Obstetric Violence as Gender Based Violence

Everyday Bioethics

Edited by
Carlo Botrugno

Volume 1

Obstetric Violence as Gender Based Violence

What it is, how it is perceived, and how it can be addressed

Edited by
Lucia Re, Irene Strazzeri and Sara Fariello

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Introduction

This book is the outcome of a Research Project of National Interest (PRIN 2022), funded by the Italian Ministry of University and Research, entitled "Giving Birth with Care. Conceptions of Maternity and Professional Ethics in Obstetrics and Gynecology for the Prevention of Obstetric Violence." The project, which started in October 2023 and is scheduled to conclude in February 2026, is nationally coordinated by Irene Strazzeri (University of Salento, Italy). At the University of Campania "Luigi Vanvitelli," the research team is led by Sara Fariello, while Lucia Re coordinates the team at the University of Florence.

The aim of the project is to conduct a sociological investigation — both theoretical and empirical — into the phenomenon of obstetric violence, understood as a form of gender-based violence (physical, psychological, and symbolic), and as a serious violation of women's human rights. Broadly defined, the term obstetric violence refers to any form of violence perpetrated by healthcare professionals in the context of childbirth and reproductive healthcare services, which include lack of informed consent, excessive medicalization, mistreatment, and degrading or humiliating practices. These acts can negatively impact women's physical and psychological health, as well as their overall experience of pregnancy, childbirth, and the postpartum period. Such violence often manifests through medical over-intervention, directive approaches to childbirth, and the pathologization of physiological processes. It may also involve creating a clinical environment that disregards a laboring woman's privacy, autonomy, and informed choices. Frequently, these behaviors are subtle, normalized, and difficult to recognize or name.

Although scholarly literature on obstetric violence is relatively recent, the phenomenon has been extensively studied in South America, where feminist movements have significantly influenced legal frameworks and public discourse. For instance, Venezuela's 2007 *Ley Orgánica sobre el Derecho de las Mujeres a una Vida Libre de Violencia* explicitly identifies and defines obstetric violence as:

> The appropriation of women's bodies and reproductive processes by health professionals, through dehumanizing treatments, abuses in medicalization or the pathologizing of natural processes, resulting in women's loss of autonomy and the ability to decide freely about their bodies and their sexuality, negatively impacting on their quality of life.

Thus, obstetric violence is the result of a constellation of interrelated social processes. It is, first and foremost, linked to the medicalization of society — a process that

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assumes particular characteristics when applied to women's bodies. The medicalization of the female body has resulted in the gradual transfer of the experience of childbirth into the realm of pathology. The pathologization of childbirth is part of the history of the biomedical paradigm which, setting itself as hegemonic, has progressively delegitimized other forms of knowledge. The emergence of obstetric surgery coincided with the systematic devaluation of female knowledge — both women's embodied experiences and understandings of childbirth, and the traditional expertise of midwives, which, from the eighteenth century onward, was progressively replaced by the ostensibly superior knowledge of physicians. The alienation generated by medicalization thus serves to uphold a broader system of control over women's bodies and subjectivities. Reproductive biopolitics colonizes women's knowledge, corporeality, and lived experiences of childbirth and motherhood. Furthermore, the fragmentation and hyper-specialization of medical expertise come at the expense of a holistic understanding of the patient, whose health is shaped by emotional, psychological, and social dimensions, as well as physical ones. On the one hand, medicine tends to frame childbirth solely as a physio-pathological process, privileging the moment of expulsion as the central event. On the other hand, childbirth remains deeply embedded in a web of cultural, religious, and social stereotypes that also shape how it is experienced and managed.

Today, obstetric violence continues to be widely underestimated and insufficiently recognized, both within society and by healthcare institutions, despite increasing international attention to the issue. Several global bodies have indeed addressed it on multiple occasions. Notably, the World Health Organization's 1985 statement, *Appropriate Technologies for Birth*, sought to limit practices that compromise the dignity of women during childbirth. More explicitly, the WHO's 2014 *Statement on the Prevention and Elimination of Disrespect and Abuse during Facility-Based Childbirth* formally identified disrespectful and abusive treatment as including:

> Outright physical abuse, profound humiliation and verbal abuse, coercive or unconsented medical procedures (including sterilization), lack of confidentiality, failure to get fully informed consent, refusal to give pain medication, gross violations of privacy, refusal of admission to health facilities, neglecting women during childbirth to suffer life-threatening, avoidable complications, and detention of women and their newborns in facilities after childbirth due to an inability to pay.

Even the Council of Europe, with the Resolution 2306/19, has addressed the issue, by relating the problem of obstetric violence with the patriarchal culture that exists in society and in the medical field, and suggesting that the difficult working conditions in healthcare can affect the treatment of patients. Dubravka Šimonović, the United Nations Special Rapporteur on Violence Against Women, in her 2019

report titled *A Human Rights-Based Approach to Mistreatment and Violence Against Women in Reproductive Health Services with Particular Reference to Childbirth and Obstetric Violence*, urged States to adopt comprehensive policies aimed at preventing and addressing such violence. Her recommendations include the systematic collection of data and the provision of appropriate training for healthcare personnel. More recently, the European Parliament, in its 2021 *Resolution on the Situation of Sexual and Reproductive Health and Rights in the EU, in the Context of Women's Health*, expressed concern over the deteriorating conditions of maternal healthcare, particularly in relation to the impact of the COVID-19 pandemic.

International human rights bodies have also played an important role in codifying, identifying and monitoring human rights violations in the context of women's sexual and reproductive health. For example, the CEDAW Committee has contributed to the recognition of obstetric violence as a form of gender-based violence against women, affirming that it constitutes a violation of women's human rights, including their right to reproductive health. Similarly, the European Court of Human Rights has repeatedly emphasized that breaches of privacy and failures to obtain informed consent represent serious infringements of fundamental human rights.

This book draws on this framework of sources, data, legal and sociological analysis. It is built on a defined theoretical basis. The starting hypothesis is that there is a common thread that links obstetric violence to the different forms of sexism and biopolitical regulation of the female body which, in turn, are connected to the different models of motherhood widespread at the social level and in the cultures of healthcare staff. Investigating these models enables interventions in the training of healthcare professionals and supports the development of tools to combat obstetric violence. Such efforts begin with a critical examination of the prevailing models of motherhood, which inform clinical practices, the organization of healthcare services, and professional ethics.

While the book comprises contributions from the members of the research teams of the Universities of Salento, Campania Vanvitelli and Florence, it also hosts essays written by some of the scholars who participated in the 16th European Sociological Association Conference held in Porto in the summer of 2024, where, in the framework of our project, we convened two panels specifically devoted to exploring obstetric violence at the intersection of trust and transformation. Finally, other scholars working on obstetric violence in different disciplinary fields were invited to join, in order to explore the topic from different methodological and cultural perspectives. For this reason, the book connects the research field of general sociology to sociology of medicine and sociology of law. These disciplines are then joined by bioethics and anthropology, without neglecting international law.

Moreover, the book examines the phenomenon of obstetric violence from an international perspective, while also focusing on specific local contexts that we

consider particularly significant or underexplored in contemporary scholarly debate. These include Latin America — where the movement against obstetric violence first gained momentum — as well as Spain, Italy, Turkey, and Finland. The essays draw on both theoretical and empirical research, addressing the phenomenon from multiple perspectives: that of the women who have experienced obstetric violence, and that of healthcare professionals. Obstetric violence is approached here as a structural issue, rather than merely the result of individual behavior. The aim is to transcend the often polarized public discourse that sets victims against healthcare providers, and instead to prioritize the development of effective strategies for prevention.

