa Rosado was a midwife who started a legal process in 1770 to achieve the right to advertise her expertise in the field. It was denied several times by the medical authority of the Spanish Kingdom, as they did not allow the practices she advertised. They argued that midwives were not sufficiently trained. Luisa Rosado, full of self-confidence about her expertise, kept insisting until the point of writing to the King, requesting to fulfill the position of the royal midwife (Ortiz, 1992).

midwives. The loss of their autonomy was fulfilled. As Monica Green (2008) states:

“The maturing of gynecology as an intellectually specialized discipline can be called a ‘masculine birth’ not only in the sense that it became a field dominated by (and in its literate aspects, solely populated by) men, but also in the more Baconian sense that it occurred largely without the input of women and, indeed, without any concern to involve them except in their roles as subordinate midwives or manual assistants and, of course, compliant patients. [...] The issue, therefore, is not women’s universal exclusion from the production and delivery of women’s medicine, but their exclusion from the production of authoritative knowledge in the field that was, in the most essential sense, their own.” (Green, 2008,p.291)

This quote brings light once again to the essential role that gender power relations play in the struggles for the ownership of legitimate knowledge to provide health care in obstetrics. The next section pays attention to the contemporary debates generated by opposite visions of what childbirth is in people’s lives and, therefore, what are the legitimated practices for carrying it out.

2.5. Natural childbirth vs. techno-medicalized childbirth:

During the 20th century the majority of Europe, North America and their colonies experienced the shift from midwives to doctors and from home-birth to hospital birth. When the transition occurred differed depending on geographical areas and cultural and economic backgrounds. In Spain in the 1950s midwives still attended childbirth at home only in rural areas. The practice was progressively seen as unsafe and backward (The Boston Women’s Health Collective, 2000, p.487). This shift also implied a change in the understanding of childbirth, which progressively has been seen as a dangerous event in need of medical intervention (Macdonald, 2006).

Since mid-19th century “gender ideals of women as frail and dependent – and thus incapable of either giving or attending births unaided by male experts – flourished during this time as well, especially among middle and upper classes” (James-Cheatelet 1989, p. 421; Mitchenson 1991, in Macdonald, 2006, p. 237). This narrative had a potent effect: On the one hand it reassured the position of physicians as the required professionals and on the other hand it reinforced gender ideals about the inefficiency and weakness of women’s bodies (Szurek in Davis –Floyd and Sargent, 1997, p. 307). These ideals, among other social events, as the extension of public services of healthcare, facilitated that in the 1950s childbirth began moving from the home to hospitals in the majority of Western countries. Previously giving birth in hospitals or welfare institutions was only an option in many countries for prostitutes, poor women in risk of death or those who were pregnant secretly due to moral reasons. Hospitals were not very safe places due to the lack of resources, the overload of people in need as well as the fact that they were the training ground of inexperienced physicians, who not always were very careful with the people they assisted (Cházaro,2004, p.31). With the improvements of the healthcare system this changed and giving birth in hospitals became the rule, rather than an exception.

Hospitals then became the place where modern obstetric values were practiced. It implied the use of technology and medicines in order to optimally minimize potential physical risks and time span of delivery. Along with this change, an increasing bureaucratization and standardization of the assistance also took place in large hospitals. Many childbirth and women health activists, midwives, doulas and naturist movements reported that practices promoted by modern obstetrics and contemporary hospitals were not always the most convenient for the welfare of pregnant women and their babies. Important critiques of the depersonalized and authoritarian behaviors of

healthcare personnel are also part of the complaints of these movements. In the 1970s, as an alternative to hospital assisted birth, these collectives began talking about the benefits of “natural childbirth”. As the anthropologist Margaret Macdonald (2006) explains, “the ideal of a natural birth has been used as a successful rhetorical strategy in scholarly and popular feminist works on childbirth to counter and critique the predominant biomedical or “technocratic” model of the pregnant and birthing body as inherently problematic and potentially dangerous to the fetus” (p.253). Also the natural birth narrative “posits women as naturally capable and strong, and their bodies perfectly designed to carry a fetus and to give birth successfully without the high-tech surveillance and interventions of physicians in a hospital setting” (p.253). A broader attention to the welfare of pregnant women, paying special care to their emotional well-being, is one of the traits that natural childbirth puts as its central aim, in opposition to physical/symptomatic-centered approach of modern medicine. This approach, however, has produced some debates in the field of feminism. As described in the “Practising childbirth: a politics of evidence” study, “more recent feminist theorising argues that such politics assume a universal female essence and an essentialised understanding of the female body as outside of history and culture, which if left to its own devices will perform a natural birth”. As we will see, some of these questions add important nuances to the approach to gender struggles made by some childbirth activist organizations.

Currently one of the most influential scientists who extensively works on the natural childbirth approach is Michel Odent. He was head of the surgery and maternity unit in the French hospital, Pithivers, between 1962-1985. He was also the first physician to write about water-birth and home-like birth in medical literature. In 1987 Odent founded *The Primal Health Research Center* in

London. This institution is explicitly dedicated to research and widespread studies about “the correlations between what happens at the beginning of our life and what will happen later on in terms of health and personality traits” (Primal Health Research Databank, 2014). Odent argues that the atmosphere of delivery is crucial to guaranteeing women’s secretion of hormones (especially oxytocin), which lead to less problematic births and postpartum experiences. Odent considers depersonalized assistance, technological monitoring or lack of privacy as key factors that obstruct the release of the necessary hormones to deliver a baby successfully. He also maintains that medical and technological interventions can have long-term consequences in the personal development of newborn children, affecting their sociability and increasing the chances of developing aggressive and suicidal behaviors (Odent, 2011, 2009, 2000).

Robbie Davis-Floyd, a medical anthropologist specialized in reproduction, coined the term 'technocratic birth' (1993). It refers to modern obstetrical medicine in opposition to 'natural birth', which is closer to the traditional midwifery and other non-Western birthing systems. As we will see during this research, the concept of 'obstetric violence' and its critique of current mainstream obstetrics is encompassed by some of the tensions that arise in the debates between these two approaches to childbirth. As we have seen throughout this theoretical framework, medicine and health care institutions, like other professional fields, is pervaded by power relations. Social hierarchies and ideologies permeate the development of any human activity, but the case of obstetrics, due to its relation with female sexuality and human reproduction, becomes a very sensitive area for the expression of male chauvinism and population's control practices, as we saw in the feminist and biopower critique. These attitudes are also mixed with a history of medicine rife with professional authoritarianism with respect to the ownership of legitimate knowledge.

Professional hierarchies in childbirth assistance and the prevalence of some childbirth practices over others are some of the consequences of this complex set of conditions, which make a difference in the obstetrics assistance provided today and in our ways of understanding what childbirth is. The next section introduces the recent inclusion of obstetric violence as part of legal texts on violence against women in Venezuela, Argentina and Mexico. The will be aim to show how the texts define 'obstetric violence' and how other previous institutional documents, such as WHO's recommendations (1985a) and human rights conventions, dealt with this issue. This will give a framework for current activism against obstetric violence in some of the main international and governmental acknowledgements of the topic.

CHAPTER 3

Obstetric violence: gender, health and human rights.

A legal review.

The term 'obstetric violence' has spread and continues to spread to different geopolitical locations, but little is known about why legal scholars and activists adopted this term. Much is also not known about what the term can contribute to understanding and raising awareness about issues regarding current obstetric assistance. In this section I would like to review some of the most significant institutional approaches to issues concerning childbirth which have influenced the current advocacy of childbirth activism and creation of obstetric violence legal texts in Venezuela, Argentina and Mexico in the last decade. First I will present the relevance of Sexual and Reproductive Health and Rights (SRHR) advocacy in making explicit the interrelation of gender issues, health and human rights that are included in obstetric violence legal regulations. SRHR advocacy spreads the idea that sexual and reproductive rights are highly relevant aspects for human welfare that cannot be overlooked within medical institutions. These rights become especially important in areas related to the care of women's reproductive processes and sexuality because they are sometimes negatively impacted by gender hierarchies and traditional male

chauvinist ideas about women's bodies. These legal texts become an interesting framework that makes visible the social dynamics that instigate obstetric violence cases. Also the texts provide a legal recognition of these issues as part of human rights struggles that women face several times in their sexual and reproductive lives. Secondly, I will pay attention to one of the most important WHO's documents regarding obstetrics assistance. On an international scale WHO's recommendations about *Appropriate Technology for Birth* (1985^a) attempted for the first time to establish some guidelines to improve concrete aspects of childbirth healthcare assistance. Women's right to information and choice, women's emotional support during delivery, the early attachment of the mother to her newborn child, and the reduction of medicalization and technological interventions were some of the main points to which these recommendations called attention. This document, also known as the Fortaleza's Declaration (WHO, 1985^a), became a legitimate source in the field of childbirth assistance and activist groups in different parts of the world still use it today as a tool to demand more respectful healthcare assistance for women, fetuses and children during pregnancy, delivery and postpartum experiences. However, some of these recommendations are not always welcomed by professionals in all parts of the world, which can negatively impact the obstetric assistance provided and lead to serious violations of sexual and reproductive rights. I argue that SRHR approach and WHO's consensus influenced important changes in the institutional approaches to reproductive health and childbirth assistance – some of which are reflected in obstetric violence legal texts adopted by Venezuela, Argentina and Mexico.

Since there is no literature specifically summarizing these legal and institutional approaches to childbirth, the last section of this chapter will be the first attempt at presenting a legal review of obstetric violence, concentrating on providing a better understanding of the terms relationship

with childbirth, gender issues, medical malpractice and the ethics of healthcare assistance. I argue it is important to review these text because the recent introduction of the concept of 'obstetric violence' to denote punishable practices under the law of Venezuela, Argentina and Mexico, indicates a crucial change in governmental attention to childbirth assistance. The legal approach taken by these three countries has provided childbirth activists globally with a legitimate way of reporting undesirable situations experienced by pregnant women when they give birth in hospitals. It is a tool with much potential, as I will illustrate throughout the Spanish case study.

3.1. Transnational efforts to ensure respected childbirths

3.1.2. Sexual and Reproductive Health and Rights approach.

Since the 1990s several authors in Latin-America began to study the problems that women face in the obstetric units of hospitals from a gender perspective and as violations of reproductive rights (Belli, 2013; Campero et al., 1998; Camarco, 2009; Castro R., 2000, 2010; CLADEM, 1998; D'Oliveira et al., 2002; Erviti, 2010, 2012; Magnone, 2011 and Valdez-Santiago et al., 2013). For the most part of these works do not employ the term 'obstetric violence', but the range of practices studied mirror practices covered by the recent usage of the concept. From the 1990s onwards the notion of 'Sexual and Reproductive Health and Rights' has become an important term in defending a person's right to have access to healthy reproductive and sexual experiences. Since it is mostly women and non-heterosexual people that experience injustice of this form, the term has been predominantly aimed at them. Human rights advocacy, feminism and LGBT activism

had an important role in defining and defending these rights, which are still in the process of being conceptualized (Tellier, S and S. Lund, ed., 2013).

Early efforts made for the recognition of these rights were accomplished by the Women's Health Movement. In different parts of the Western world the Women's Health Movement "emerged as a result of changes both in women's values and in the objective conditions of healthcare during the late 1960s and early 1970s" (Burt, 1978, p.9). Some women rights organizations began to build centers with the aim of spreading information and providing help with different aspects of women's health. Above all, they strove to inform women about issues related to reproduction and sexuality, which were generally not well received by traditional healthcare institutions. Dissatisfaction with the services provided by obstetricians and gynecological professionals and restricted access to abortion and contraceptives were some of the main problems detected and, were often interpreted by activist movements as the consequence of the male domination of medicine (p.10). Centers for family planning were some of the first attempts to provide alternatives to conventional healthcare assistance⁸. These movements reported how traditional gender roles are reinforced when women cannot make decisions about their own health and when the information about sexuality and reproductive choices is denied through strong dynamics of professional authoritarianism in healthcare assistance (Burt, 1978). Hence, the Women's Health Movement, LGBT movements and the development of human rights advocacy did and do contribute to increase attention to sexual and reproductive health as a key factor in human well-being. The SRHR approach inherited the aforementioned movements' support of the

⁸ Some of them were: The American Birth Control League founded by Margaret Sanger in 1921, which in 1952 with other national organizations, created the International Planned Parenthood Federation (IPPF). Marie Stoppes and her initiative, Society for Constructive Birth Control and Racial Progress (1921) in the UK, and the French Maternité Heureuse founded by Lagroua Weill-Hallé and Evelyn Sullerot in 1956, were some of the first relevant results of this movement (Ortiz et al. 2011, and Tellier, S and S. Lund ed., 2013).

idea that people, regardless their gender identity and sexual orientation, have the right to make decisions about their sexual and reproductive life, as it is a key factor in ensuring their autonomy and creating more gender balance. This idea shatters the distinction between private and public issues and calls attention to the importance of sexual and reproductive health as essential factors for human well-being.

When *The Universal Declaration of Human Rights* was approved in 1948, the conditions for healthy living were endorsed as a fundamental right (Article 25.1., UN, 1948). The document made an explicit reference to reproductive health regarding the state of motherhood and childhood: "Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection" (Article 25.2. UN,1948). *The Convention on the Elimination of All Forms of Discrimination against Women* (CEDAW), adopted in 1979 by the UN General Assembly and also known as the bill of rights for women, encourages states 'to eliminate discrimination against women in the field of healthcare [...]' and "to ensure appropriate services in connection with pregnancy, confinement and the post-natal period [...]" (article 12, UN, 1979). However, it was not until 1994 that the concept of sexual and reproductive health was adopted by the International Conference on Population and Development (ICPD) organized by United Nations in Cairo. It showed an important change in the approach to these questions. Sexual and reproductive health is not considered just a question to control fecundity and maternal and children mortality anymore, but an important factor in human welfare and a key aspect in women's autonomy (Mazarrassa and Gil, 2008, p.5).

Recognizing the right to sexual and reproductive health implies an admission that in order to achieve the human right of "a standard of living adequate for the health and well-being" (Article

25.1., UN, 1948) it is necessary overcome all discrimination, with special emphasis on gender, that do not allow people proper access to education, information and healthcare which allows them to decide freely about the their own reproduction and sexuality. This approach recognizes a wide range of violent practices against women and acknowledges gender violence as a public problem with many causes and consequences that states must regulate. *The Inter-American Convention on the Prevention, Punishment and Eradication of Violence Against Women – Convention of Belém do Pará – (OAS,1995)* is an international convention which offers the most extended declaration on the topic:

“For the purposes of this Convention, violence against women shall be understood as any act or conduct, based on gender, which causes death or physical, sexual or psychological harm or suffering to women, whether in the public or the private sphere (Article 1, UN, 1995) [...]

a. that occurs within the family or domestic unit or within any other interpersonal relationship [...]

b. that occurs in the community and is perpetrated by any person, including, among others, rape, sexual abuse, torture, trafficking in persons, forced prostitution, kidnapping and sexual harassment in the workplace, as well as in educational institutions, health facilities or any other place; and

c. that is perpetrated or condoned by the state or its agents regardless of where it occurs.” (Article 2, OAS, 1995).

This understanding is shared by the obstetric violence's legal texts of Venezuela, Argentina and Mexico, since they include obstetric violence as part of their regulations concerning violence

against women. In spite of the fact that obstetric violence occurs in public settings, it is exercised by health personnel and entails explicit and subtle forms of violence, from psychological to physical abuses. SRHR advocacy represents a large identification of the strong interrelations between gender issues, health and human welfare, which are highly important to understanding the main concerns of childbirth assistance to which obstetric violence draws attention.

The next section will provide information about the inputs that WHO's recommendations about *Appropriate Technology for birth* (1985^a) added to the struggles against medicalization of childbirth and the undermining of women's right to a decision that the critique of obstetric violence implies.

3.1.3. WHO's recommendations:

Between 1979-1985 an innovative study about Perinatal Health Care in Europe was carried out by the European regional office of the World Health Organization (WHO). It is be considered the first step to making a change in the childbirth institutional healthcare paradigm. Later regulations -e.g. the obstetric violence legal texts-, several national healthcare guidelines -e.g. the latest Spanish *Strategy for Assistance at Normal Childbirth in the National Health System* (Ministerio de Sanidad y Consumo, 2007)-, and childbirth activists use WHO's study extensively as a referential document to ground their approach to childbirth assistance.

The study was the result of a demand made during one of WHO's European meetings in 1979, where some representatives complained "that their perinatal services were costing more and more

with no evidence of improved benefits and little evaluation of efficacy” (Wagner in Davis –Floyd and Sargent 1997, p.369). As a result, it was decided to form a group to study and evaluate European maternal and neonatal services. The group was headed by Marsden Wagner, who at that time was the Responsible Officer for Maternal and Child Health at WHO. The group's most important finding was the enormous “gap between science and practice” (Wagner in Davis –Floyd and Sargent 1997, p.369). Only 10% of all routine obstetrical procedures had an adequate scientific basis, which was expressed in the “great variation in obstetrical practices with little or no relationship to perinatal outcome” (p.370). For example, which technological device was used for the same operation differed greatly across geopolitical areas – in continental Europe, a vacuum extractor was the preferred technology for delivery, while forceps were predominantly used in UK and the former British colonies (p.370). This reflected that customs had a more important weight in making decisions about the preferred technology used during childbirth, rather than studies and discussions about it. Other controversial topics discussed within this study group were home births and the role of midwives. The group concluded that home births can be as safe as a hospital births for a woman with an uncomplicated pregnancy. Likewise, later recommendations in Fortaleza (Brazil) stated that “the training of professional midwives or birth attendants should be encouraged. Care during normal pregnancy, birth, and afterwards should be the duty of this profession” (WHO, 1985, p.436). The experiences of European countries with major autonomy and a large number of midwives entailed less medicalized childbirths (Wagner in Davis –Floyd and Sargent, 1997, p. 368). According to the European regulation on Midwifery⁹, midwife education provides enough knowledge to perform episiotomies or breech births. Midwives are personnel trained to assist women during pregnancy, normal deliveries and issues regarding the health of

⁹European Parliament and Council. Directive 2005/36/CE. September 7, 2005. Accessed June 15, 2014:<http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CONSLEG:2005L0036:20110324:EN:PDF>

the mother and baby until the 28th day of the child, as well as other aspects of women's health during their reproductive life. In line with this, WHO advocates midwives assistance during childbirth rather than physicians, who are professionals specialized in pathologies, and required in cases of risky childbirths, which demand surgery or other major medical procedures.

The result of the study on Perinatal Health Care in Europe entailed data collection with a clear goal to redefine the role of medical interventions during childbirth, in opposition to the general tendency to medicalize childbirth by mainstream European obstetrics. The introduction of WHO's book, *Having a Baby in Europe* (1985b), compiled by Mardsen Wagner, was based on the conclusions of this study. The book shows a clear change in the opinions and approaches childbirth: "Most health care providers no longer know what non-medical birth is. This is an overwhelmingly important issue. [...] The entire modern obstetric and neonatological literature is essentially based on observation of medicalized birth" (WHO, 1985, p.85). This approach, in favor of reducing medicalization and technological interventions during childbirth, was widespread throughout several WHO regional offices. The most important event was the creation of *Appropriate Technology for Birth*, also known as *Recommendations of Fortaleza*, edited in the medical magazine *Lancet* (WHO, 1985a). These guidelines were agreed during the Consensus Conferences organized by the European branch of the World Health Organization and the Pan American Health Organization, which took place in 1985 in Fortaleza, Brazil. The most important recommendations reinforced a woman's right to information and choice, emotional support for women during delivery, the early attachment between the mother and her newborn, and the reduction of medicalization and technological interventions.

Table 1. Some WHO's recommendations in *Appropriate Technology for Birth* (WHO, 1985a).

Right to Information and Choice:	<ul style="list-style-type: none"> • The whole community should be informed of the various procedures in birth care, so as to enable each woman to choose the type of birth care she prefers. • Women who give birth in an institution must retain their right to decide about clothing (hers and her baby's), food, disposal of the placenta, and other culturally significant practices. • The training of health professionals should include communication techniques in order to promote sensitive exchange of information between members of the health team and the pregnant woman and her family.
Emotional support:	<ul style="list-style-type: none"> • The well being of the new mother must be ensured through free access to a chosen member of her family during birth and throughout the postnatal period. In addition, the healthcare team must provide emotional support.
Mother-child attachment:	<ul style="list-style-type: none"> • The healthy newborn must remain with the mother whenever possible. Observation of the healthy newborn does not justify separation from the mother. Immediate breastfeeding should be encouraged even before the mother leaves the delivery room.
Cesarean section:	<ul style="list-style-type: none"> • Countries with some of the lowest perinatal mortality rates in the world have caesarean section rates of less than 10%. There is no justification for any region to have a rate higher than 10-15%. • There is no evidence that caesarean section is required after a previous caesarean section birth. Vaginal deliveries after a caesarean should normally be encouraged wherever emergency surgical intervention is available.
Technological monitorization:	<ul style="list-style-type: none"> • There is no evidence that routine fetal monitoring has a positive effect on the outcome of pregnancy. Electronic fetal monitoring should be carried out only in carefully selected cases related to high perinatal mortality rates and where labour is induced. Research should investigate the selection of women who might benefit from fetal monitoring. Meanwhile, national health services should abstain from purchasing new equipment.
Routine practices:	<ul style="list-style-type: none"> • There is no indication for shaving pubic hair nor for an enema before delivery. • Artificial early rupture of membranes, as a routine process, is not justifiable.
Medicalization:	<ul style="list-style-type: none"> • The perineum should be protected wherever possible. Systematic use of episiotomy is not justified. • The induction of labour should be reserved for specific medical indications. No region

	<p>should have rates of induced labour higher than 10%.</p> <ul style="list-style-type: none">• During delivery, the routine administration of analgesic or anesthetic drugs (not specifically required to correct or prevent any complication) should be avoided.
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Today these recommendations are a source of authoritative knowledge in the field of childbirth assistance that activist groups in different parts of the world use as a tool to claim more respectful healthcare assistance for women, fetuses and children during pregnancy, delivery and postpartum. For example, the main organizations in Spain discussed in this research (*El Parto es Nuestro*, *Plataforma pro Derechos del Nacimiento* and *Dona a Llum*) use these recommendations. As previously mentioned, the legal texts on obstetric violence share the main principles of these recommendations and some national healthcare documents also use them as the main document with which to base their guidelines (Ministerio de Sanidad y Consumo, 2007). However, some of these recommendations are not welcomed or followed in all the cases by some groups of professionals in different parts of the world, as we will see in the case study on Spain. Generally these groups do not follow the recommendations because they entail a change of obstetrics' educational training which has become routine in some hospitals. and the recommendations also restrict the actions of obstetricians in favor of midwives. As Mardsen Wagner reports in "Confessions of a dissident" (1997) several groups of doctors tried to discredit these recommendations by attacking his authority in the field – some physicians argued he was an epidemiologist and only obstetricians have the necessary expertise, to make such judgments, that he was not scientifically objective, and that the recommendations he advocated were merely his opinion and not part of WHO's publications (p. 366-393).

"Important lessons can be learned from the way in which the medical establishment has attempted to discredit *Having a Baby in Europe* and the consensus

recommendations. With regard to the knowledge in these publications, I do not know any attempt to directly challenge their validity or 'truth': there are no articles that take on specific recommendations to show why they were not scientifically justified, no requests to debate the specifics. Rather, other strategies were employed. One was to say that these recommendations were relevant only to the Third World (i.e. maybe the knowledge is valid but it doesn't apply to us). But by far the most common approach has been to attack the authority rather than the knowledge" Mardsen Wagner (1997, p.375.)

However, further consensus documents in line with the first WHO's recommendations were created. One example is WHO's training program based on the document *The Ten Principles of Perinatal Care* (1989), created to disseminate and evaluate this approach among obstetrics' professionals (Chamblers, Magniaterra and Porter, 2001). Many activists still frame part of their activity on the spreading and advocacy of these recommendations. SRHR's approach and WHO's recommendations against medicalization of childbirth are therefore significant initiatives which demonstrate an international change in the approach perinatal assistance in public institutions. As we will see in the next section current obstetric violence regulations share certain aspects with the aforementioned documents.

3.2. Legal texts: Venezuela, Argentina, and Mexico.

Today even though the remarkable prevalence of the concept of 'obstetric violence' in activist initiatives and academic research as well as media coverage of obstetric violence cases, the history of the emergence of the term has not been thoroughly studied. I could not find any literature

about its usage before its implementation as a legal term in 2007 in Venezuela's "Organic legal text on the Right of Women to a Life Free of Violence"¹⁰. However, it appears that before its recognition as a legal term, women's and reproductive rights advocacy popularized the concept of 'obstetric violence'.

Currently the largest amount of literature and online social networks with references to obstetric violence are related to the three countries that recognize obstetric violence in their law, namely Venezuela, Argentina and Mexico. However, on Spanish and Brazilian online platforms there is a remarkable amount of references to the concept of 'obstetric violence'. Allusions to this term mostly occur within childbirth activism documents, and, to a lesser extent, in articles in the media and institutional and NGO documents. In order to provide some information about how 'obstetric violence' is defined within the legal frameworks of Venezuela, Argentina and Mexico, the this section reviews relevant aspects of their regulations. I finish with some general considerations about different conceptions of childbirth, the role attributed to sexism and the practices of professional authoritarianism that these legal texts imply.

Venezuela:

During the 1980s different institutional initiatives and social movements arose campaigns to improve sexual and reproductive rights in the country. The main problems reported were high

¹⁰ "Ley orgánica de 19 de marzo de 2007, sobre el derecho de las mujeres a una vida libre de violencia" .2007. *Gaceta Oficial*. n.38, 647. (March 19, 2007). Accessed March 20, 2014: http://www.gparlamentario.org/spip/IMG/pdf/Ley_Organica_sobre_el_Derecho_de_las_Mujeres_a_una_Vida_Libre_de_Violencia.pdf

rates of adolescent pregnancy, child and maternal morbidity and mortality, sexual abuse in young people, the prevalence STDs (including HIV) among young people and a lack of quality in health care assistance in the obstetric field¹¹. We can find the first outline of the future legal text against obstetric violence in 2003 in "Official Regulation for the sexual and reproductive health care assistance"¹². This policy attempted to establish some guidelines for improving healthcare assistance during reproductive processes, with special attention to the right of pregnant women to make decisions, to be informed during their hospitalization, and to avoid medicalization and technical intervention in low risk births. They are all aspects which later were included in the 2007 legal text "on the right of women to a life free of violence"¹³, where the term 'obstetric violence' was explicitly used for the first time in a legal text.

This Venezuelan regulation from 2007 codifies obstetric violence as one of the 19 kinds of punishable violences against women. The document describe obstetric violence as:

"...the appropriation of the body and reproductive processes of women by health personnel, which is expressed as dehumanized treatment, an abuse of medication, and to convert the natural processes into pathological ones, bringing with it loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting the quality of life of women." (translation by Pérez, 2010, p. 201).

¹¹ "Norma Oficial para la Atención Integral de la Salud Sexual y Reproductiva". 2003. Decreto Ministerial N° 364. *Gaceta Oficial* n. 37, 705 (July 03,2003) p.9. Accessed March 20, 2014: http://venezuela.unfpa.org/documentos/ssr_norma_inicio.pdf

¹² Ibid.

¹³ "Ley orgánica, de 19 de marzo de 2007, sobre el derecho de las mujeres a una vida libre de violencia".2007.*Gaceta Oficial*. n.38 647 (March 19, 2007). Accessed March 20, 2014: http://www.gparlamentario.org/spip/IMG/pdf/Ley_Organica_sobre_el_Derecho_de_las_Mujeres_a_una_Vida_Libre_de_Violencia.pdf

Article 51 of this regulation describes for the first time what are considered acts of obstetric violence. Included were the following:

“(2) Forcing the woman to give birth in a supine position, with legs raised, when the necessary means to perform a vertical delivery are available.