The first chapter is devoted to a bioethical approach to obstetric violence. Even though both the study of this phenomenon and its contrast are undeniably part of the sphere of knowledge and action of bioethics, obstetric violence has not received due attention from scholars in bioethics. Carlo Botrugno discusses the epistemic debate about the definition of obstetric violence itself in light of the evidence provided by the available literature and the first protection tools that have emerged at the legislative and soft-law level. He highlights the factors that may have fueled the disinterest of bioethics towards obstetric violence and finally, he focuses on some key elements that are deemed essential to build a perspective of everyday bioethics to stimulate further research and contrast obstetric violence.

Consistently, the second chapter outlines the theoretical and epistemological framework, situating the analysis within the tradition of narrative bioethics — critical, intersectional, feminist, and ultimately decolonial. It addresses the very concept of obstetric violence, with particular attention to its manifestations in Spain, and explores its connection to epistemic injustice through the lens of feminist phenomenology. In this context, Ester Massó Guijarro's contribution examines the intersection of obstetric violence and epistemic injustice, applying the latter as a critical framework for understanding the conceptual and practical controversies that surround the former. Her work seeks to construct a nuanced, multifaceted perspective on this contested notion, and on the broader "interregnum" in which it currently resides.

The third chapter, written by Sara Dal Monico, frames the issue of gynecological and obstetric violence from a human rights law perspective. Considering the lack of a comprehensive legally binding definition, the essay serves as a starting point to reflect further on the notion and enhance scholarly debate on the matter through the European Court of Human Rights case-law and the specific contribution of the CEDAW Committee. It argues in favor of the recognition of gynecological and obstetric violence as a form of gender-based violence. It also suggests that attempts at drafting a definition should embrace a human rights-based and intersectional approach focused on gender.

Camilla Giugliani, in chapter four, presents an overview of obstetric violence, mainly from a Latin American perspective: concepts, definitions, legal aspects, and statistics are described to support the assertion that obstetric violence is a matter of gender, race and class. She defines obstetric racism, along with the consequences of obstetric violence, and she reflects on the debate involving the terms. Finally, she presents ideas to prevent and eliminate obstetric violence.

Along the same lines of argument, in the fifth chapter, Giulia Stolfi analyzes the measures taken in Brazil to prevent obstetric violence: the initiatives promoted in public facilities, inherent in the implementation of the humanized childbirth model, aim to improve maternal health through a model of care centered on the respect and protagonism of women. The humanization of childbirth, which developed from the contributions of professionals and activists and the critique of the medicalized and technocratic model of childbirth, has provided a decisive impulse for the transformation of obstetric care through a holistic approach that considers childbirth not only as a biological event, but as a psychosocial one. The paradigm shift, which affects both the organization of healthcare systems and the profile of the professionals involved, is not limited to eliminating certain practices, but rather aims to promote structural, ethical and cultural change, reducing cases of obstetric violence and ensuring a better childbirth experience while respecting women's human rights.

In chapter six, Katja Vihreäsalo examines the tension between objectification and self-determination in the context of an obstetric violence campaign in Finland. At the core of this study lie narratives collected in 2019 by Finnish Me Too in Childbirth campaigners to document experiences of obstetric violence. These accounts are analyzed within the broader framework of activism, specifically the effort to label and redefine such experiences as instances of violence and violations of self-determination. The MTIC campaign challenges dominant medicalized narratives by reframing problematic routine practices as violations, thereby contesting hegemonic ideals of heroic resilience in childbirth. The narratives reveal how patriarchal structures manifest through objectifying practices fundamentally contradicting self-determination. As birthing individuals are reduced to non-persons, decisions concerning their care are made and discussed as if the individual themselves were absent. This exclusion and isolation erode the very foundation of personhood and rights, both of which are essential to self-determination as outlined in the Patient's Rights Act. Theoretically, this study integrates phenomenological perspectives on shame applying Foucauldian analyses of power, offering a conceptual framework for understanding the intersection of corporeal experiences and rationalities of medical care.

Chapter seven, written by Sezen Yaraş, Eylem Mercimek, and Dilek Cindoğlu, explores a specific form of obstetric violence that emerges within the framework

of neoliberal paternal authoritarianism in contemporary Turkey. This context not only undermines women's autonomy over their reproductive rights but also erodes the professional authority of doctors by exposing them to economic, legal, and reputational risks. The hyper-medicalization of birth characterizes obstetric care in referring to a decline of medical autonomy as well as increased managerial, legal and governmental monitoring of the birth-giving process. Medical interventions, especially episiotomies, are routinized in this context for a risk-free and efficient birth, creating high vulnerability to obstetric violence. Based on recent fieldwork, it is argued that this context is used by women as an historical opportunity to claim autonomy and respect, not as patients, clients or mothers, but as the central actors in birth. A detailed analysis is offered on how they narrate their prenatal care experiences as an ongoing negotiation with their obstetricians and how they generate self-support mechanisms by mobilizing medical, familial and market resources. The chapter discusses the possible effects of their attempts to build resilience against the context-specific vulnerabilities to obstetric violence.

Chapters eight and nine present the findings of two qualitative empirical studies conducted as part of the project by the research teams of the University of Campania and the University of Florence. These contributions are based on semi-structured or in-depth interviews with midwives, working in both hospital settings and private practice, in the Italian regions of Campania and Tuscany. The chapters investigate how midwives perceive their own role in childbirth care and their professional ethics. Building on an analysis of the professionalization of midwifery and their prevailing ethical codes, the studies examine midwives' role, highlighting hierarchical dynamics, power asymmetries, and gender relations in the workplace. The research primarily focuses on how midwives perceive the issue of obstetric violence, aiming to explore their interpretations, experiences, and the professional and organizational factors that shape such perceptions. The perspective adopted in both researches represents a significant advancement in studies on obstetric violence, as it shifts the focus toward birth care professionals and professional ethics, thereby addressing a gap in the literature, which has so far predominantly focused on maternal experience.

Chapter eight, authored by Sara Fariello and Giuditta Mitidieri, identifies critical issues posing significant barriers to the exercise of midwifery autonomy in Campania, such as gaps in training, lack of social recognition, and a subordinate dynamic to gynecologists. The chapter highlights how the midwifery model — widely recognized as the gold standard in childbirth assistance — struggles to take root in the local context, where a prescriptive, standardized, and hierarchical approach still predominates. Despite persistent structural challenges, there is evidence of a positive shift compared to previous decades, with a partial reduction of practices such as episiotomy and the Kristeller maneuver, although the rate of C-sections remains

the highest nationwide. A growing willingness, particularly among younger generations, to adopt a more dynamic model of care is emerging — one that is grounded in scientific evidence and aimed at promoting women's empowerment. However, this transition is hindered by a professionalization that is somehow incomplete in midwifery: midwives often face precarious working conditions, low pay, and a lack of social recognition of their professional role within the broader community.

Chapter nine, written by Lucia Re and Chiara Magneschi, explores the different concepts of motherhood, care, and professional ethics that inform midwives' work. Attention is paid not only to childbirth but also to the prenatal and postnatal phases, with a focus on identifying good practices, strategies, and experiences aimed at the humanization of care. Significant attention is devoted to structural challenges within the healthcare system (e.g., work shifts, lack of resources, precarious working conditions), which increase the physical and emotional workload and may foster the emergence of unprofessional or even violent behavior. The authors argue that developing effective preventive measures requires a deep understanding of the professional culture, with midwives playing a central role in the development and implementation of these strategies.

Chapter ten, authored by Daniela Bandelli, presents findings from qualitative interviews and focus groups with birthing women, homebirth midwives, doulas, and other birth professionals in Italy. These data highlight how, among certain groups of women, hospital birth can be perceived with distrust, as a setting where women and newborns are vulnerable to disrespect and invasive practices. Although homebirth remains marginal in Italy, the contribution sheds light on the complex reasons that make it a preferred option for some women and a daily professional commitment for care providers. The chapter also explores the interviewees' understanding of the roots and manifestations of violence in medicalized childbirth and their perspectives on possible forms of integration between home-based care and the public healthcare system.