(3) Impeding the early attachment of the child with his/her mother without a medical cause, thus preventing the early attachment and blocking the possibility of holding, nursing or breast-feeding immediately after birth.

(4) Altering the natural process of low-risk delivery by using acceleration techniques, without obtaining voluntary, expressed and informed consent of the woman.

(5) Performing delivery via cesarean section when natural childbirth is possible, without obtaining voluntary, expressed, and informed consent from the woman”(p.202).

These practices can be punished with a fine of 250 TU to 500 TU¹⁴ and disciplinary actions put forth by the institution responsible¹⁵. The Society of Obstetrics and Gynecology of Venezuela argued that educational aspects, like the fact that the Venezuelan universities only teach how to assist a delivery where women lay horizontally, have to be taken into account before this regulation is applied (p.202). Some healthcare personnel also argued that this legal text could facilitate users refusal or request of practices which go against a proper execution of their work. They claim that “the state, rather than creating a law that punishes for exercising their profession,

¹⁴In February 2014, from 3,666 euros to 7,333 Euros.

¹⁵ “Ley orgánica, de 19 de marzo de 2007, sobre el derecho de las mujeres a una vida libre de violencia” .2007. *Gaceta Oficial*. n.38 647, (March 19, 2007). Accessed March 20, 2014 http://www.gparlamentario.org/spip/IMG/pdf/Ley_Organica_sobre_el_Derecho_de_las_Mujeres_a_una_Vida_Libre_de_Violencia.pdf

should make substantial improvements in hospitals to ensure optimal care for pregnant women” (my translation, Guerra, 2008, p.6).

Similarly, the states of Argentina (2004) and Mexico (2008)¹⁶ presented regulations about childbirth assistance in their laws, which later were complemented with specific legal texts against obstetric violence, as we will see in the following sections. Recently, in April 2014, the national senate of Mexico also modified its general legal regulations on violence against women to include obstetric violence as a punishable practice¹⁷.

Argentina:

In 2009 the government of Argentina created a national regulation called the “Act of full protection for the prevention, sanction and eradication of violence against women in their personal relationships”¹⁸ In chapter 6 of the document, 'obstetric violence' appears for the first time in the Argentinian law. Like in Venezuela, Argentinean regulation includes obstetric violence in its national legal text about violence against women and it describes it as the practices which entail dehumanization, medicalization and pathologization of women’s reproductive processes by healthcare personnel. The only difference between Venezuelan law, is that Argentina increased the

¹⁶Ley Nacional 25.929 de Derechos de Padres e Hijos durante el Proceso de Nacimiento”. 2004. *Declaración de Interés del Sistema Nacional de Información Mujer, por parte del Senado de la Nación* (August 25, 2004). Accessed January 7, 2014: http://www.unicef.org/argentina/spanish/ley_de_parto_humanizado.pdf and “Ley de Acceso de las Mujeres a una Vida Libre de Violencia del Distrito Federal”. 2008. *Gaceta Oficial del Distrito Federal*. 17^a, n. 263, (January 29, 2008). Accessed January 7, 2014: <http://bit.ly/VL0uV5>>

¹⁷“Comunicado 749” 2014, Senado de la República, (April 30, 2014). Accessed June 7, 2014: <http://comunicacion.senado.gob.mx/index.php/informacion/boletines/12513-senado-aprueba-sancionar-violencia-obstetrica.html>

¹⁸“Ley 26.485 sobre la protección integral para prevenir, sancionar y erradicar la violencia contra las mujeres en los ámbitos en que desarrollen sus relaciones interpersonales”. 2009. *Congreso Argentino*. (March 11, 2009). Accessed January 7, 2014: http://www.oas.org/dil/esp/Ley_de_Proteccion_Integral_de_Mujeres_Argentina.pdf

number of practices included under obstetric violence. As it was already recognized in the 2004 "Act of Humanized Childbirth"¹⁹ the Argentinian legal text on obstetric violence includes that a pregnant woman has the right:

1) "to be addressed with respect, in a personalized and individualized way, with guaranteed intimacy during the entire process and with consideration to their cultural rules" (my translation).

2) "to be considered during the childbirth process, as a healthy person, such that a woman's participation has to be facilitated in leading her own birth" (my translation).

3) to have a natural childbirth, which is described as "respectful with the biological and psychological times, that avoids invasive practices and the administration of medication which are not justified by the state of health of the mother or the unborn person" (my translation).

The violation of some of these rights in Argentina were reported in pioneering research that two women's organizations – the Institute of Gender, Law and Development of Rosario (INSGENAR) and the Committee on Latin America and the Caribbean for the Defense of the Rights of Women (CLADEM) – carried out in the city of Rosario in 2003. The research, called *Con todo al aire* ("Full exposure") (Chiaroti et al., 2003), was reported before the Ombudsman's Office and the Health Care Office of the city. It revealed that within the studied hospitals, pregnant women were subjected to cruel and degrading treatments, no protection of privacy and a lack of necessary

19 "Ley Nacional 25.929 de Derechos de Padres e Hijos durante el Proceso de Nacimiento". 2004. *Declaración de Interés del Sistema Nacional de Información Mujer, por parte del Senado de la Nación* (August 25, 2004). Accessed March 20, 2014: http://www.unicef.org/argentina/spanish/ley_de_parto_humanizado.pdf

information. In Argentina abortion is an illegal practice which is not only penalized, but also socially condemned. Women who attempt to sidestep the law and seek an abortions outside of the healthcare system risk serious health problems. The report draws attention to several cases in which women, who after a clandestine abortion sought health assistance, or who present symptoms that resemble abortion, were mistreated by healthcare personnel and in some cases threatened with legal action (Chiaroti et al., 2003, p.31). These cases illustrate how the violation of reproductive and sexual rights and the employment of practices related to obstetric violence are the consequences of male chauvinistic views of women's reproductive and sexual autonomy.

Mexico:

In Mexico the local acts "on Women's Access to a Life Free of Violence" of the states of Durango²⁰ (2007), Veracruz²¹ (2008), Guanajuato²² (2010) and Chiapas²³ (2012) include regulations against obstetric violence. Recently a change approved in the national Senate (2014)²⁴ also

²⁰ "Ley de las Mujeres para una Vida sin Violencia del Estado de Durango", 2007, *Periódico Oficial del Estado de Durango*. n. 53 (Dicember 30, 2007). Accessed January 7, 2014: <http://info4.juridicas.unam.mx/adprojus/leg/11/416/9.htm?s=>

²¹ "Ley Número 235 de Acceso de las Mujeres a una Vida Libre de Violencia para el Estado de Veracruz de Ignacio de la Llave". 2008. *Gaceta Oficial del Estado de Veracruz*, n. 65, (February 28,2008). Accessed January 7, 2014: <http://bit.ly/VKZW1A>

²² "Ley de Acceso de las Mujeres a una Vida Libre de Violencia para el Estado de Guanajuato". 2010. *Periódico Oficial del Gobierno del Estado de Guanajuato*. n. 189, (Novemeber 26, 2010).Accessed January 7, 2014: <http://bit.ly/TVFpaK>

²³ "Ley de Acceso a una Vida Libre de Violencia para las Mujeres en el Estado de Chiapas". 2009. *Periódico Oficial del Estado de Chiapas*, n.152, (March 23, 2009), p.5. Accessed January 7, 2014: http://www.cndh.org.mx/sites/all/fuentes/documentos/programas/mujer/5_LegislacionNacionalInternacional/Legislacion/Estatal/Chiapas/B/Ley%20de%20Acceso%20a%20una%20Vida%20Libre%20de%20Violencia%20para%20las%20Mujeres.pdf

²⁴"Comunicado 749".2014. *Senado de la República*, (April 30, 2014). Accessed June 7, 2014: : <http://comunicacion.senado.gob.mx/index.php/informacion/boletines/12513-senado-aprueba-sancionar-violencia-obstetrica.html>

allowed the introduction of the issue of obstetric violence in the national legal texts on violence against women.

In 2008, before any specific regulation against obstetric violence, the national government had already approved a reform of its legal text on "Women assistance during pregnancy, childbirth and puerperium."²⁵ This document established new criteria to reduce the risks of routine and unnecessary practices during childbirth assistance in hospital settings. It included regulations to reduce medicalization, such as: the prohibition of sedatives as routine and without consent, the reduction of cesarean sections and the prohibition of potential denigrating practices (e.g. enemas and pubic shaving) without medical necessity and the woman's consent. All of these aspects were later included in the legal texts against obstetric violence.

Currently, Veracruz, one of the aforementioned Mexican states, has the strictest regulation against obstetric violence. Included within their penal code are punishments from 6 months to 6 years of prison and fines up to 300 days of salary depending on the kind of crime (Veracruz, art. 363, Penal Code in GIRE, 2013, p.128). Unlike the other Mexican states, Veracruz's regulation also includes "the bullying and psychological or offensive pressure towards a pregnant women in order to inhibit her free decision about motherhood" (my translation, p.128). This make clear the important weight that psychological pressure can have during childbirth assistance. This is specially interesting because it implies a subtle way to coerce women through knowledge and gender hierarchies, situations which are difficult to identify and report.

²⁵ "Ley de Acceso de las Mujeres a una Vida Libre de Violencia del Distrito Federal". 2008. *Gaceta Oficial del Distrito Federal*. 17, n.26, (January 29, 2008). Accessed February 20, 2014: <http://bit.ly/VL0uV5>>

The NGO GIRE (*El Grupo de Información en Reproducción Elegida*/Group of information for elected reproduction) presented a report in 2013 about reproductive rights in Mexico with special section dedicated to obstetric violence. This document (GIRE, 2013) argues that even with the existence of obstetric violence regulations since 2007, the number of reports because of it have been very few. Legal procedures are only applied with cases of obstetric violence that entail dramatic results, such as the death of the woman, fetus or child (GIRE, 2013,p.140). Relevant institutional mechanisms to eradicate these practices have also not been applied after the creation of the legal texts. The authors draw attention to the fact that one of the major concerns regarding obstetric violence in Mexico is an increasing number of cesarean sections. Currently the national rate is at 38% and it increased to 50.3% in 2001, thus far from the 10% of cesarean sections per total of childbirths that WHO recommends. A cesarean section is not a recommended practice because it requires major surgery that entails several risks for the woman and fetus or child, which can be avoided through vaginal delivery²⁶. The increasing number of cesarean sections, therefore, seem not to be a response to a scientific evidence concerning human welfare, but a trend which, in many cases, is a substitution to a feasible vaginal delivery. However, the main issue is that c-sections usually occur without a proper weighing of the risks and benefit and without properly informing pregnant women's so as to limit their choice in the matter.

²⁶The Spanish organization El Parto es Nuestro has a large amount of information about this practice, which can be consulted here. Accessed, March 9, 2014: <http://www.elpartoesnuestro.es/informacion/parto/la-cesarea>

3.2.1. Reflections: the critiques underneath obstetric violence legal texts.

If we take into account the different factors that these regulations mention we can form a picture of what are the main problems that acquired a relevant role in the reproductive health care and gender policies in these countries. These regulations clearly point out three main connected problems of current institutional childbirth assistance:

- 1) the pathologization of pregnant bodies.
- 2) the medicalization of women's reproductive processes
- 3) and the dehumanizing or denigrating treatments towards women who give birth.

This definition of obstetric violence as practices that medicalizes, pathologizes and denigrates pregnant women and women giving birth entails a specific approach to childbirth and pregnancy. I argue that in these legal texts there is an implicit assumption that childbirth is a natural/normal event in women's lives. It also assumes that women are "naturally" capable of delivering a baby without several common medical interventions – this view characterizes medicalization in low-risk childbirth as a way of constricting a women's potential to give birth. It is described as "an abuse of medication, and to convert the natural processes into pathological ones"²⁷. The prohibition of altering the natural process of low-risk delivery "by using acceleration techniques or performing delivery via cesarean section, when natural childbirth is possible"²⁸ is, for instance, one of the issues related to medicalization that is regulated in obstetric violence legal texts. The government

²⁷My translation: "Ley orgánica, de 19 de marzo de 2007, sobre el derecho de las mujeres a una vida libre de violencia".2007. *Gaceta Oficial*. N.38, 647, (March 19, 2007). Accessed January 7, 2014: http://www.gparlamentario.org/spip/IMG/pdf/Ley_Organica_sobre_el_Derecho_de_las_Mujeres_a_una_Vida_Libre_de_Violencia.pdf and "Ley 26.485 sobre la protección integral para prevenir, sancionar y erradicar la violencia contra las mujeres en los ámbitos en que desarrollen sus relaciones interpersonales". 2009. *Congreso Argentino* (March 11, 2009). Accessed January 7, 2014: http://www.oas.org/dil/esp/Ley_de_Proteccion_Integral_de_Mujeres_Argentina.pdf

²⁸ Ibid.

of Argentina explicitly recognizes “the right to a natural childbirth”, described as “respectful with the biological and psychological times”²⁹. Hence, these legal texts advocate the idea that pregnancy does not have to be considered a pathology, but a “natural” process – i.e. a process that is not medicalized or accelerated. This consideration also entails a change in the pregnant women's status, – they are no longer seen as sick, but capable of making decisions and experiencing childbirth in the way that makes them feel most comfortable. One of the legal texts which more emphatically points out this aspect is the Argentinean one. It says that a woman has the right “to be considered within her position in the childbirth process, as a healthy person, so her participation has to be facilitated as the leading of her own birth”³⁰. At the very least, a woman's free choice of delivery position, recognized by all legal texts, is one of the facts which go hand in hand with the view that defends a woman's right to decide about her pregnancy/childbirth process.