Finally, chapter eleven, written by Irene Strazzeri, Anna Maria Rizzo, and Maria Chiara Spagnolo, concludes the volume by reaffirming the need to recognize obstetric violence as a distinct form of gender-based violence. The chapter centers its analysis on the female body, which is frequently constructed as an "object" of medical and social control — even, and perhaps especially, within the context of maternity. Processes of medicalization have profoundly shaped the ways in which women's reproductive bodies are observed, perceived, and controlled. Over time, the female body has been redefined in strictly biological terms — treated as a system to be monitored, regulated, and corrected. As a result, key reproductive processes such as the menstrual cycle, pregnancy, childbirth, and menopause have increasingly been brought under the purview of medical science. Although childbirth was, for centuries, a private event managed by women within the domestic

sphere, the rise of scientific and technological advancements led to the progressive involvement of healthcare professionals, who came to assume control over pregnancy and the physiology of birth. Over time it has become a hospital-based event in Western societies. This shift significantly reduced the risks associated with complications from homebirths, while contributing to a rise in unnecessary medical interventions. Consequently, the scientific evolution in childbirth care has highlighted both the invasive nature of interventions such as induced labour, episiotomy, and caesarean section, and the resulting indirect erosion of a pregnant woman's decision-making power. The chapter also takes up some analyses by Patrizia Quattrocchi on the role of *parteiras* — traditional midwives — in Yucatan and, finally, addresses female genital mutilations and their impact on pregnancy and childbirth, opening up further fields of inquiry that the literature on obstetric violence will increasingly need to consider in the context of contemporary pluralistic societies.

Carlo Botrugno

Obstetric Violence from the Perspective of Everyday Bioethics

Abstract: Obstetric violence is a phenomenon of growing interest on a global scale. Despite the fact that both the study of this phenomenon and efforts to counter it undeniably fall within the domain of bioethics, our community has not paid due attention to it. In this chapter, I engage with the epistemic debate around the definition of obstetric violence itself, in light of the evidence provided by the available literature and the first protection tools that have emerged at the legislative and soft-law level. Afterwards, I highlight the factors that may have fueled the disinterest of bioethics towards obstetric violence. Finally, I focus on some key elements that I deem essential to build a perspective of everyday bioethics, so as to stimulate further research and contrast obstetric violence in routine practice.

1 Introduction

Obstetric violence is a phenomenon of growing interest on a global scale. This is confirmed by an increasing number of studies (e.g. Leite et al. 2024; Garcia 2024; Ramallo-Castillo et al. 2024; Zanardo et al. 2017; Castrillo 2016; Vacaflor 2016), particularly qualitative studies (e.g. Santana et al. 2024; Lima et al. 2021; Oliveira and Merces 2017) which aim to gather evidence regarding a multifaceted phenomenon whose causes are several and much more investigated than the obstetric violence itself. These include the asymmetry in the care relationship, the socio-economic inequalities and the disparities in the healthcare sector, the problems related to gender equality, or rather the state of subordination against which women still often have to fight to see their rights guaranteed in contemporary societies.

The increased attention to obstetric violence is due to the emergence of a new sensitivity towards the conditions that women are forced to endure in the care relationship in the obstetric field. This sensitivity has led to the approval of the first regulatory instruments to contrast it, including the Organic Law on the Right of Women to a Life Free from Violence (law no. 38.668/2007) adopted in Venezuela in 2007, and the law on the Comprehensive Protection to Prevent, Punish, and Eradicate Violence against Women (law no. 26.485/2009) adopted in Argentina in 2009. These first national regulations were accompanied by a series of soft-law instruments, including the WHO Statement on “The prevention and elimination of disrespect and abuse during facility-based childbirth” adopted in 2015 (cf. WHO 2014),

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and the UN 2030 Agenda for Sustainable Development, which includes among its objectives gender equality and the emancipation of women, the elimination of all forms of discrimination and violence against them, and the guarantee of universal access to sexual and reproductive health services and reproductive rights.

It should be remembered that the protection of women against all forms of discrimination had already been the subject of the Convention on the Elimination of All Forms of Discrimination against Women, adopted by the United Nations General Assembly in 1979 (CEDAW 1979). As anticipated, however, the recently adopted normative and para-normative instruments — some of which I mentioned above — seem to be the expression of a new and more specific sensitivity, guided by the emergence of scientific evidence resulting from qualitative research of a sociological and anthropological nature that has given a name and a form to the phenomenon of obstetric violence. This has been accompanied by the activism of feminist movements and associations that have mobilized to defend women's rights in the obstetric, gynaecological and maternity fields.

This sensitivity, however, does not seem to have involved the domain of bioethics (Martín-Badia et al. 2021), despite the fact that both the study of this phenomenon and efforts to counter it undeniably fall within the sphere of knowledge and action of this discipline. The serious misdemeanours that can be traced back to obstetric violence, together with its global reach, in fact, mean that dealing with this problem should be a primary mission for bioethics. Despite this, metaphorically speaking, it can be said that bioethics has remained "silent" in the face of it. Reflecting on the reasons that have led to a substantial disinterest on the part of the community of bioethics scholars with respect to the topic of obstetric violence therefore appears to be the first step to stimulate a broader debate, therefore not only to continue to accumulate precious knowledge in this area but also and above all to use the latter to combat this phenomenon. To achieve this goal, in fact, it seems necessary to promote a new sensitivity among health workers and reorient organizational practices so that they adhere to moral principles and values underlying the protection of the woman giving birth and of women more generally. As already seen in other works (Botrugno 2023a), however, the change in practices cannot occur without a critical reflection on the role of knowledge, or on the epistemic level that informs and shapes the beliefs, visions, attitudes, and therefore the daily practices of health workers and all those who play a role in the provision of health services in the area of maternity.

In the continuation of this chapter, therefore, I will try to delve into the epistemic debate around the definition of obstetric violence (section 2) in light of the evidence provided by the available literature and the first protection tools that have emerged at the legislative and soft-law level. Later (section 3), I will try to highlight the factors that may have fueled the disinterest of bioethics towards the topic of

obstetric violence, the emergence of which seems to be linked to a sensitivity developed in other disciplines. Subsequently (sections 4-6), I will focus on some key elements that emerge as essential in the perspective of building an everyday bioethics perspective for obstetric violence.

2 The epistemic debate around the definition of obstetric violence

As mentioned at the beginning of this chapter, numerous studies show that obstetric violence is a global phenomenon. For example, as highlighted by Martínez-Galiano et al. (2023) in a recent study:

> The prevalence of women who have perceived inadequate treatment or obstetric violence during childbirth varies depending on the type of study and how obstetric violence is conceptualized. Despite this, the reported prevalence of obstetric violence in different studies is high, ranging from 25 to 78%. In addition, a higher incidence of maternal and neonatal morbidity has been associated with a woman's perception of experiencing obstetric violence during childbirth (Martínez-Galiano et al. 2023, 2).

Other authors have noted that obstetric violence has become even more serious during the COVID-19 pandemic, which has served as a pretext for the cancellation of women's fundamental rights (Massó-Guijarro 2023, 3). Evidence shows that "violent" behaviors in the obstetric field are caused by "work overload, scarce human resources, physical and mental exhaustion of professionals, precariousness of the conditions for care provision, and lack of adequate infrastructure in institutions" (Jardim and Modena 2018, 9; see also Re and Magneschi in this volume). Among the negative repercussions of obstetric violence, the reference literature reports permanent physical, mental and emotional damage in women giving birth (Jardim and Modena 2018, 2), need for mental health assistance in the postpartum period (Ramallo-Castillo et al. 2024, 68), problems in the physical structure of the newborn (Matos et al. 2021, 3; Simpson and Catling 2016), as well as high rates of maternal mortality and perinatal morbidity (Pasche et al. 2010).

Despite the evidence collected so far in this area, a univocal definition of obstetric violence does not yet exist; indeed, the debate records numerous divergences precisely with respect to the appropriateness of using the expression "obstetric violence." In confirmation of this, consider, among others, the fact that the WHO has — deliberately or not — avoided using the term "violence" in its documents, which seems to be attributable to a certain reluctance to legitimize an expression that nevertheless has a strong emotional charge. In this regard, in Spain, one of

the European countries where the debate on obstetric violence is particularly intense (Massó-Guijarro 2023; see also Massó-Guijarro in this volume), there has been a clash of views between some scientific societies, in particular between the Spanish Society of Gynecology and Obstetrics (SEGO) and the Federation of Midwives' Associations of Spain (FAME). As Ramallo-Castillo et al. (2024) highlight in a recent study, SEGO stated that the use of the expression "obstetric violence" should be totally rejected because it is "inappropriate, partial and unjust," because it carries a presumed legal meaning of a malicious nature, or else because it evokes the intention to cause harm, the intention to injure, and the use of force or threats, punishable by law (Ramallo-Castillo et al. 2024). On the other hand, FAME stated that it is necessary to put aside any "euphemism" and start considering obstetric violence for what it really is — violence — and therefore fight it with firmness and determination (FAME 2021).

This sort of dispute over the existence of obstetric violence has also been recorded in Brazil (Lima et al. 2021, 4910; see also Stolfi and Giugliani in this volume), a country where in 2019 the Ministry of Health issued a statement declaring itself against the use of the expression obstetric violence, followed by the Federal Council of Medicine (CFM 2019) which in the same statement considered the use of this terminology "aggressive" towards health professionals, in particular gynecologists and obstetricians. These statements have raised a wave of protests from associations and social movements, to which was added a document from the Ministério Público Federal (MPF 2019) in which the Government and the CFM were invited to initiate a broad reflection on the phenomenon of obstetric violence rather than entrenching themselves in the aggressiveness of this expression. As underlined by Lima et al. (2021), it must be considered that Brazil is a country where this debate is particularly urgent in light of the high rate of maternal mortality — data from 2017 report 59 deaths per 100,000 newborns in the country (Lima et al. 2021) — and the high rate of surgical births — data from 2011–2012 show 52% of surgical births against the rate of 15% that the WHO (2018) recommends not to exceed. As Lima et al. (2021, 4910) highlight in this regard, "Among those who had children vaginally, only 5.6% of parturients did not undergo any human intervention. It is interesting to note that this percentage reflects an attention that appears interventionist, or suggests that the use of techniques, maneuvers or drugs does not occur out of a just necessity."

The literature that deals with obstetric violence has attempted to classify the behaviors that can be considered as attributable to this phenomenon. For example, Jardim and Modena (2018) identify five forms of obstetric violence:

> 1 - routine and unnecessary interventions and medicalization (on the mother or the infant); 2 - verbal abuse, humiliation or physical aggression; 3 - lack of material and inadequate facilities; 4 - practices performed by residents and professionals without the woman's permission

> after providing her comprehensive, truthful and sufficient information; 5 - discrimination on cultural, economic, religious and ethnic grounds (Jardim and Modena 2018, 8).

The behaviors most frequently identified in the literature (e.g. Jardim and Modena 2018; Lima et al. 2021; Matos et al. 2021; Leal et al. 2014; Perez 2022; Ramallo-Castillo et al. 2024) as characteristic of obstetric violence include: the high prevalence of obstetric interventions and the perception of inadequate care during childbirth, with particular reference to emergency caesarean sections, instrumental births and, more generally, the patient's perception that she has lost control during childbirth (Ramallo-Castillo et al. 2024, 68); unnecessary episiotomies, vaginal palpations without consent or painful interventions performed in the absence of anesthesia (Perez 2022, 74); examinations and interventions performed in the absence of privacy (Perez 2022, 75); physical and verbal abuse and violence (Matos et al. 2021; Lima et al. 2021); sexist or disrespectful behavior by health professionals towards women in labor (Perez 2022, 74); forced sterilization and forced abortion (Perez 2022, 75); restriction of freedom of movement, birth in the lithotomy position and the strategy of pushing the baby to accelerate delivery (Lima et al. 2021); immobilization of women already deprived of personal freedom (Perez 2022, 75); denying the presence of the woman's partner, deprivation of food and the possibility of walking (Perez 2022, 75); frequent use of oxytocin to accelerate labor (Perez 2022, 75); forced ingestion of liquids or food during labor (Lima et al. 2021); use of non-pharmacological methods to relieve pain (Lima et al. 2021).

In 2007, Venezuela enacted the Organic Law on the Rights of Women to a Life Free of Violence, the first national law in the world that defines obstetric violence and adopts a series of guarantees aimed at combating and sanctioning this phenomenon. In particular, art. 15, paragraph 13 defines obstetric violence as:

> the appropriation of women's bodies and reproductive processes by healthcare personnel, which is expressed in dehumanizing treatment, an abuse of medicalization and the pathologization of natural processes, leading to a loss of autonomy and free decision-making regarding their bodies and sexuality, with a negative impact on women's quality of life.

Argentina has also adopted legislation aimed at protecting women during pregnancy and childbirth. This protection is now the result of a series of subsequent interventions, the first of which dates back to 2004, when the Law on Humanized Childbirth (law no. 25,929) was approved. However, it did not address the definition of obstetric violence, even though it set out provisions applicable to this phenomenon. In 2009, however, with the law called Comprehensive Protection to Prevent, Punish, and Eradicate Violence against Women (law no. 26,485), in Argentina rules were adopted aimed at obtaining more complete protection, in order to prevent, punish and combat violence against women, and to do this it was decided to use the

notion of obstetric violence as directed specifically against women. It was defined as the violence "exercised by health personnel on women's bodies and reproductive processes, which is expressed in dehumanized treatments, abuse of medicalization and the pathologization of natural processes." Argentina continued to refine its legislation for the protection of women in 2010, with the issuance of regulatory decree no. 1011/2010 of the Global Protection Law, which addressed gender violence from a broader perspective than that provided for by previous Argentine legislation. Finally, in 2015, Regulatory decree no. 2035/2015 of law no. 25,929 of 2004 was approved, which specifies the rights of women during pregnancy, and those of their children during labor and the postpartum period.

Still in Latin America, between 2007 and 2017, some States in Mexico, and the State of Santa Catarina in Brazil and Uruguay in 2017 also enacted specific laws against obstetric violence.

3 From silence to an everyday bioethics perspective for obstetric violence

As stated in the introduction, the sensitivity that has developed so far around the topic of obstetric violence does not seem to have involved — if not marginally — the field of bioethics, and yet this phenomenon, in its gravity and proportions, certainly represents a theme of fundamental importance for our discipline. This substantial "silence of bioethics" therefore seems to be attributable to various factors. First of all, it can be hypothesized that, like some sectors of modern medicine — see the examples reported above relating to Spain and Brazil or the failure to use this expression by the WHO itself — the delay of bioethics in addressing obstetric violence can be traced at least in part to the discomfort in using such a highly evocative expression, in a negative sense. Obviously, this cannot be a justification, even more so if one considers that dealing with "uncomfortable issues," that is, ethically complex and divisive ones, is an unavoidable mission for bioethics.