Another aspect which is highly considered a problem in these legal texts is the dehumanizing treatment of pregnant women within the obstetric field. Some of the practices we can categorize as dehumanizing are those which entail infantilization of women and a lack of respect towards their intimacy. Women are treated as infants when they are not recognized as subjects capable of making decisions about their health nor understanding what is happening in their bodies. This belief is very related to the pathologizing tendency already mentioned, which sees pregnant women as sick and handicapped people. Male chauvinistic societies that see women as irrational and emotional subjects and whose duty is to be uncomplaining mothers, are factors to be taken

²⁹ “Ley Nacional 25.929 de Derechos de Padres e Hijos durante el Proceso de Nacimiento” .2004. *Declaración de Interés del Sistema Nacional de Información Mujer, por parte del Senado de la Nación* (August 25, 2004) Accessed January 7, 2014: http://www.unicef.org/argentina/spanish/ley_de_parto_humanizado.pdf

³⁰ Ibid.

into account when we try to understand the reasons behind obstetric violence. It is not a coincidence that obstetric violence regulations are part of all the cases of broader texts about violence against women. Obstetric violence is considered in all three Latin countries as one kind of gender violence, which women suffer due to their position in gender hierarchies. Therefore, these legal texts recognize the gender bias that society, but also healthcare system and its personnel, perpetuates. Some factors regulated throughout the obstetric violence texts that aim to avoid the retributions of these chauvinist attitudes are those which ban to perform medical procedures “without obtaining voluntary, expressed and informed consent of the woman”³¹, or “the bullying and psychological or offensive pressure towards a pregnant woman in order to inhibit her free decision about motherhood” (Veracruz, art. 363, Penal Code in GIRE, 2013, p.128). Argentinean regulation also highlights the right “to be addressed with respect, in a personalized and individualized way, with guaranteed intimacy during the whole process and with consideration for their cultural rules”^{32, 33}. These obstetric violence legal texts introduce the novelty

³¹My translation: “Ley orgánica, de 19 de marzo de 2007, sobre el derecho de las mujeres a una vida libre de violencia”. 2007. *Gaceta Oficial*. n. 38 647, (March 19, 2007). Accessed January 7, 2014: http://www.gparlamentario.org/spip/IMG/pdf/Ley_Organica_sobre_el_Derecho_de_las_Mujeres_a_una_Vida_Libre_de_Violencia.pdf ; “Ley 26.485 sobre la protección integral para prevenir, sancionar y erradicar la violencia contra las mujeres en los ámbitos en que desarrollen sus relaciones interpersonales”. 2009. *Congreso Argentino*. (March 11, 2009). Accessed January 7, 2014: http://www.oas.org/dil/esp/Ley_de_Proteccion_Integral_de_Mujeres_Argentina.pdf; “Ley de las Mujeres para una Vida sin Violencia del Estado de Durango”. 2007. *Periódico Oficial del Estado de Durango*. n.53 (December 30, 2007). Accessed January 7, 2014: <http://info4.juridicas.unam.mx/adprojus/leg/11/416/9.htm?s> ; “Ley Número 235 de Acceso de las Mujeres a una Vida Libre de Violencia para el Estado de Veracruz de Ignacio de la Llave”. 2008. *Gaceta Oficial del Estado de Veracruz*, n. 65, (February 28, 2008). Accessed January 7, 2014: <http://bit.ly/VKZW1A> and “Ley de Acceso a una Vida Libre de Violencia para las Mujeres en el Estado de Chiapas”. 2009. *Periódico Oficial del Estado de Chiapas*, n. 152, (March 23, 2009), p.5. Accessed January 7, 2014: http://www.cndh.org.mx/sites/all/fuentes/documentos/programas/mujer/5_LegislacionNacionalInternacional/Legislacion/Estatal/Chiapas/B/Ley%20de%20Acceso%20a%20una%20Vida%20Libre%20de%20Violencia%20para%20las%20Mujeres.pdf

³²Note that in Argentina there are several indigenous communities that want to maintain their own childbirth practices.

³³“Ley Nacional 25.929 de Derechos de Padres e Hijos durante el Proceso de Nacimiento”. 2004. *Declaración de Interés del Sistema Nacional de Información Mujer, por parte del Senado de la Nación* (August 25, 2004). Accessed January 7, 2014:

of an institutional recognition of the fact that healthcare personnel can be influenced by sexism and authoritarian behaviors that can turn into violent acts against the welfare of women and children.

In this chapter I have illustrated that obstetric violence legal texts seem to imply the recognition of critiques of medicalization and violations of sexual and reproductive rights that has already received attention from institutional bodies on an international scale. The advocacy of SRHR put the free enjoyment of a healthy sexuality and reproduction as central factors in human welfare. These rights have to be protected and promoted, paying special attention to the obstacles that gender hierarchies can imply in its compliance. In the specific field of childbirth in the 1980s WHO promoted the dimedicalization of childbirth and women's right to free, informed decisions. They can be read as important achievements in the recognition of the claims for respected childbirth, which are still used to add legitimation to their advocacy. The recent inclusion of all these factors in obstetric violence legal texts offer a new source of recognition. Obstetric violence legal definitions combine the recognition of the critiques against medicalization with the SRHR's acknowledgment of the importance to protect women's free decisions about their sexuality and reproduction in the specific field of childbirth assistance. I argue, therefore, that the use of the concept of 'obstetric violence' implies the assumption of several critiques shared by current childbirth activism, which is the reason why obstetric violence, beyond a legal term, can be powerful concept to strengthen activist arguments. The next section will go deeper into this idea with the case study of Spanish childbirth activism.

CHAPTER 4

Case Study: Obstetric violence and childbirth activism in Spain.

"If this movement began with women telling their stories of alienated childbirth, botched illegal abortions, needless cesareans, involuntary sterilizations, individual encounters with arrogant and cavalier physicians, these were never mere anecdotes, but testimony through which the neglect and abuse of women by health-care system could be substantiated and new institutions created to serve women's needs."

Adrienne Rich (1986, p.xi)

In 2012 the private channel *La Sexta* broadcasted the Spanish version of the British reality show "One Born Every Minute". With 40 cameras recording 24 hours per day, for two months the program shows the reality of the childbirth rooms at the Madrilenian hospital Gregorio Marañón. While the mass media published several articles about the innovative TV show as a positive

document, many blogs related to childbirth activism and some professional reactions³⁴ expressed their discontent about the high number of bad practices that this program, based on real cases, recorded. Fco. José Pérez Ramos, Coordinator of the Project for a Humanized Perinatal Assistance in Andalusia (PHAPA), comments about it, "it is surprising how naturally they apply the non-recommended practices and how naturally they do not apply those practices which are recommended" (my translation, *El Parto es Nuestro*, n.d.). No free choice of position during delivery, episiotomies, Kristeller's method, the use of oxytocin, no early attachment between the mother and new-born and paternalist and blaming expressions towards women in labor are among the violences showed in this TV program. These facts situate Spanish childbirth assistance far from international and national guidelines. The organization, *El Parto es Nuestro*, in its press notice described *Baby Boom* "as a TV document about *obstetric violence*, that spreads and reproduces, as never before, maltreatment towards the woman and her baby during the childbirth process" (my translation, *El Parto es Nuestro*, 2012).

One of the most interesting aspects about the contradictory reactions about this TV program is that it shows to what extent practices described as obstetric violence, or against a respected childbirth, are assumed as usual circumstances women and their fetus/children have to face during the birthing process. Since 2007 the Spanish government has considered the *Strategy for Assistance at Normal Childbirth in the National Health System* (Ministerio de Sanidad y Consumo, 2007), which is in line with 1985 WHO's recommendations on childbirth assistance. However, the prevalence of high rates of medicalization of childbirth, a lack of a women's free right to make informed decisions and disrespectful attitudes towards women in labour are still strongly criticized

³⁴See the list of on-line published reactions about the program "Baby Boom". Accessed January 7, 2014: <http://www.elpartoesnuestro.es/blog/2012/06/13/violencia-obstetrica-en-television-grabada-y-emitida-por-baby-boom>

by Spanish childbirth activism. Francisca Fernández Guillén (2003), a lawyer and member of one of the main important organizations for respected childbirth, *El Parto es Nuestro*, collected several real stories that illustrate the wide range of situations current Spanish childbirth activism tries to put to an end.

"I had refused that they give me oxytocin,³⁵ because I knew it was a dangerous intervention. They lied to me, they said they would administer only "dextrose". While I did not realize it, they delivered oxytocin through a hand-pump, increasing the risk of overdose, which actually happened. I suffered from hypertension and a ring on the cervix.³⁶ It was very painful and the worst is that when I squirmed and asked for the epidural the gynecologist mocked me, 'didn't you want a natural birth?', she said to me, 'then suck it up.' I had to beg anesthesia and I felt deeply humiliated."

F.G. in Hospital de Móstoles -Madrid- (my translation in Fernandez, 2003, p.12)

"[...]When a nurse detected fetal distress, the doctor replied: "the fetus cannot but suffer with a mother who does not know how to push."

Mónica in Hospital Materno Infantil de La Coruña -Galicia- (my translation, p.14)

"[...]Nurses did not introduce themselves or asked my name, but they called me "honey" and "sweetheart". When I asked about some interventions or the progress of labor the doctor told me "quiet, I know what I do" and did not answer me. They treated me as a child; they made me feel very small. I felt like a

³⁵Oxytocin is a hormone. Synthetic oxytocin is administrated during childbirth in order to induce the process of delivery. It makes the uterus contract strongly. The main risks are harmful contractions for the woman, and too many contractions for the fetus, who may not be able to breathe in enough oxygen between the contractions. This can provoke fetal suffering and, therefore, the fetus has to be monitored constantly, which reduces the options of mobility for the woman, increasing the pain. This pain is usually stopped through the administration of the epidural that draws out the delivery and then more oxytocin is required, starting the cycle again.

³⁶In this context it seems to refer to the fact that the cervix (the entrance of the uterus) was not in a good stage to give birth due to the impossibility of safely opening the birth canal.

mental handicapped and not a woman of 36 years old, full-fledged"

Anonymous (my translation, p.7)

"They shaved my genitals with open doors, there for all to see".

Anonymous (my translation, p.7)

According to the second *European Perinatal Health Report* (EURO-PERISTAT, 2008, p.114) Spain has one of the highest results for perinatal mortality – mother, fetus and newborn–37 in Europe. However, as these quotes show, women's questions about medical interventions performed on their bodies are strongly disregarded by health care personnel. Women who do not act as the medical staff commands are verbally punished and unnecessary medical interventions are also practiced. A lack of consideration with the protection of the women's privacy is also shown by the last quote. They are all expressions of what we can summarize as practices of medicalization, professional authoritarianism and sexism. The acknowledgment of these issues within the Latin-American legal framework has brought a new source of legitimation to the claims of childbirth activists. These practices are recognized as acts of violence and specifically based on gender discrimination. As Stella Villarmeá points out, in the last few years Spanish childbirth activism had to constantly look for new concepts to express their concerns (Villarmeá, n.d., p.1). Respected childbirth, humanized childbirth, non-intervened childbirth, and natural childbirth are some of the terms they used to frame their arguments. The increasing use of the concept of 'obstetric violence' among Spanish childbirth activists is a novelty which I argue can help to strengthen their critique of some current damaging childbirth practices. The concept of 'obstetric violence' could be a good tool for drawing attention to the serious damage produced by practices which are, as

³⁷ 3,2 fetal mortality for every 1000 childbirths (EURO-PERISTAT, 2008, p.114)

childbirth activism reports, in many cases perpetuated by healthcare professionals but also assumed without criticism by a big part of Spanish society. In order to analyze the benefits and risks the term can add, in this section I will review the main matters of concern of current Spanish childbirth activism, the strategies they find relevant and why and how activists use the concept of 'obstetric violence'. First I will offer a brief introduction to Spanish childbirth activism in relation to pioneering Women's Health Movement, which arose during mid-20th century as a reaction to modern Western healthcare assistance which they saw as unaccommodating to women.

4.1. Women's health movements and Spanish childbirth activism:

Specific activism aimed at improving and increasing user' choices regarding childbirth assistance in Spain can be found from the 1970s onwards. However, in 1955 the first influential book criticizing the idea that common medical management and interventions during childbirth are always necessary was published in the country. Consuelo Ruiz Vélez-Frías (1914-2005) was a Spanish midwife, who trained in US and France, brought back to Spain the method of "psicoprophyllactic" childbirth assistance, also known as Lamaze technique³⁸. Through the book "Childbirth without pain" (*Parto sin dolor*, 1955) she spread the idea that with enough information about and self-confidence of their bodies, women can give birth without constraining and risky medical interventions. She argued that knowing our own bodies and the processes that take place in them is the only way to face situations like childbirth. Beliefs about pain and women's physical

³⁸ "a program that prepares women for giving birth by teaching them the physiologic characteristics of the process, exercises to improve muscle tone and physical stamina, and various techniques of breathing and relaxation to promote control and comfort during labor and delivery." Accessed 16/05/2014: <http://medicaldictionary.thefreedictionary.com/psychophysical+preparation+for+childbirth>

incapability impede women from feeling enough to stay strong during the process. She stated that "pain was created and institutionalized because of ignorance and it is kept alive because it is a great power tool" (my translation, Ruiz, 2010). She died in 2005 but her books are still an important referent for childbirth activism today³⁹.

The idea that knowledge is a powerful tool for improving women's health and that health care systems have kept this information away from their users, especially from women, was one of the main issues criticized by the Women's Health Movement during the 1960s and 1970s. They instigated important critiques to healthcare assistance, shared today by childbirth activists. In the 1970s the Women's Health Movement was exceptionally active in US, but also in some European countries, Canada, Australia and New Zealand (Burt, 1978, p. 144). They criticized the patriarchal bias of medicine and the male chauvinistic societies that keep women away from knowledge regarding their bodies and sexuality and they claimed it was a way to control them and impeding their emancipation. In order to subvert this situation, groups and centers where women could share information about their health and sexuality were built. The main initiatives carried by these groups were based on "(1) health education and "conscious raising"; (2) referral; (3) patient advocacy; (4) gynecological care; and (5) routine obstetrical care; and (6) abortion" (p.145). Self-examination of reproductive organs and information about contraceptive techniques, known as the self-help method, were also activities encouraged by some of these organizations as a way to increase women's knowledge and autonomy regarding their own bodies and sexuality. The production of health literature especially addressed to women was also an important result of the effort to increase information and choices for women. Relevant works on women's health that were written were the core of this movement (Burt, 1978). One of the best known works of this

³⁹The latest republication of her book "Childbirth without fear" (*Parir sin miedo*) dates from 2010.

field is the book *Our bodies, Ourselves* (1973) produced by the Boston Women's Health Collective. The book had an impressive impact beyond the borders of US and was converted into one of "the most frequently translated feminist books" (Davis, 2007, p.5). Numerous adapted versions of *Our bodies, Ourselves* appeared in Europe, South America, Africa and Asia, which shows the great transnational impact that the Women's Health Movement had⁴⁰. According to Kathy Davis (2007) the case of *Our bodies, Ourselves* was an interesting example of the possibilities that transnational alliances can bring to social movements (Davis, 2007, p.208). In this book important sections are dedicated to issues regarding pregnancy, childbirth and postpartum assistance. Also at the core of this movement other works that called attention to the problems of modern obstetric assistance are also worthily of mention. Sheryl Burt points out the relevance of works written by The Boston Women's Health Course Collective in 1971, Cagan in 1970, Groesser in 1972, Ostrum in 1975. Pollard in 1969, Shaw in 1972 and Treseder in 1970⁴¹ (1978,p. 48).