A second, perhaps more decisive, factor that may have favored the inertia of bioethics with respect to the phenomenon is certainly the "discomfort" that our discipline suffers in adapting its knowledge and methods to an object whose investigation requires a certain mastery of qualitative research methodologies. As highlighted elsewhere (Botrugno 2023b), bioethics has long remained trapped in the distinction — now antiquated — between facts and values, which is the counterpart to the vision according to which sociology, as an essentially descriptive science, would provide the "facts," while bioethics, as an eminently prescriptive (or normative) area of knowledge, prepares the moral framework through which to evaluate them

(Haimes 2002, 99; Musschenga 2005). This separation has been contested by several authors (Nelson 2000), including Tom Beauchamp and James Childress, who in the most recent versions of their Principles of Biomedical Ethics (2001), distinguish a "descriptive ethics" (as is the case) from a "normative ethics" (as should be the case). However, the authors admit that the main task of ethics remains that of finding a moral justification for certain actions, and that descriptive ethics still has a marginal place in bioethical research (Beauchamp and Childress 2001, 2; Hedgecoe 2004, 130).

More recently, some authors have evoked the advent of an "empirical turn" in bioethics (Borry et al. 2005; Musschenga 2005; Hurst 2010), that is, a successful interpenetration of bioethical perspectives, themes and theories and the methods of empirical research, which have always had a privileged connection with disciplines such as sociology and anthropology (Turner 2005; 2004). On the other hand, such interpenetration is certainly the outcome of a progressive expansion of bioethics, which has brought to light the need to produce autonomous knowledge, guided by the questions and research perspectives that are of most interest to the members of this community. In other words, bioethics today is no longer content to simply "import" empirical findings produced in other areas of knowledge and then analyze and reuse them from its own perspective, or rather, from the multiplicity of perspectives that compose it. Bioethics today increasingly appears capable of "promoting" and "producing" empirically oriented knowledge. Nonetheless, as demonstrated by the absence of bioethics in research on the phenomenon of obstetric violence, the integration of empirical research methods within our discipline remains a concrete need. Such integration is of fundamental importance to reorient professional practices and stimulate a change capable of involving the entire organizational structure of health systems, especially where the protection of rights and respect for the preferences, needs, values and expectations of patients depend on it.

In this regard, Leigh Turner has highlighted that, unlike disciplines such as sociology and anthropology, bioethics has not been able to adequately cultivate its connections with the sphere of public health (Turner 2005, 374). This would explain why bioethics today appears largely obsessed with cutting-edge issues and dominated by typical middle-class concerns and fears (Turner 2005, 374). Without denying the importance of these issues, Turner is keen to underline how this has led bioethics to lose interest in the social, political and economic context within which some important ethical questions are determined, including health, illness, social life, and moral experience (Turner 2005, 374).

Turner's vision leads to a third factor that may have contributed to the lack of interest of bioethics in obstetric violence, namely the fact that this phenomenon has been commonly traced back to low-income countries (Garcia 2024), in which bioethical reflection seems to be less developed from a theoretical point of view

and the penetration of bioethics in health systems appears weaker than in Western countries. This point is certainly of crucial importance if we consider that, as described above, the first regulatory instruments to contrast obstetric violence were adopted in Latin America, that is, precisely in a context of low-income countries. This could certainly derive from a greater scope and severity of obstetric violence in those countries. It should not be forgotten, however, that the bioethics that has developed in the Latin American context — marked by social injustice, economic and health inequalities, as well as difficulties and disparities in access to health services — appears very dissonant from the "white bioethics" (Raymundo and Lorenzo 2023; Botrugno 2023a; Myser 2003) that expresses visions, theories and approaches typical of some academic and scientific elites. The latter ultimately reflect values, preferences and beliefs that, far from being universal, are typical of the "mainstream" bioethics practiced and taught in the richest areas of the planet. Conversely, Latin American and Caribbean bioethics has developed around a precise identity, more politicized than elsewhere, and it is no coincidence that it has assumed the label of "critical bioethics" or "bioethics of the global South" (Cunha and Lorenzo 2014; Garcia 2012; Hall and Tandon 2017; Lorenzo and Garaffa 2011; De Lopez et al. 2016). The conceptualization of such bioethics starts indeed from the recognition of the profound social inequalities existing in the area of health and in access to health services offered to the population. At the same time, Latin American and Caribbean bioethics emphasizes the political responsibility of the international community for the persistence of mechanisms that have historical roots and that still today fuel discrimination and social injustice, phenomena that have a negative impact on the health of many people in their countries.

The bioethics of the global South shares the same assumptions as everyday bioethics (Botrugno 2018; Botrugno 2023a). This perspective draws inspiration from the pioneering work of the Italian doctor and bioethicist Giovanni Berlinguer (Berlinguer 2000; 2003) and aims to stimulate research and in-depth analysis of issues that are often "forgotten" by the mainstream bioethics debate in favor of issues considered "cutting-edge" and generating "ethical dilemmas." As highlighted above, Leigh Turner expressed similar concerns, underlining the distance of bioethics from certain research interests and, consequently, also from qualitative research methodology (Turner 2005). Everyday bioethics thus aims to privilege issues that have an impact on the majority of the population of contemporary societies, such as health equity, access to health services, inequalities and discrimination in health, primary healthcare, and public health. From the perspective of everyday bioethics, therefore, obstetric violence is no longer just an "epidemiological issue," but also and above all a problem of global social justice — an urgent issue for a bioethics that aims to take "action" (Botrugno 2019) to protect women's rights in the obstetric field. By virtue of the above, therefore, in the following I will

analyze some factors that emerge from the state of the art of obstetric violence and that seem essential in the construction of a bioethically oriented critical vision in such a domain. These factors are: the vulnerability of women in the obstetric field, the relationship between autonomy and informed consent with reference to obstetric violence, and the impact of medical racism in the obstetric field. Although they are extremely interconnected with each other, these factors will be treated separately below for the sole purpose of simplifying their analysis. The latter obviously does not claim to be exhaustive but is intended as a stimulus for both theoretical discussion and empirical research conducted in the field of bioethics.

4 From vulnerability to the vulnerabilization of women in the obstetric field

The condition of vulnerability in which women find themselves in the obstetric field seems to be an unavoidable starting point for everyday bioethics. However, this factor does not seem to have found adequate support in the literature on obstetric violence so far. This data clashes with the growing moral concern among bioethicists about vulnerability and the increasing attention towards this condition within applied ethics in the healthcare field, especially in the European context (Botrugno and Re 2020; Rendtorff 2022). Here, it is worth recalling that the notion of vulnerability represents a pillar of the Helsinki Declaration on the protection of human beings in biomedical research and has also been expressly included in the Declaration on Bioethics and Human Rights adopted by UNESCO in 2005 (see Art. 8).

Attempts to define vulnerability in bioethics are many and have given rise to a fervent debate, aimed at clarifying its contours, focusing on the factors that influence it and determining the role that individuals, institutions and society must assume in order to neutralize or mitigate its effects. Some scholars (Luna 2012) have questioned the very heuristic capacity of the concept of vulnerability, considered too broad and potentially ubiquitous. Conversely, others have criticized it as too narrow, since it would reduce vulnerability to a question of competence to give one's informed consent to research, thus flattening it on the evaluation of factors that can alter this capacity (Rogers et al. 2012, 15). According to some scholars (Rendtorff 2002), an individual is vulnerable when their autonomy, dignity and integrity are threatened. In this sense, vulnerability can be considered an ontological condition, one that arises from the intrinsic characteristics of our being in the world, therefore from the conditioning of our body and from the very finitude of the human being (O'Neill 1996, 192). The concept of vulnerability, however, is often

used by specialized literature to evoke a quid plus, that is, the fact that individuals are exposed to different risk factors and possess different resources to react to them.

The absence of a broader bioethical debate on the vulnerability of pregnant and birthing women seems due to the fact that this concept has often taken on a connotation of exploitation of the weakest. This finds concrete confirmation in two main respects: first, the vulnerability of participants in scientific research, a notion enshrined above all within the aforementioned Helsinki Declaration on biomedical research. The second concerns acts involving the disposition of one's body — situations in which an individual authorizes the donation or use of one's organs, or parts thereof, for the benefit of others. This is typically the case with surrogacy or organ donation. With reference to such acts, in fact, it is evident that, especially in the context of the so-called "developing" countries, the will of donors may be based more on potential economic need than on the actual determination to dispose of one's body.

This predilection of bioethics for a connotation of vulnerability in terms of potential exploitation has translated into the great influence acquired over time by the principle of autonomy, within a broader context that has elevated the theory of principles (Beauchamp and Childress 2001) to one of the most influential frameworks in bioethics and medical ethics in industrialized countries (Dawson 2006; Harris 2003). The unchallenged favor that this theory has enjoyed for a long time has led to the spread of a voluntary-contractualist vision, within which the individual — understood as an "autonomous agent" — asserts their "free will" through the expression of informed consent to the treatment that concerns them. As has been underlined (Demény 2016, 182), the predominance of this vision has led to a flattening of the complexity that inspires bioethics to a sort of checklist about compliance with some formal requirements (Botrugno 2021). On the other hand, the great influence acquired by this vision seems to be inextricably linked to the tendencies of commodification and medicalization (Evans et al. 2020; Botrugno 2020; Botrugno and Re 2020), whereby the individual is hyper-responsible for the choices relating to their own health and illness (I will deal with this more extensively in section 5).

This dimension of the vulnerability — that of exploitation of the weakest — is accompanied by another, which arises from the analysis of social inequalities and brings to the fore the issue of health justice. In this perspective, vulnerability is described as the level of exposure to a certain risk for the protection or maintenance of one's health (Flaskerud and Winslow 1998). In this sense, a "vulnerable population" is made up of those who, due to a series of social, economic, cultural factors, are unable to satisfy their needs in an adequate manner.

Both dimensions just described, however, do not seem to contribute in a decisive way to a bioethical reflection on the phenomenon of obstetric violence. For this reason, it is appropriate to distinguish three possible layers of vulnerability, which

overlap: inherent vulnerability, situational vulnerability, and pathogenic vulnerability (Rogers et al. 2012, 24). Inherent vulnerability refers to factors that are coessential to the human condition, starting from our embodied nature and the resulting range of physical and emotional needs, the latter deriving from our intrinsically social nature. Situational vulnerability, on the other hand, can be traced back to a specific context, as it arises from exposure to a series of social, cultural, political, and economic factors which can affect both the individual and a social group. This type of vulnerability engenders the moral imperative to provide support to those who are exposed to such factors, reducing their impact and, at the same time, adopting actions and measures that, as far as possible, place these subjects outside the condition of vulnerability (Rogers et al. 2012, 24). Finally, there is the vulnerability of a pathogenic nature, which occurs when exposure to the factors previously mentioned is ignored or not adequately countered and when paternalistic or even discriminatory actions and policies aggravate this condition, making it a sort of self-perpetuating vicious circle (Rogers et al. 2012, 24).

The behaviors classified above as attributable to the phenomenon of obstetric violence seem to be relevant for all the three layers of vulnerability. The vulnerability of pregnant and birthing women is in a way "inherent" to the condition of subordination in which women still find themselves today, across industrialized and non-industrialized societies (Brah 2006; Lima et al. 2021). The situational vulnerability is clearly linked to the situation of pregnant and birthing women, involving a necessary "reliance" on the care offered by others. In industrialized contexts, this is equivalent to dealing with care pathways that can be characterized by a high level of depersonalization and standardization. The woman's body is often exposed and deprived of its autonomy (Martín-Badia et al. 2021), which translates into a dehumanization of obstetric care (Ramallo-Castillo et al. 2024; Santana et al. 2024). Finally, pathogenic vulnerability emerges where situations of abuse and denial of rights — such as those attributable to obstetric violence — are completely ignored and "normalized" within the care routine, taking on the contours of "institutional violence" (Oliveira and Merces 2017; Matos et al. 2021).

These three levels of vulnerability are very clearly outlined in the work of Lima et al. (2021), who recall the process of passivization of women as a routine, "normal" element and qualify the failure to recognize the experience of pain and discomfort by birthing women as a "silencing strategy" (Lima et al. 2021, 4914):

> The hospital routine requires that women have docile behavior, in order to receive routine medical interventions without too many questions. One of the behaviors transmitted to women, in a hidden or obvious way, and which is evident from the phrase "Don't make a scene!," is that they must obey and collaborate. This is the imposed institutional logic: doctor/protagonist/unlimited power and birthing woman/cooperating role/limited power (Lima et al. 2021, 4914).

The combination of silencing and passivization seems to emerge as a characterizing element in the literature on obstetric violence (Oliveira and Merces 2017). Some authors note that "women remain silent in the face of pain to protect themselves from institutional violence, since it is assumed that if the woman remains silent during labor, she will be better assisted" (Matos et al. 2021, 5). In this regard, the passivization of birthing women also seems to be often attributable to a lack of awareness regarding their sexual and reproductive rights:

> In reality, women are unable to realize whether or not they suffered violent acts because they trust the caregivers, and also because of the very physical and emotional fragility that obstetric processes entail. They end up accepting procedures without any questioning, they do not express their desires, their doubts and they suffer in silence without even knowing they were violated (Jardim and Modena 2018, 9).

The growing attention to the topic of obstetric violence in recent years seems to have stimulated a greater awareness on the part of some women, as demonstrated by the rise of numerous movements and associations with the objective of making laboring women more aware of the possible problems related to pregnancy and childbirth. This new awareness could be problematic in a different sense, since some women could mistakenly believe that they have undergone obstetric violence due to the fact that they underestimate childbirth as a health intervention (see Re and Magneschi in this volume). Regardless of this, recalled findings highlight that women's vulnerability in the obstetric field, far from being an ontological condition, appears to be the outcome of processes that unfold along the three levels previously exposed — inherent, situational and pathogenic vulnerability — and which cause women to become structurally and institutionally vulnerabilized.

5 Obstetric violence, autonomy and informed consent

The vulnerabilization of women in the obstetric field is closely related to the intrinsic weakness of informed consent as a tool for the protection and guarantee of rights in the health field (Grady 2015; Cocanour 2017; Hagopian 2024) and especially in the obstetric field (Martín-Badia et al 2021; Kingma 2021; Jolly et al. 2019). A study that collected narrative testimonies from several midwives (Martín-Badia et al. 2021) highlighted that women's autonomy in the obstetric field is threatened by the inadequate consideration of the tool of informed consent. In this context, it was noted that:

> sometimes professionals have poor communication skills (it is not about providing long explanations, but about ensuring that women understand what they are told), they provide biased or manipulated information (in order to direct women's answers), and there is even a lack of information (Martín-Badia et al. 2021, 9).

Further testimonies from midwives (Newnham and Kirkham 2019) reveal that the health system is perceived by them as "sexist and paternalistic," one where professionals are often led to make decisions on behalf of patients.[1]

Bioethics has always been aware of the problems that affect the doctor-patient relationship in the health systems of industrialized countries. In particular, the negative repercussions of asymmetry in the care relationship have long been known (Cazzullo and Poterzio 2007; Osorio 2011), as well as the existence of different communication languages (Silverman 1987; Ha and Longnecker 2010; Dowrick 1997; Clark and Mishler 1992). These factors represent a serious obstacle to promoting an encounter between what can be considered the patient's "life world," with their suffering, meanings and the social context in which they are immersed, and the technical, standardized, highly bureaucratized and jargon-based knowledge system that the doctor is the bearer of. In addition to this, since the 1980s, an authoritative sociological and philosophical body of literature has highlighted — from extremely different theoretical perspectives — that what is established between doctor and patient can be considered in all respects a "power relationship" (Illich 1976; Szasz 2007; Conrad 2007; Foucault 1963; 1975; 1979). This helps to explain why patients often find themselves in a condition of subordination not only in their relationships with physicians but also, more generally, in finding their way through the intricacies of contemporary health systems (Donati 1984; Da Gama 2001).