In Spain examples of this growing transnational Women's Health Movement can be found during the 1970s. Self-help methods, for instance, were introduced in 1976 during the first Catalan Woman's Congress by Leonor Taboada, after her experiences with U.S.'s Women's Health Movement (Taboada, 1978). This took place after the death of Francisco Franco and the end of his 40 years of dictatorship. The groups created in Spain around this idea were mainly focused on

⁴⁰ In the 1970s it appeared in Western Europe, Japan and Taiwan. In the 1980s some Hebrew and Arabic versions were published. In the 1990s a Telugu translation was made for India and a Russian translation also appeared. In the 2000s a Spanish version was translated for South America, a French one for francophone region of Africa, as well as some translations for Tibet, Poland, Bulgaria, Serbia, Moldova, Armenia, China, Thailand, South Korea, and Indonesia. Some translation projects are also starting in Brazil, Turkey, Nigeria and Vietnam (Davis, 2007, p.5.)

⁴¹ However awareness of these issues can be found in the anthropological works of Margaret Mead from 1948 and Helene Deutsch from 1945. They drawn attention to the fact that male-dominated obstetrics was designed for the benefit of obstetricians rather than women, who were deprived of their active participation in this vital moment (Burt, 1978, p.49)

facilitating contraception techniques, the advocacy of right to abortion and to the improvement of the sexual choices of people – which were highly repressed by the Catholic and conservative Francoist regime. In this context, the issues of childbirth assistance were considered within these movements, but they were not at the top of their list of priorities. Maria Fuentes – founder of the organization for home-childbirth assistance *Nacer en Casa* – argues that Spanish feminist health activism in the 1970s and 1980s prioritized topics related to abortion and contraceptive techniques, rather than childbirth assistance, due to the patriarchal resonances that motherhood had for the feminist thought at that time (Gabarrí and Taboada, 2008). Nonetheless, their critique of the patriarchal bias of medicine was an important legacy for understanding issues in obstetrics that later movements adopted. Another current of thought that began promoted an “alternative childbirth assistance” was naturist movement, which proposed a close-to-nature lifestyle and alternative healthcare far from hegemonic biomedicine. Some of the pioneering initiatives in Spain, which usually included the feminist critique of patriarchal medicine and a naturopathy health approach, were among others. For example, *Colectivo Acuario*⁴² (Valencia) a private hospital, carried out respectful abortions when it was illegal. Other activists include the physicians Eneko Landaburu and Cristina Aznar in the Bask Country, Carmen Pascual in Zaragoza, Mercedes Serrano in Guadalajara, “*Grup de parts*” (later *Titania i Dones per la Salut*) and Chus Montes in Catalonia (Gabarrí and Taboada, 2008). In the late 1980s referential organizations as *Nacer en Casa*⁴³ (1988), a professional network specialized in home-birth assistance and the promotion of this childbirth option, and *Via Lactea*⁴⁴ (1978), a women's support group focused in the promotion of lactation and general encouragement during pregnancy and the first stages of motherhood, also appeared.

⁴² See the mention of Colectivo Acuario in the Spanish mass media. Accessed April 5, 2014 : http://ccaa.elpais.com/ccaa/2012/05/13/valencia/1336934682_890488.html

⁴³ See their website. Accessed April 5, 2014 : <http://nacerencasa.jimdo.com/>

⁴⁴ See their website. Accessed April 5, 2014 : <http://vialactea.org/node/17>

Currently other important organizations regarding women and fetus/children's health and rights during pregnancy, childbirth and post-childbirth are *Plataforma pro Derechos de Nacimiento*, *El Parto es Nuestro*, and *Dona a Llum*.

A study done by Madeleine Akrich, Maire Leane, Celia Roberts and João Arriscado (2012) concerning three different European childbirth activist groups describes Western childbirth activism as organizations that work mainly "around four key goals: (1) problematising medical/technical intervention in birth; (2) promoting "natural"/"normal" or "mother friendly" birth; (3) demanding birth practices and settings that are attentive to and respectful of the desires of birthing women and their families and (4) championing women's right to make informed choices about type and place of birth." (Akrich et al, 2012, p.2). They also call attention to the important work these organizations do related to knowledge production and dissemination about childbirth practices and the tensions between this activism and some feminist approaches to the question of choice (p.1). In line with this description, Spanish childbirth organizations present a pragmatic profile focused on the spreading of information, in providing support for concerns regarding childbirth assistance in Spain and a strong advocacy for the compliance of the WHO's recommendations about perinatal health care in Spanish hospitals. Their approach to gender issues is not explicit and none of them recognize themselves as feminist or women organizations, but activists for a respected childbirth according to the already established guidelines by WHO and Human Rights consensus. They do not introduce themselves as organizations that are pro natural childbirth, but a great deal of their material supports this approach to childbirth, as well as a view of childbirth as a crucial moment in a woman's life and the future life of her newborn child. Some of them also see childbirth as a potential moment when women can feel strongly

empowered if they can relax and feel comfortable. Likewise, they argue women may feel the opposite, namely weak and incapable, if the birthing conditions are not appropriate.

In order to go into depth about their understanding of current issues in childbirth and the strategies they find relevant, in the next section I will combine information provided by different activist platforms about the Spanish childbirth assistance and the results of the interviews I did to representatives of the childbirth activist organizations: *El Parto es Nuestro*, *Dona a Llum* and *Plataforma pro Derechos de Nacimiento*. I will also include an interview with a representative from *La Revolución de las Rosas/Roses Revolution*, because it is the first movement that specifically works against obstetric violence in Spain. A short description of the interviewee organizations is presented below by seniority:

Plataforma pro Derechos del Nacimiento (Platform for the Rights of Birth) is a platform that unifies a total of 31 organizations, groups and independent midwives that share a concern about the negative consequences that disrespectful interventions during pregnancy, childbirth and post-childbirth can have in the future lives of newborn children. They draw attention to a lack of consideration payed to the fetuses and children during the process of childbirth, putting stress on the necessity to ensure the rights of birth. Different from other approaches to childbirth, which are more focused on the experiences of the women in labour, *Plataforma pro Derechos del Nacimiento* aims to raise awareness about the experience the fetus and child undergoes, which in their opinion, is highly mistaken. Their work is inspired by the thesis of scientists such as Michel Odent and Nils Bergman. The platform participated as adviser to the redaction of the *Strategy for Assistance at Normal Childbirth in the National Health System* (Ministerio de Sanidad y Consumo, 2007) of the Spanish Ministry of Health Care and are currently part of the national Women's

Health Observatory. The representative interviewed was Ángeles Hinojosa, director of the platform.

El Parto es Nuestro (Childbirth is ours) is one of the largest and most active organizations regarding Childbirth activism in Spain. It started in 2003 with the aim to provide psychological support for women who suffered from cesarean sections and traumatic childbirths. In 2004 it was officially founded as a non-profit organization for the improvement of conditions during pregnancy, childbirth and post-childbirth assistance. They argue for more respect for the rights of parents, fetuses and children within healthcare assistance. Their main activities are spreading information regarding recommended medical practices during pregnancy, childbirth and post-childbirth, providing emotional and legal support for traumatic experiences and carrying out awareness campaigns among civil society. They count on an active mutual aid net through an e-mail group where women and professionals of the field of obstetrics share information and advice. They have 751 members (users and professionals of obstetrics), who were also advisers of the *Strategy for Assistance at Normal Childbirth in the National Health System* (Ministerio de Sanidad y Consumo, 2007). The representative interviewed was Adela Recio, its current president.

Dona a Llum (Woman give birth/Give birth) is the most important organization for the respected childbirth in the region of Catalonia. It was founded in 2006, as a division of the previously mentioned organization *El Parto es Nuestro*. They share the aim to improve the conditions of pregnancy, childbirth and post-childbirth current assistance and they also work a great deal on the application of WHO's recommendations (1985). Their activism is also focused in the provision of

information and support among healthcare users in the area of obstetrics, legal advice on rights and sources like the Childbirth Plan and the launch of initiatives to raise awareness about the current issues in obstetrics assistance. They offer services such as face-to-face support sessions and conferences open to people with doubts regarding childbirth. They have 176 members. The activists interviewed were Sílvia Salvador and Judith Reyes, part of Dona a Llum's board of directors.

La Revolución de las Rosas/ Roses Revolution is an on-line movement that calls attention to the prevalence of obstetric violence all over the world. It was founded in 2011 by Jesusa Ricoy, a Spanish Antenatal Teacher who lives in the UK. It was founded as a reaction to the offensive vignettes that appeared in the magazine of The Spanish Society of Obstetrics and Gynecology (SEGO), who mocked women's struggles in obstetrics units⁴⁵. One of the main initiatives of this movement has been placing roses in front of the SEGO's offices and Spanish city councils during the International Day for the Elimination of Violence Against Women (25th of November) in memory of the women who suffered violence in Spanish obstetric assistance. Articles in the media and the dissemination of information sources are other activities carried out by this initiative. So far, initiatives with a name that corresponds to 'Roses Revolution' have also been launched in other countries such as Italy, France and Australia. The interview was done with its founder: Jesusa Ricoy.

Some of the opinions expressed by the interviewed people are personal and not necessarily shared by all the others members of the organizations which they represent, therefore in order to

⁴⁵ More information about this happening in p. 88. of this document.

keep this distinction I will use their names and in brackets the initials of their organizations. The interviews were carried in Catalan and Spanish therefore the quotes I show are my translation of extracts of their words.

4.2 Matters of concern of current Spanish childbirth activism:

4.2.1. Medicalization:

One of the main matters of concern all of the interviewed activists pointed out is the negative effects that the current medicalization of childbirth, through the administration of medicaments, performance of surgery and abuse of technology, play in Spanish obstetrics assistance. One important reason for the prevalence of these practices is, according to the activists Sílvia Salvador, Judith Reyes (DLL) and Angeles Hinojosa (PDN), that childbirth is taught in universities as a pathology in need of medical intervention without awareness of the side effects this view has on women, fetuses and children. Sílvia Salvador and Judith Reyes (DLL) argue that many practices within current childbirth assistance can be described as iatrogenic effects of medical interventions. In other words, the medical assistance itself provokes the creation of problems that need more medical intervention⁴⁶. One example of this is the use of the fetal monitoring that they argue was created just to control risky childbirth, but today is used in the first stages of the most of childbirths. For Ángeles Hinojosa (PDN) fetal monitoring *"makes women forget about their bodies*

⁴⁶ Ivan Illich was one of the first authors to criticize the iatrogenesis implicit in modern Western medicine. He explains that "Iatrogenesis can be direct, when pain, sickness, and death result from medical care; or it can be indirect, when health policies reinforce an industrial organization which generates ill-health; it can be structural when medically sponsored behaviours and delusion restrict the vital autonomy of people by undermining their competence in growing up, caring, aging; or when it nullifies the personal challenge arising from their pain, disability and anguish" (Illich, 920)

*and their own strength while they wait worried for what appears on a screen*⁴⁷. As she explains it keeps women laying on a bed without the possibility of movement, increasing their anxiety. It also depersonalizes the assistance because professionals are more focused on the results of the machines than in the necessities expressed by people. These anxious situations, provoked by unnecessary medical interventions and social narratives about women's strong suffering during childbirth, are also described by activists as factors that lead to a lack of confidence and a fear of giving birth among women. It promotes and justifies medical interventions such as cesarian sections or the use of an epidural. Cesarean sections are especially seen as a relevant matter of concern pointed out by all the interviewed representatives. Ángeles Hinojosa (PDN) sees cesarean sections as a very dangerous practice for the future welfare of the children, *"who are deprived of their first challenging experience in life as it is to push and to pass through the vaginal canal"*⁴⁸. For her it negatively impacts a person's capacity to be responsible for their own lives. Regarding the option of elective cesarean sections chosen by some women, Sílvia Salvador and Judith Reyes (DLL) point out that it is a trend connected to the strong influence of social and medical discourses about childbirth, namely labor as a very painful and dangerous moment: *"Childbirth is seen as annoying and painful, as everything connected with femininity"*⁴⁹. They see the trend of medicalization as a complex multi-causal social problem which negatively impacts women and children's health. Another practice mentioned during the interviews was the episiotomy. Adela Recio (EPN) describes the fact that Spanish hospitals have reached rates of over 40% of episiotomies per childbirth against national and international recommendations as an alarming

47 Original quote in Spanish: "las mujeres se olvidan de su cuerpo y su propia fuerza mientras están pendientes y angustiadas por lo que aparece en una pantalla".

48 Original quote in Spanish: "A los niños se les niega el primer reto de su vida: empujar y pasar a través de la vagina"

49 Original quote in Catalan "El part es veu com molest i dolorós com tot allò relacionat amb la feminitat".

situation. For Jesusa Ricoy (RR) this practice shows a total lack of consideration towards women's sexuality within obstetrics field: "Women's sexuality is looked down and crippled through these kind of practices"⁵⁰.

They are all practices not recommended by WHO nor the *Strategy for Assistance at Normal Childbirth in the National Health System* (Ministerio de Sanidad y Consumo, 2007). However, as the table below shows, in 2010 administration of oxytocin, inductions of labor, episiotomies, instrumental delivery, obligatory vaginal delivery after a previous cesarean section, lithotomy⁵¹ position during delivery, Kristeller's method or early attachment between the mother and her newborn child were still usual practices in Spanish obstetric services.