These considerations are amplified when considering the subordinate condition often endured by women in the health systems of industrialized countries, where the female body appears more and more often "redefined" in a purely biological sense that tends to reduce it to an instrument of human reproduction (cf. Strazzeri et al. in this volume). Qualitative evidence shows that the care relationship in the obstetric field is often paternalistic, which implies that women, "seen as the fragile sex, need to be kept under patriarchal authority" (Jardim and Modena 2018, 3) and that birthgiving is increasingly understood as a "professional centered act and subject to violent practices" (Jardim and Modena 2018, 3). Asymmetry in the care relationship and abuse of medical authority towards women emerge as key elements in this testimony on routine obstetric practices in Brazilian healthcare:

1 See Fariello and Mitidieri; Re and Magneschi in this volume.

> Health professionals, clothed in their technical scientific authority and backed by unequal power relationships before female users, use authority to maintain obedience to rules, disrupting human interactions and leading to the weakening of links among their patients and the crisis of confidence in the care that is provided as such approach entails the loss of the woman's autonomy and her right to decide on matters related to her body (Jardim and Modena 2018, 2).

From a different point of view, the biologization of the female body is accompanied by a significant medicalization, that is, an extension of the medical gaze to every area of its functioning. The processes of technological innovation and the hyper-specialization of medical knowledge within modern health systems fuel the tendency to fragment the patients' bodies and to objectify medical categories (Botrugno 2020). These processes have the final effect of reinforcing a health imperative (Evans et al. 2020) within which the patient in general, and women in particular, are hyper-responsible for their choices in the health sector (Botrugno and Re 2020). This responsibility for the management of one's health — and possibly of one's illness — occurs through proactive adherence to a set of activities, benefits and services whose final effect is to question the conventional relationship between the use of traditionally understood healthcare and the care of one's personal well-being (Botrugno and Re 2020). This trend appears extremely controversial since it is carried out under the aegis of a greater empowerment of patient autonomy, a goal that is certainly laudable "on paper." However, attributing to the patient such a high degree of autonomy and agency often appears incompatible with the condition of suffering that typically accompanies the disease — sometimes even just the suspicion of being ill — or in any case the condition of those who are about to benefit from healthcare. This type of autonomy of individualistic-contractual inspiration characterizes the patient as an independent and self-sufficient being (Zwijsen et al. 2011), relegating to a secondary level the importance of social relationships and other factors that influence and condition individual autonomy, and therefore the adoption of certain choices in the healthcare field. In this regard, Martín-Badia et al. (2021, 9) underline that "Appropriately accompanying women during delivery means that authority should be, at least, shared by women and professionals."

In other words, respect for the patient's autonomy cannot be reduced only to respecting the patient's will — as could be the case from the perspective of an individualistic autonomy. Rather, it resides in processes of negotiation and co-construction of a will by the patient within which information, awareness and empathy play a fundamental role. It is no coincidence that in fields other than obstetrics, shared decision-making approaches (Faiman and Tariman 2019) and patient empowerment (Hagopian et al. 2024) represent coessential elements of medical practice. The excessive responsibility placed on the individual in the healthcare field risks causing the core of health protection to slip from the social level to that of personal

responsibility. This process can exacerbate the reductionism of the biomedical paradigm by transforming medical epistemology into an "epistemology of the individual" (Botrugno and Re 2020, 14).

6 Obstetric violence, racism and bioethics

A vast literature has shown that combating racism is a decisive factor in maintaining health levels and in the possibility of accessing adequate care. Today, racism and discrimination in healthcare are in fact considered to be social determinants of health and disease (Marmot 2015; Oppel et al. 2020). For example, empirical evidence relating to the Brazilian healthcare system reports very clear data in this regard:

> In Brazil, maternal mortality among Black women is approximately double that among white women. (...) An analysis of racial disparities in obstetric care observed that, compared to white women, women who identify as Black (...) have a higher risk of having fewer prenatal visits and of not having a companion [during childbirth]. Those who identify as Black, in addition to the previous risks, are more likely to report having no connection with the maternity hospital, making several travels to it and facing higher risks of not receiving local anesthesia during an episiotomy (Lima et al. 2021, 4911).

Racism is not a self-contained phenomenon, but feeds on and in turn it fuels other discriminatory phenomena, thus generating a "socio-pathogenic spiral" (Botrugno 2018) that further aggravates the vulnerability of the discriminated person. Studies that analyze the intersection between different factors of discrimination have crystallized starting from the theoretical work of Kimberly Crenshaw (2002) on intersectionality, which today represents a framework of reference for research in this area (Brah 2006; Lima et al. 2021). In this regard, Brah (2006) recalls how class structures, racism, gender and sexuality cannot be treated as "independent variables" because the oppression of each is inscribed in the other. Racism also appears to be a central element in the analysis of obstetric violence. It emerges very clearly in the literature from some contexts — especially Latin America, where miscegenation is particularly marked and the attention paid to this theme is certainly greater than elsewhere (e.g. Jardim and Modena 2018; Lima et al. 2021; Santana et al. 2024). However, it cannot be excluded that even where obstetric violence is less investigated or traced back to expressions of abuse or mistreatment, racism can have a decisive impact.

The point of convergence of the literature that has worked on the connections between between racism and obstetric violence is very clear: the risk of encountering obstetric violence is greater for Black women (Lima et al. 2021, 4910) or in

any case for groups of women who can be considered more vulnerable (Jardim and Modena 2018). Among these are: "those belonging to ethnic minorities, adolescents, poor, with low school education, drug users, homeless women, women without prenatal care, and without companion at the time of care" (Jardim and Modena 2018, 8). For example, the study by Lima et al. (2021) in the Brazilian context reports that:

> When analyzing the percentages of women who reported verbal, physical or psychological violence during childbirth, these were higher among Black women, those with a lower level of education, those aged 20 to 34 and those from the Northeast. In the postpartum period, Black women are more vulnerable to the risk of infection at the surgical site after a cesarean section, a condition closely related to the poor quality of postpartum care (Lima et al. 2021, 4911).

In the perspective adopted by these authors, the greater exposure of Black women to the phenomenon of obstetric violence can be traced to the highly asymmetric relationship between patient and doctor (Lima et al. 2021, 4913), which — in line with what was described in the previous section — must be considered as a knowledge-power relationship. Within it, "formal and expert knowledge occupies a privileged place, thus giving rise to a hierarchy of knowledge" (Lima et al. 2021, 4913). The asymmetry in the relationship worsens to the extent that further factors of discrimination are added to this hierarchy, such as race, social class, economic conditions: "In these encounters, when 'the patient' is a Black woman, this asymmetry is reinforced not only by the mechanisms of gender oppression, but also by race" (Lima et al. 2021, 4913).

One of the major contributions to the study of the relationship between obstetric violence and racism is certainly that of the US anthropologist Dana-Ain Davis (2019). As she states, "While obstetric violence is a potent analytic to understand how abuse is experienced at any time during maternal healthcare processes, it does not adequately take into account the contours of racism that materialize during Black women's medical encounters" (Davis 2019, 2). First, Davis's work is useful for highlighting historical evidence showing how the Black female body has been surrounded by racist prejudices and stereotypes (e.g. Berry 2017; Cooper Owens 2017; Wilkie 2003; Hoberman 2012). As Davis effectively points out, in fact "Medical racism is woven into the historical narrative of reproduction, gynecological, and obstetric practices in which Black women's bodies have been valued as 'medical superbodies'" (Davis 2019, 2). Davis then coins the expression "obstetric racism" as a phenomenon at the intersection between medical racism and obstetric violence, and identifies seven possible dimensions where it manifests itself: diagnostic errors; negligence, indifference or disrespect; intentionally causing pain; coercion; degradation ceremonies; and medical abuse (Davis 2019).