Indicator	Result % (Spain, 2010)	Recommended standard % (WHO, 1985)
Administration of oxytocin	53,3	5-10
Inductions of labour	19,4	<10
Episiotomies	41,9	15
Instrumental delivery	19,5	15
Vaginal delivery after a previous cesarean section	44,2	60-80
Lithotomy position during delivery	87,4	<30
Kristeller's method	26,1	0
Early attachment between mother and her newborn child	50,2	> 80%

⁵⁰ Original quote in Spanish "La sexualidad de la mujer es despreciada y mutilada a través de este tipo de prácticas".

⁵¹ Horizontal position with the back on a bed, the legs raised and the knees bent. It is usually performed to practice medical explorations or surgery related to genitals or the abdominal area. It is also a common childbirth position for Western obstetrics.

⁵² Table 2. Adapted from one made by El Parto es Nuestro according to the data compiled by the Spanish Ministry of Health Care, Welfare and Equality in 2010. Accessed 1 March 2014: <http://www.elpartoesnuestro.es/blog/2012/11/25/25-de-noviembre-dia-internacional-contra-la-violencia-hacia-las-mujeres>

Ángeles Hinojosa (PDN) also stressed the fact that there is a lack of knowledge about the effects that these kind of interventions during childbirth can have on the fetus and child. She points out that most part work on this topic is done from the perspective of women but just a few from the perspective of the babies, who are the most vulnerable in these moments due to the fact that they cannot express their feelings with words. She explains that through methods, such as regressive therapy, it is possible to understand how the experiences during, before and after childbirth stay registered in a person's mind, affecting the ways they understand the world. Therefore, she argues that aggressive performances can have very negative consequences, such as emotional traumas or difficulties during development.

Medicalization and abuse of technology are some of the main recurrent matters of concern of childbirth activism. However, the anti-medicalizing postures implicit in many childbirth activist discourses are questioned by some feminist scholars due to the essentialism they sometimes include. Katherine Beckett (2005) points out that the tendency to see women who do choose interventionist practices (e.g. cesarian sections) as victims of the dominant biomedical and male chauvinistic discourses can be problematic. According to her insistence on the fact that women "*can/should/do*" experience childbirth without strong medical interventions "...neglects the diversity of women's bodies and experiences, and deflects rather than grapples with the possibility that medical technology may, in some instances, serve women's interests" (Beckett, 2005, p.19). Nonetheless, she also recognizes that childbirth activism strongly works to change "the danger that women's positive assessment of their experience with medical technology is based in part on a lack of awareness of its risks, and that women's choices may be shaped by social relations and dynamics that subordinate women's needs and interests." (p.19).

4.2.2. The lack of theory in practice: routine and professional hierarchies.

As Adela Recio (EPN) points out, the main problem in the Spanish obstetric assistance “*is a big lack in the adequacy of the theory to the practice*”⁵³. She comments that 25 years ago important sources of information to improve obstetrics healthcare, such as WHO's recommendations, were available. Since 2007 the national guideline, *Strategy for Assistance at Normal Childbirth in the National Health System (Ministerio de Sanidad y Consumo, 2007)*, has also been available, but it is not widely applied in obstetrics units. The *Strategy for Assistance at Normal Childbirth in the National Health System* brings attention to the practices that should and should not be performed during childbirth, according to the current scientific consensus, popular beliefs about family involvement and emotional factors concerning perinatal assistance. Common controversial questions regarding childbirth assistance such as (a) genital shaving and enema, (b) accompaniment and emotional support, (c) healthcare assistance during the period of dilatation, (d) measures against pain, (e) women's position during delivery, (f) episiotomy, (g) medical interventions during delivery, (h) instrumentation used during childbirth (e.g. forceps and vacuum extractors), (i) cesarean sections, (j) early attachment between women and their newborn child and (k) postnatal checks up and lactation are reviewed with a final recommendation for every one of them. This document has become an important achievement for childbirth movements as some organizations including *El Parto Es Nuestro* and *Plataforma pro Derechos del Nacimiento* participated in its creation with professionals from the different autonomous regions in Spain, professional societies of obstetrics and gynecology, and associations and national commissions of midwives. It is also relevant because, from a governmental level, the document acknowledges that,

⁵³ Original quote in Spanish : “hay un gran falta de adecuación entre la teoría y la práctica”.

even though Spain does not have bad data about perinatal health of women and babies, aspects related to “the quality and warmth” (my translation, Ministerio de Sanidad y Consumo, 2007, p. 13) of perinatal assistance should be improved. It also points out how the increasing women's claims about their rights to be informed and to participate in their own childbirth decision-making have to be heard. Increasing legal measures against healthcare personnel and complaints about the relationship between women and this professional collective are some of the consequences of this lack of communication (p.12). Finally, the document draws attention to the side effects of technology. It recognizes that medicalization in low-risk childbirth has become a problem and that the view of childbirth as just a physiological process should prevail (p.13). Again, like the legal texts about obstetric violence from Latin-America, Spanish guidelines advocate a view of childbirth as a natural event, not a pathological medical issue, in line with current childbirth activism. The goal was to provide a roadmap for future actions aimed at improving childbirth assistance. However, no legal mechanisms were applied to ensure its application in hospitals. Under these circumstances, it works well as a source of information for perinatal units of hospitals, which were already willing to change some of their routine⁵⁴, but not for those whose directors are not concerned about these issues. Ángeles Hinojosa (PDN), Sílvia Salvador, Judith Reyes (DLL) and Jesusa Ricoy (RR) see strong dynamics of routine, a lack of innovation and carelessness among professionals of obstetrics behind the limited application of regulations for obstetric assistance – a close-mindedness that they say impede the improvement of the field. Tras la falta de aplicación de las regulaciones sobre la atención obstétrica ven fuertes dinámicas de rutina, falta de innovación y pasotismo entre los profesionales. Currently, it is the regulations are mainly used as a

⁵⁴ On page 80 of the document (Ministerio de Sanidad y Consumo, 2007) you can find different examples of hospitals which already applied actions according to “the good practices” described. Accessed 13 May 2014: <http://www.msssi.gob.es/organizacion/sns/planCalidadSNS/pdf/equidad/estrategiaPartoEnero2008.pdf>

tool that legitimates some of childbirth activism's petitions, and also a document users can employ as a source of information to accept or reject some practices. There are no specific data about the regulations' application, but data from 2009 study pointed out that 38 public hospitals spread throughout the country offer "humanized childbirth assistance": 10 in Catalonia, 20 in Andalusia, and 8 in the autonomous region of Valencia (Toledo and del Pozo, 2009). According to this study published by the Andalusian Autonomous government, which discusses the applicability of practices for a "humanized birth" (Bretín and Gómez, 2009), the main barriers identified within the Spanish system were:

- a) A general lack of medical personnel especially midwives which leads to entails an overload of work, which thus results in a less quality assistance for health care users.
- b) A shortage of spaces dedicated to "childbirth": especially private rooms to guarantee the privacy of pregnant women in process of delivery.
- c) Hierarchies and disagreements about goals and best practices among medical personnel that make it very difficult to change established protocols.

In line with these barriers current childbirth activists report how strong hierarchies among professionals within this group is a relevant obstacle for the introduction of new approaches to childbirth. Sílvia Salvador, Judith Reyes (DLL) and Adela Recio (EPN) agree that some professionals who aim to change old routines in hospitals often meet the rejection of superiors or more veteran colleagues. Similarly, representatives from all the activist organizations point out how favoritism for obstetricians over midwives is an aspect that should be improved. The interviewed childbirth activists also agreed that midwives should be the main professional in charge of low risk childbirth

assistance – while midwives are not trained to assist pathologies related to birth, they are fully capable of assisting during normal childbirth. They are also seen as less inclined to perform medical interventions. Jesusa Ricoy (RR) and Ángeles Hinojosa (PDN) also characterized the existence of women's professionals in childbirth assistance as positive due to a greater ease in empathizing with the women who are giving birth⁵⁵. Ángeles Hinojosa (PDN) también ve la existencia de mujeres profesionales en la atención al parto como positiva pues las ve más inclinadas a empatizar con las mujeres que dan a luz. Midwives are defined within Spanish law as a healthcare professional who “[provides] integral assistance to the sexual, reproductive and maternal healthcare of women”(my translation, Ministerio de Sanidad y Política Social, Orden SAS/1349/2009). They are trained to carry out medical examinations during pregnancy and maternity and birth preparation sessions, as well as assist normal childbirth (FAME, 2013, p.7). However in Spain a historical lack of regulation in the midwifery profession between 1953 and 1987 has contributed to the ambivalent role these professionals play in current institutional childbirth assistance (Serrano, 2002 and Pi, 2008). Since 1992 midwifery has been a specialization within the university degree for Nursing. However, as professional collectives report, in Spain there is a great lack of midwives, which are too often substituted by nurses without the specialization, or obstetric physicians, trained to to handle high-risk births but not normal cases(FAME, 2013; Pi, 2008, and El Parto es Nuestro, 2014). Data from 2008 report a deficiency of 2,500 midwives in the whole country (Pi, 2008). As the “Pink tide”⁵⁶ reported: in Andalusia there are areas where only four midwives have to attend to a population of more than 230,000 women

⁵⁵ It is important to note that midwifery in Spain is a profession which can be carried by women and men, however today it is mainly practiced by women.

⁵⁶ Different social tides against cuts to people's rights and the budget of the country's public services are currently taking place in Spain. Every colour has a different target (green tide for education, white tide for health care, violet for women's rights, etc.) The pink tide refers to midwifery and women's health care assistance

between 15 and 65 years old (El Parto es Nuestro, 2014). This deficiency also contributes to professional competition and hierarchies within childbirth assistance. Often the competences and responsibilities of midwives are displaced when the physician appears. As a Spanish midwife reports, "we are pilots during the night and flight attendants during the day" (Bretín and Gómez, 2009, p.53). According to Jesusa Ricoy (RR): midwives had to work a great deal to be recognized as full professionals by their physician colleagues, which creates professional tensions that negatively impacts the assistance provided. For example, midwives have adopted medicalizing routines and authoritarian behaviors in many cases in order to gain acceptance and respect. These factors can create a tense atmosphere in childbirth rooms, which hinders the quality of assistance.

As this section has shown, the views of childbirth activists seem to have gained the attention of governmental organizations, but their solutions remain unused in daily-life of hospital practice. In this case, one could so far as to say, that this is a big aspect were Spanish policies, as well as Latin-America obstetric violence legal texts have failed. As the NGO GIRE reported in Mexico, even though legal sources to protect women's rights during childbirth assistance exist, no relevant institutional mechanisms have been applied to eradicate these practices⁵⁷. However, as it will further develop in the section about Spanish childbirth activism strategies, traditional hospital obstetric practices can be challenged through the empowerment of healthcare's users by providing them with information about their rights. Maybe then the gap between theory and practice will be bridged.

⁵⁷ See p. 57 of this document.

4.2.3. Authoritarianism and sexism:

Authoritarian behaviors, paternalistic and sexist attitudes towards women in labor are also seen as a large obstacle that blocks women's autonomy to make decisions about their childbirth. As Adela Recio (EPN) points out, *"medical personnel feel total freedom of action because until few years ago nobody had questioned them"*⁵⁸. A pregnant woman who attended a support session organized by *Dona a Llum* commented that she felt surprised when, during a childbirth preparation session in the hospital, only a few women asked questions about the medical procedures during childbirth. Others women present even expressed discomfort with these questions, arguing that *"the physicians are the ones who know about that"*⁵⁹. Ángeles Hinojosa (PDN) sees these kinds of statements as expressions of a tendency among women and health care professionals, and generally in Spanish society, to avoid responsibility for their decisions. As she comments, *"many women do not want to know about childbirth and prefer to transfer the decision-making to medical staff"*⁶⁰ and *"many professionals hide behind protocols and routines to avoid the great responsibility of their acts"*⁶¹. Sílvia Salvador and Judith Reyes (DLL) framed this issue within gender struggles: *"Within patriarchal discourse everything related to femininity is looked down upon, that's why women reject processes like childbirth. We took the option to live according to the*

⁵⁸ Original quote in Spanish: "El personal médico siente total libertad de acción porque hasta hace pocos años nadie les había cuestionado".

⁵⁹ Original quote in Catalan: " els metges són els que saben d'això".

⁶⁰ Original quote in Spanish: "Muchas mujeres no quieren saber nada acerca del parto y prefieren delegar la toma de decisiones en el personal médico".

⁶¹ Original quote in Spanish: "Muchos profesionales se escudan tras protocolos y rutinas para escapar de la gran responsabilidad de sus actos".

*masculine ideal to which we have delegated these kind of experiences*⁶². In line with this comment, Jesusa Ricoy (RR) argues how patriarchy has great prevalence in the field of obstetrics because it works very close to women's sexuality and reproduction: *"Women are seen as containers for babies and the narrative of sacrifice is used to legitimate practices which do not respect our bodies"*⁶³. Ángeles Hinojosa (PDN) adds that high levels of violence during childbirth assistance take place because the power that a woman expresses during childbirth goes against the male chauvinist ideals about women that are today unconsciously prevalent in society: *"The power that a woman shows while giving birth is startling, however a single violent gesture can break it"*⁶⁴. She explains that losing this power can be the reason behind problematic childbirths and postpartum depression. Adela Recio (EPN) did not give further comments about the role gender hierarchies play in childbirth assistance, but she recognized that problems within the obstetric field have a gender component. As previously mentioned, none of these organizations describe themselves as feminist or activists for gender equality, but organizations that aim to ensure the rights of obstetrics users and promote respected childbirths. However, in their personal explanations for the reasons behind damaging practices in childbirth assistance, they recognize the influence of male chauvinistic views on health care personnel. In 2011 a much talked about case illustrated the tensions between the claims for respected childbirth and traditional obstetric views towards women and pregnancy that take place in Spain. The Spanish Society of Obstetrics and Gynecology (SEGO) published several humorous vignettes in its on-line magazine, where women and their

⁶² Original quote in Catalan: "Dins del discurs patriarcal tot allò relacionat amb la feminitat es desprecia, per això hi ha dones que rebutgen processos com el part. Hem optat per viure d'acord a l'ideal masculí, delegant tot aquest tipus d'experiències."

⁶³ Original quote in Spanish: "Las mujeres son vistas como contenedores de bebés y se usa la narrativa del sacrificio para legitimar prácticas que no respetan nuestros cuerpos".

⁶⁴ Original quote in Spanish: "El poder que muestra una mujer dando a luz es sobrecogedor, sin embargo un simple gesto puede quebrarlo".

obstetric issues were mocked, occasionally even in a sexist and degrading way⁶⁵. The vignettes appeared under the headline, "a touch of humour" on different pages of the magazine, the author of which was Javier Server Gozábez, a doctor of gynecology at the Hospital de Gandía. For example, in one an overweight woman is lying on a stretcher while a gynecologist talks about her as a cow while standing in a group of his colleagues. In another one a good-looking woman does not understand why her gynecologist suggested she should practice cytology very often (while he does not suggest this to other not-so-attractive users). Additional vignettes imply the rejection of medicine that promotes less interventions and timing respectful to childbirth practices, both inline with WHO's recommendations, and joke about rules for women's rights to informed consent for medical interventions during childbirth. Obstetric health care users and several women and respected childbirth organizations complained about the images immediately after their publication. The Ministry of Health Care had to request their removal due to the comics' male chauvinistic and offensive tone. In the words of a representative from the Spanish childbirth organization, El Parto es Nuestro, "The Spanish Society of Obstetrics and Gynecology openly mocks the female physiological processes as well as their diseases and ailments, looking down on and trampling without shame the genital sexuality and dignity of their patients" (my translation, El Parto es Nuestro, 2011). *La Revolución de las Rosas/ Roses Revolution*, the first on-line movement dedicated specifically to raise awareness of obstetric violence in Spain appeared as a reaction to these vignettes. Its founder, Jesusa Ricoy, says that the indignation she felt from this blatant lack of respect for women by the professionals who should support women's health, led her to create this initiative to make known the serious damage these attitudes inflict on women. She sees these

⁶⁵A compilation of different pages in the magazine "Gazeta electrónica" which contains the vignettes can be consulted here under the label "Un toque de humor": http://www.elpartoesnuestro.es/sites/default/files/2011/09/gaceta-electr3b3nica_1.pdf

vignettes as an expression of *"the strong weight that patriarchy has in the field of medicine"*⁶⁶ along with powerful dynamics of medical authoritarianism that are especially strong in Spain.

In light of these facts and reflections, sexism seems to be an important issue that is recognized by childbirth activists, even though it is not an explicit problem they address in their advocacy work. They lean towards to a pragmatic approach based on the support of obstetric service users who seek for information about their choices and risks with current childbirth assistance. They also advocate for the application of guidelines legitimated by organizations such as the WHO. The fact that obstetric violence legal texts define these kinds of practices as violence that women are subjected to because of gender hierarchies, which is an important factor to which the Latin-American legal framework brought attention. Therefore, I argue that the concept of 'obstetric violence' could help strengthen the critique of the role played by sexism that seems unrecognized by Spanish childbirth advocacy movements.

4.2.4. The user's right to free, informed consent:

Another recurrent problem that was pointed out during the interviews was the lack of respect regarding the women's consents for the presence of students during childbirth. They noted that many reports are made by women who, without their permission, are explored and assisted by residents physicians, usually by a group of them. A recent case legally reported by the organization El Parto es Nuestro are the injuries that Nancy Narváez and her baby suffered due to a "forceps training" that took place during her childbirth in the Hospital Clínic of Barcelona in April

⁶⁶ Original quote in Spanish: "el patriarcado tiene un peso muy fuerte en al campo de la medicina".

2011. During the childbirth, four students and one tutor were in the room and all of them tried to pull the baby out with the use of forceps. As the roommate of Nancy Narváez, present during the childbirth, reported, the tutor screamed at one point, “*not like that, you could break the baby's head!*”. The baby suffered serious injuries, including severe cranial fracture, intracranial bleeding, cortical-subcortical infarction, convulsions, an epidural hematoma, a lack of muscular tone, and an ischemic infarction near the cranial fracture. Because of these injuries, the baby had to be transferred to another hospital. The mother, Nancy Narváez, also suffered an episiotomy which was performed so that the forceps could be used⁶⁷. This report shows the tragic consequences of an instrumental delivery. In national guidelines both practices, episiotomy and instrumental delivery, are not recommended except with pathologies, though it is still preferable to use a vacuum over forceps (p. 29). Spanish childbirth activists also point out that another common infraction of users' rights occurred during this case: the training of students without the explicit consent of the people involved. The state prosecutor working on this case, the association *El Parto es Nuestro*, reports that the hospital personnel took advantage of Nancy Narváez's vulnerable position – a woman from Paraguay with no family and ties in Spain, who gave birth with only her roommate at her side – to train their students (El Parto es Nuestro, 2013). This case demonstrates the terrible outcomes that can result from power relations between not only doctors and patients, but also men and women, students and teachers, foreigners and natives, and the rich and the poor. As I mentioned in the theoretical framework, one of the first steps in creating universal access to quality health care assistance is to be aware of the power hierarchies that permeate all

⁶⁷ See the English press release about this case made by the association El Parto es Nuestro. Accessed May 5, 2014: http://www.elpartoesnuestro.es/sites/default/files/public/documentos/notasdeprensa/2013_08_ndp_forceps_training.pdf

aspects of society – even medicine.

Users' right to informed consent for medical procedures is recognized within Spanish law in the legal text on “the autonomy of patient and the rights and obligations on clinic information documentation” (Cortes Generales, 41/2002). It is also a topic of concern shared by obstetric violence legal texts which explicitly prohibit healthcare personnel from performing procedures “without obtaining voluntary, expressed and informed consent of the woman”⁶⁸. In Spain in order to address the particularities that the applicability of this regulation entails in childbirth assistance activists for respected childbirth are promoting the use of the “Childbirth plan”. This is a document where women can express in advance which practices they would and would not like to experience during childbirth, which is in line with their right to informed decisions. The next section will provide further information about this strategy that current Spanish childbirth activists advocate.

⁶⁸ My translation: “Ley orgánica, de 19 de marzo de 2007, sobre el derecho de las mujeres a una vida libre de violencia”. 2007. *Gaceta Oficial*. n. 38 647, (March 19, 2007). Accessed January 7, 2014: http://www.gparlamentario.org/spip/IMG/pdf/Ley_Organica_sobre_el_Derecho_de_las_Mujeres_a_una_Vida_Libre_de_Violencia.pdf ; “Ley 26.485 sobre la protección integral para prevenir, sancionar y erradicar la violencia contra las mujeres en los ámbitos en que desarrollen sus relaciones interpersonales”. 2009. *Congreso Argentino*. (March 11, 2009). Accessed January 7, 2014: http://www.oas.org/dil/esp/Ley_de_Proteccion_Integral_de_Mujeres_Argentina.pdf; “Ley de las Mujeres para una Vida sin Violencia del Estado de Durango”. 2007. *Periódico Oficial del Estado de Durango*. n.53 (Dicember30,2007). Accessed January 7, 2014: <http://info4.juridicas.unam.mx/adprojus/leg/11/416/9.htm?s> ; “Ley Número 235 de Acceso de las Mujeres a una Vida Libre de Violencia para el Estado de Veracruz de Ignacio de la Llave”. 2008. *Gaceta Oficial del Estado de Veracruz*, n. 65, (February 28, 2008). Accessed January 7, 2014: <http://bit.ly/VKZW1A> and “Ley de Acceso a una Vida Libre de Violencia para las Mujeres en el Estado de Chiapas”. 2009. *Periódico Oficial del Estado de Chiapas*, n. 152, (March 23, 2009), p.5. Accessed January 7, 2014: http://www.cndh.org.mx/sites/all/fuentes/documentos/programas/mujer/5_LegislacionNacionalInternacional/Legislacion/Estatal/Chiapas/B/Ley%20de%20Acceso%20a%20una%20Vida%20Libre%20de%20Violencia%20para%20las%20Mujeres.pdf

4.3. Childbirth activism's strategies:

In order to avoid undesirable situations during the birthing process, users are increasing employing a strategy called the "Childbirth Plan". This plan does not a specific legal status, but it is understood as an expression of part of the legal text on "the autonomy of patient and the rights and obligations on clinic information documentation" (Cortes Generales, 41/2002). This legal text aims to ensure that patients count by providing them with proper information concerning their right to consent for medical interventions. With the "Childbirth Plan" women can express their preferences, necessities and expectations about childbirth to the hospital they plan to give birth before the birth actually takes place. The plan's aim is to help women avoid specifying these preferences when arrive at the hospital and are under emotional pressure and/or pain. However, women can change their preferences anytime and medical personnel can suggest to perform treatments outside of the women's preferences, if the health of the women or fetuses/children are at risk and, with the women's informed consents. There are templates⁶⁹ written by the Ministry of Health Care, Social Policies and Equality and some autonomous regions' health care units. Some hospitals have their own childbirth plan models and also some childbirth organizations offer some templates. Nonetheless, the plan can also be created directly by the users. The main factors these templates include are:

- a) accompaniment (who can stay with her during the process)
- b) space and comfort (clothes; intimacy; low light intensity; assistance materials such as balls, mirrors, pillows, etc.)

⁶⁹ Some templates can be found on the website of the Catalan organization Dona a Llum. Accessed, March 12, 2014: <http://donallum.org/part-respectat/drets/pla-de-part-i-consentiment-informat/>

- c) pre-delivery procedures (enemas, genital shaving, liquid ingestion)
- d) fetal control (frequency and variant of fetal control)
- e) methods against pain (relaxation, massage, anesthesia, epidural)
- f) actions during delivery (position, bath, episiotomy, oxytocin, companion, moment to cut off the umbilical cord)
- g) post-childbirth (early attachment, preferences for lactation, time of hospital stay, treatments on the baby such as medication, inoculations, etc).
- h) Special necessities (language, cultural necessities, physical issues)

The organizations who work in favor of respected childbirth strongly campaign in support of the plan and offer advice about how to write a personalized Childbirth Plan in which users can reject the practices they do not want to experience at all costs (episiotomy, oxytocine, administration, forced positions to deliver, etc.). Therefore, even though some institutional mechanisms began the trend of ensuring the rights of the childbirth assistance's users, activist movements also seem crucial to spreading information and to making sure add the users' voice is heard in the policy-making process.

In sum, the activist organizations stress that the main action needed to change the current context of obstetric assistance in Spain is through the empowerment of health care users, giving them more control over the whole process. They argue that if women are well-informed and can count on support networks that petition for the assistance they desire, health care professionals will be forced to change their practices. As Alicia Recio (EPN) comments, the ideas for how to

improve childbirth assistance is already in writing – they just need to be applied, as health care users have increasingly demanded. Alicia Recio (PDN), Sílvia Salvador and Judith Reyes (DLL) say more women today than in the past contact their organizations because they want to be informed when making decisions about their pregnancy and childbirths. This differs from past years because generally only women who had already had negative experiences in hospitals contacted them. Ángeles Hinojosa (PDN), with only the little effort shown by governmental policies, argues that what is needed is strong social involvement in requesting better assistance in obstetric units. For her, an important ally for achieving this goal would be the involvement of the media for raising awareness about these issues. She complains that the media ignores the presence of obstetric violence in the hospitals. Sílvia Salvador and Judith Reyes (DLL) also share the idea that users have to be given more information, and thus power, in order to change these tendencies. In line with the necessity of change, they comment on how pedagogical initiatives to break traditions about childbirth among young people can be a good strategy. They also point out how more transparency about current assistance in hospitals is necessary in order to have corroborated data to plan policies. Jesusa Ricoy (RR) adds that the complex reasons for the prevalence of obstetric violence need a wide social change, which entails time: "*People need to realize that a lot of practices simply should not take place within childbirth assistance and professionals should change their understanding about childbirth*"⁷⁰. In order to accomplish all of this, the activist organizations spread a wide range of informational sources: statistics about current childbirth assistance, informative documents on common medical interventions, informational talks, compilations of legal mechanisms, relevant bibliographical sources, educational campaigns on

⁷⁰ Original quote in Spanish: " La gente necesita darse cuenta de que muchas prácticas simplemente no deberían tener lugar en la atención al parto y muchos profesionales deberían cambiar sus concepciones acerca de lo que es el parto".

current issues, etc.

Similarly at what is pointed out in the study "Practising childbirth: a politics of evidence" (Arich et al. 2012) based in the experience of childbirth activism in France, UK and Portugal, in Spanish childbirth activism "the production, elaboration re-shaping or translation of knowledge" (p.6) is a central aspect of their work. The study argues that this centrality is because "Organizations consider that giving women access to knowledge and evidence can help to open up spaces for self determination and for meaningful discussion with professionals" (p.34). As this section has shown it is clearly shared by the organizations interviewed. Due to the importance of spreading information about matters of concern associated with woman's reproductive health, the next section aims to analyze in what ways the concept of 'obstetric violence' can add to improving obstetric assistance in hospitals.

4.3. Usage and possibilities of 'obstetric violence' concept:

During 2014, *El Parto en Nuestro* and *Plataforma pro Derechos del Nacimiento* organized different activities to raise awareness about the obstetric violence during birth within the *Mundial Week for a Respected Childbirth and Birth*. During these events a documentary called "Obstetric Violence in Birth" (*Violencia Obstétrica en el Nacimiento*), produced by *Plataforma pro Derechos del Nacimiento*, was shown and information regarding what obstetric violence practices are, were spread⁷¹. All of the organizations were also part of campaigns against obstetric violence in solidarity with Adélir, a Brazilian women who was arrested in April 2014 when she decided to give

⁷¹ See the activities organized. Accessed June 15, 2014: <http://diamundialderechosdelnacimiento.wordpress.com/campana-2014/>

birth at home after refusing a cesarean section at the hospital. Police brought her to the hospital and the cesarean section was finally performed⁷². Jesusa Ricoy of *Roses Revolution* presented one definition of obstetric violence in a lecture for a World Congress celebration at the Royal College of Obstetrics & Gynaecologists in India last March 2014:

“Obstetric violence is the act of disregarding the authority and autonomy women have over their own sexualities, their bodies, their babies and their birth experiences. It is also the act of disregarding the spontaneity, the positions, the rhythms and the time labor requires in order to progress normally when there is no need for intervention. It is also the act of disregarding the emotionalities of the mother and baby throughout the whole labor process.”⁷³

This definition is different of others presented by the Latin-American legal texts, but the same issues are pointed out in them. This example shows the capacity with which childbirth activism has to define reality and to shape and existent discourses when expressing their matters of concern. The fact that different 'obstetric violence' definitions travel from one country to another reveals how 'obstetric violence' has become part of the international language of activism related to childbirth. Currently all the interviewed organizations employ the concept of 'obstetric violence' in several communications and as a slogan for some of their activities. However, it does not appear in their list of main goals, except for the initiative of *Roses Revolution*, which is a movement explicitly focused against obstetric violence. Why then do they use 'obstetric violence' in their

⁷² Report and more information about the case can be found here Accessed June 15, 2014: http://www.elpartoesnuestro.es/sites/default/files/public/blog/20140407CasoBrasil/denuncia_adelir-torresrs-sdh.pdf

⁷³ Video available at this link. Accessed June 15, 2014: <http://jesusaricoy.blogspot.co.uk/2014/04/violencia-obstetrica-de-genero-e.html>

advocacy? What merit do they see in it? And would they like to see it included as a punishable practice in Spanish legal texts, as in it is Latin-America? This section aims to address these questions.

A common aspect that the interviews revealed is that none of the representatives have a clear idea of how they first heard of the concept. They knew that it is included legal texts in Venezuela, but they do not express further knowledge about the other regulations. However, different reasons were given for their current use of 'obstetric violence' Sílvia Salvador and Judith Reyes (DLL) say they incorporated this concept easily into their work. They see it as another kind of gender violence that *"can help to put a name to the malaise that many women feel after childbirth, even though society tells them that everything is alright and all that is important is that the baby is alive"*⁷⁴. They believe that having new terms for these experiences is an important contribution to legitimating the pain that many women feel after negative experiences during childbirth assistance. They argue that having words to describe these unfair situations and to realize that it is part of an unfair violence can become a tool for transforming a traumatic experience into a chance to question and change reality. For Adela Recio (EPN) 'obstetric violence' can be a powerful concept to draw attention to the fact that issues they report in childbirth assistance is violence. In her words: *"This is a question of violence, serious and aggressive, that women and children pay for with their bodies and health"*⁷⁵. Ángeles Hinojosa (PDN) sees 'obstetric violence' as an appropriate term to describe the situations they report, but she is unsure about its the social

⁷⁴ Original quote in Catalan: "Pot ajudar a posar nom al malestar que moltes dones pateixen després del part, encara que la societat els digui que tot està bé i que l'important és que la criatura està viva"

⁷⁵ Original quote in Spanish: "Es una cuestión de violencia, seria y agresiva, que las mujeres y los niños pagan con sus cuerpos y su salud"

acceptance. Jesusa Ricoy (RR) explains that the initiatives she promoted under the name of 'obstetric violence' are useful to recognize the abuse: *"It is a way to put an end to the blindness around this topic"*⁷⁶. She says that through the demonstrations against obstetric violence carried out on the 25th of November people could discharge and express that those are acts should not have happened.

In light of these reflections Spanish childbirth activism seems to find a chance to emphasize and recognize the serious damage and consequences of what they describe as violent practices in this concept. According to their aim of increasing the social awareness about childbirth issues, what they say is the first step in changing the situation, 'obstetric violence' could be a powerful concept that aids in doing that. However, it has to be used with measure and explaining thoroughly why these situations are considered violence. An overuse of the word 'violence' I argue, can reinforce the vision of women as over-complaining users of the healthcare system, who are put once again in the role of victims. Therefore, in order for obstetric violence to work in favor of the empowerment of women as health care users, the term needs to be used along with a strong core of arguments. In this way, simple explanations which undermine the issues that women have to face in obstetrics services can be avoided.

Regarding the possibilities that the inclusion of 'obstetric violence' into the law could bring, there are different opinions. Nonetheless, it is important to mention that none of the organizations interview have the inclusion of 'obstetric violence' in the law as a priority of their advocacy. Jesusa Ricoy (RR) comments that institutional regulations are not always useful, as protocols about

⁷⁶ Original quote in Spanish: "Es una forma de terminar con la ceguera entorno a este tema".

childbirth assistance have shown. However, she acknowledges that its inclusion in the law can add more legitimacy to reports against it. In a similar way, Adela Recio (EPN) comments that the inclusion of obstetric violence as an explicitly punishable practice can raise more awareness about it. Ángeles Hinojosa (PDN) sees the term's inclusion in the law as positive because: *"including obstetric violence in the law can become a good tool for demanding another kind of assistance, as well as a way that all the abuses bring to light"*⁷⁷. For Sílvia Salvador and Judith Reyes (DLL) it is not a priority because firstly it is important *"to work on the lack of training and information"*⁷⁸. However, they stress that formally reporting cases against institutions should occur more regularly, otherwise the problem will remain invisible.

Dissimilar views about the options that the creation of legal texts about obstetric violence could bring are exhibited by the interviewed people. In favor of its adoption, they argue that legal texts against obstetric violence can bring to light the issues they report and add more legitimacy to their advocacy. In disagreement, they doubt about its usefulness in favor of more important problems related to a lack of information and awareness about the whole phenomena. Taking into account the reflections given by their strategies, in Spain childbirth activism seems more focused on raising awareness and expanding policies of already existent institutional guidelines than on the advocacy of legal texts, similar to the ones that were created in Latin-America. Therefore, I argue 'obstetric violence' as a concept is more powerful as a tool for strengthening the social impact of the issues that childbirth activism in Spain aims to address, than a matter that is merely discussed on a legal level.

⁷⁷ Original quote in Spanish: "incluir violencia obstétrica en la ley puede ser una buena herramienta para reclamar otro tipo de atención, así como una forma de que todos los abusos salieran a la luz".

⁷⁸ Original quote in Catalan: "s'ha de treballar en la manca de formació i informació".

CONCLUSIONS:

Obstetric violence legal texts adopted in Venezuela, Argentina and Mexico in the last decade try to solve some issues related to the negative effects that practices of medicalization, professional authoritarianism and sexism have on women and fetuses/children who use public and private obstetrics services in these countries. These practices imply, among others, the violation of women's and children's right to be addressed with respect within health care institutions and women's right to a free, informed choices about the medical procedures performed on their bodies and their children. Since obstetric violence legal texts appear in the international sphere, childbirth activism in different parts of the world began introducing this concept in their advocacy for respected childbirth. Focusing my attention on the case of Spanish childbirth activism, some of my questions were why and how activists use 'obstetric violence' to report issues and what the concept adds to their previous strategies. Do they have shared meanings of 'obstetric violence,' namely as a consequence of practices of medicalization, professional authoritarianism and sexism? Since feminist activism has paid little attention to this topic and childbirth organizations do not describe themselves as organizations with gender equality goals, I was especially concerned with their perception of the role gender hierarchies play in this issue. In line with Maria Llopis, a queer activist who works in the field of motherhood, I also wonder: "where is our feminist practice if we ignore the uterus?"⁷⁹

⁷⁹ "¿Dónde está nuestra práctica feminista si ignoramos al útero?" in Manrique, Patricia. 2014. "El feminismo

As my theoretical framework has shown, the reasons for the medicalization of childbirth and the abuses and lack of information reported by users of Western/Westernized health care institutions are rooted in a complex set of circumstances. Medicine, like any field of knowledge, translates into its teachings and practicing hierarchies, the interests and beliefs that exist in society. The sexism of patriarchal societies that suggests that women's bodies can be manipulated ruthlessly in favor of a fast and aseptic delivery can be read as one of the male chauvinistic ideals that pervade the practice of medicine. From the status of a legitimate knowledge that medicine has gained, through hospitals medicine counts on a big power to regulate the bodies. As Foucault (1975) states, which bodies need medical care and which situations and people are considered normal, are defined by the medical discipline. Medicine owns what Brigitte Jordan (1997) defines as authoritative knowledge. From this position, Western obstetrics during the twentieth century spread the idea that childbirth is a medical event. Continuous monitoring, medication administration and professional intervention are seen as essential practices to assist the birthing process –what is known as the medicalization of childbirth. Different aspects related to the side effects of this trend were already criticized in the second half of the 20th century by some scholars and activists of women's health care movements, movements for sexual and reproductive rights and specifically activism surrounding the process of childbirth. Some of the achievements of these groups were the recognition of these issues by public institutions. As we have seen in the third chapter of the thesis, WHO's 1985 recommendations against the medicalization of childbirth and the approach provided by the SRHR reconsidered the relationship between human rights, health and gender issues. WHO's 1985 recommendations was one of the first international consensuses

debe trabajar la maternidad como experiencia de gozo". Diagonal. April 27. Accessed June 2, 2014. https://www.diagonalperiodico.net/culturas/23017-feminismo-debe-trabajar-la-maternidad-como-experiencia-gozo.html?fb_action_ids=10203865070097000&fb_action_types=og.recommends

which paid attention to obstetric assistance issues. SRHR contributed by considering access to a quality health care assistance not pervaded by male chauvinist attitudes as one of the main factors that will put an end to the violation of women's rights, especially in the area of sexuality and reproduction. At the beginning of the 21st century, obstetric violence legal texts combined critiques of childbirth medicalization, professional authoritarianism and disrespectful attitudes towards women under the label of violence against women based on gender issues. No regulations before took into account all these aspects together. According to obstetric violence legal texts, this violence is expressed by the pathologization of pregnant bodies and childbirth, which perpetuates the subordination of women, who are seen as subjects incapable of making decisions about their own health and their children's health.

In the fourth chapter on Spanish childbirth activism, I pointed out how the use of 'obstetric violence' as a concept can increase the impact of the critique of current childbirth advocacy in the country. Even though Spanish activists have not reflected deeply about the legal texts and possibilities of obstetric violence, all the groups see the use of this concept as a chance to increase the awareness of the serious damage (psychological and physical) that medicalization, disrespectful attitudes and uninformed decisions regarding childbirth have for women and children. I agree with them that the term 'violence' can help to stress the gravity of the issue and, as one of the organizations mentioned, it can help to give a name to the undermined suffering that some women feel after they experience a childbirth where obstetric violence practices take place. However, I am concerned about the adverse effect that haphazardly using a concept which includes the word 'violence' related to women experiences can entail. I argue that superficial usages of the term 'obstetric violence' can reinforce the vision of women as over-complaining

users of health care system, who are put once again into the role of victims. Therefore, the spreading of this concept, especially among mass media, should be accompanied by a strong core of arguments to avoid simple explanations that can undermine the real issues experienced in Spanish obstetric assistance. In collaboration with current activism, more research should be done in this area. Childbirth is a question which at least in one point of life directly affects every person in this world and reproductive issues have for so long been a problematic question in women's lives. The informed choice is one of the key aspects the activism interviewed work on, which I believe can have very positive effects on improving obstetric assistance. Informed choice implies that users of health care can count on proper information to make choices about their health. Well-informed citizens contribute to limiting professional authoritarianism in any field of expertise. In other words, 'knowledge is power'. In the specific case of health care, knowledge helps to create responsible users, who more empowered and less ignorant of their health, increase the chances of more balanced and cooperative relations between health care users and its personnel. A challenge of current activism interested in this goal could be, in my opinion, to provide as much diverse and contrasted information as possible in order not to fail in advocating for specific ways of childbirth/motherhood, as current obstetric assistance does. As some childbirth activists argued, perhaps we do not need legal texts about obstetric violence, but rather a great deal of information and research. On that point I argue information does not have to be provided only to users, but also to the professionals trained in universities. What would happen if potential physicians, nurses and midwives could have the chance to talk with childbirth activists? And to read about gender issues, the history of science, the anthropology of childbirth or obstetric violence legal texts? Would it change some of the issues pointed out in this research? I argue yes.

As I already mentioned, gender issues are one of my main concerns since reproduction and motherhood have been the main trench from where patriarchy operates. The fact that Spanish childbirth does not work from an explicit gender concerned position, even though some of their representatives share strong statements about the relevant role gender hierarchies play in obstetric assistance issues, leads me think until to which extent taboos about motherhood and gender struggles remain. Many currents of thought in Western feminism maintain distant positions regarding issues related to childbirth and motherhood, while childbirth activism seems to stay away from discussing gender struggles in obstetric assistance. As the Spanish anthropologist Mari Luz Esteban (2003) comments:

“On a general level, it can be affirmed that health passed from being crucial in the feminist theory and practice in the 1970s and 1980s to having a secondary status, and at the same time hyper-specialized, in the 1990s and the beginning of the 21st century. That means that the contents referred to health and gender have lost their previous centrality within feminism and also the ideas, debates and alternatives about different issues are generated and kept in a perfectly enclosed space, where specialist, professionals of medicine and psychology/psychiatry above all, own the protagonism⁸⁰” (My translation).

I argue that this lack of reflection about health, and health care assistance during childbirth, from a gender perspective leaves the debate about obstetric assistance issues shaky and blind to one of the most important issues that contemporary societies have to face. It is especially important

⁸⁰ See original article in: Esteban, Mari Luz. 2003. El trabajo feminista en el ámbito de la salud. MyS. 11-12. On line. Accessed July 4, 2014. http://mys.matriz.net/mys-1112/articulos/art_1112_01.html

since this allows uncritical motherhood-friendly narratives to occupy the positions which advocate for a quality childbirth assistance.

Obstetric violence is not a new phenomena, but a new concept that childbirth activists are using to raise awareness about issues that women have to face in hospitals. Obstetric violence appears in some legal texts in Latin America, but as the case study on Spain has shown, this violence does not occur only there. Obstetric violence, I argue, is merely a concept not a solution in itself. However, it can be useful for rethinking old issues that still hinder proper childbirth assistance, for adding new strategies to the field of activism and for calling attention to an interesting and unexplored topic of research.

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