The "folk" characterization of the Black woman's body has proven to be functional to the perpetration of abuse not only in everyday healthcare, but also in biomedical experimentation, as it was considered "immune" to pain, therefore susceptible to being subjected to surgery even in the absence of anesthesia (Santana et al. 2024, 6). In this regard, Santana et al (2024) recall:

> It is important to understand that much of the medical knowledge in obstetrics acquired and still practiced today was developed from the experience with poor or slave women of the time. A well-known example is the American doctor James Marion Sims, considered the "father of modern gynecology." Sims performed surgery on women without anesthesia, because, according to him, Black women had an unusual physiological tolerance to pain. The myth according to which Black women were resistant to pain arises from these experiences of cruel and inhuman interventions. This theory is still used today to refute the existence of abusive and violent behaviors in the care of Black women during childbirth (Santana et al. 2024, 6).

7 Conclusions

In this work, I have tried to sketch an overview of the phenomenon of obstetric violence from the lens of bioethics, and in particular from the perspective of the everyday bioethics. This reflection takes on particular importance in light of the fact that, so far, the community of bioethics scholars has shown substantial disinterest in the topic of obstetric violence. I have highlighted three key elements, intended as a starting point for a reflection that will hopefully assume greater scope and depth. First, I reinterpreted the condition of vulnerability of women in the obstetric field as a process, avoiding a notion of ontological vulnerability to underscore the social, historical and epistemic factors that contribute to the passivization of women, thereby exposing them to the risk of obstetric violence. Second, I have discussed the topic of women's autonomy in the obstetric field starting from informed consent and their fragility as a tool for the protection of rights in healthcare. Finally, I have analyzed medical racism as a fertile ground for the proliferation of behaviors associated with obstetric violence — a phenomenon that is particularly marked in some contexts, whose roots lie in colonial history and the exploitation of some social groups for the benefit of others.

Obstetric violence represents a concrete threat to the reproductive health of women and the wellbeing of their children, a threat that is aggravated in the case of racialized or particularly vulnerable groups. For this reason, developing greater knowledge and combating the phenomenon of obstetric violence becomes an unavoidable ethical imperative. An everyday bioethics perspective for obstetric violence such as the one I have tried to outline here cannot consider this phenomenon

merely as an epidemiological-health issue. Rather, obstetric violence must be understood as an expression of oppression and exploitation, or a question of social injustice of a global scale. This means that obstetric violence should be considered one of the areas in which bioethics more actively engage — not only to gather valuable knowledge, but above all to use the latter to tacking this phenomenon. As already anticipated in the introduction, this knowledge is indeed fundamental to re-orient organizational practices in everyday life, so that the healthcare policies, the organization of healthcare systems and the actions of health professionals are respectful of the principles and moral values underlying the protection of women in childbirth, and of women more generally. This objective can be certainly achieved by building on the awareness that has emerged across some disciplines, yet without the in-depth involvement of the community of bioethics scholars.

References

Beauchamp, Tom L., and James F. Childress. 2001. *Principles of Biomedical Ethics.* Oxford: Oxford University Press.

Berlinguer, Giovanni. 2000. *Bioetica quotidiana.* Firenze: Giunti.

Berlinguer, Giovanni. 2003. *Everyday Bioethics: Reflections on Bioethical Choices.* New York: Baywood Publisher.

Berry, Daina R. 2017. *Their Price for Their Pound of Flesh: The Value of the Enslaved from Womb to Grave in the Building of a Nation.* Boston, MA: Beacon Press.

Borry, Pascal, Paul Schotsmans, and Kris Dierickx. 2005. "The Birth of the Empirical Turn in Bioethics". *Bioethics* 19: 49-71.

Botrugno, Carlo. 2018. "Healthcare, migrations and everyday bioethics: Weighing the difference". *L'altro Diritto* 1 (2): 91–118.

Botrugno, Carlo. 2019. "Diritto alla salute e migrazioni internazionali: per una bioetica in azione". *Jura Gentium* 16 (2): 102–126.

Botrugno, Carlo. 2020. "Innovazione tecnologica in salute e commodification: verso un nuovo dovere di protezione dell'individuo?". *Jura Gentium* 17 (1): 140–167.

Botrugno, Carlo. 2021. "Information technologies in healthcare: Towards a new geography of right to health". *Italian Journal of Legal Philosophy* 1: 163–188.

Botrugno, Carlo, and Lucia Re. 2020. "Homo Medicus e Commodification: una prospettiva bioetica?". *Jura Gentium* 17 (1): 7–28.

Botrugno, Carlo. 2023a. "The racial epistemicide of bioethics". In *Bioethics and Racism: Practices, Conflicts, Negotiations and Struggles*, edited by Carlo Botrugno, Marcia Mocellin Raymundo, and Lucia Re. Berlin: De Gruyter.

Botrugno, Carlo. 2023b: "Bioetica ed etnografia: note riflessive sui dilemmi etico-metodologici nella conduzione di ricerca in ambito medico-sanitario". *Ragion Pratica* 1: 205–218.

Brah, Avtar. 2006. "Diferença, diversidade, diferenciação." *Cadernos Pagu* 26: 329–376.

Castrillo, Belen. 2016. "Tell me by whom is defined and I'll tell if it is violent: a reflection on obstetric violence". *Sexualidad, Salud y Sociedad* 24: 43–68.

Cazzullo, Carlo, and Franco Poterzio. 2007. *Paziente e medico: fenomenologia e prassi della relazione terapeutica.* Rome: Edizioni internazionali.

CEDAW 1979. "Resolution no. 34/180." 18 December. https://www.ohchr.org/sites/default/files/cedaw.pdf (last accessed September 22, 2025).

CFM [Conselho Federal de Medicina] 2019. "CFM apoia MS em decisão sobre o termo violência obstétrica". 9 May. https://portal.cfm.org.br/noticias/cfm-apoia-ms-em-decisao-sobre-o-termo-violencia-obstetrica (last accessed September 22, 2025).

Clark Jack A., and Elliot G. Mishler. 1992. "Attending to patients' stories: referencing the clinical task". *Sociology of Health and Illness* 14: 344–372.

Cocanour, Christine S. 2017. "Informed consent. It's more than a signature on a piece of paper". *American Journal of Surgery* 214 (6): 993–997.

Conrad, Peter. 2007. *The Medicalization of Society*. Baltimore, MD: The Johns Hopkins University Press.

Cooper Owens, Deirdre. 2017. *Medical Bondage: Race, Gender, and the Origins of American Gynecology.* Athens, GA: University of Georgia Press.

Crenshaw, Kimberly. 2002. "Documento para o encontro de especialistas em aspectos da discriminação racial relativos ao gênero". *Estud Fem* 10 (1): 171–188.

Cunha, Thiago, and Cláudio Lorenzo. 2014. "Bioética global na perspectva da bioétca crítica". *Revista Bioética* 22 (1): 116–125.

Da Gama, A. Dinis. 2001. "La crise de la medicine contemporaine ou la second mort d'Hyppocrate". *Journal des Maladies Vasculaires* 5 (26): 287–289.

Davis, Dana-Ain. 2019. "Obstetric racism: the racial politics of pregnancy, labor, and birthing". *Medical Anthropology* 38 (7): 560–573.

Dawson, Aangus, and Eve Garrard. 2006. "In defence of moral imperialism: Four equal and universal prima facie principles". *Journal of Medical Ethics* 32 (4): 200–204.

De Lopez, Verges Claude, Delia Sánchez, Volnei Garrafa, and Andrea Peralta-Corneille. 2016. "The Impact of the UNESCO International Bioethics Committee on Latin America: Respect for Cultural Diversity and Pluralism". In *Global Bioethics: The Impact of the UNESCO International Bioethics Committee. Advancing Global Bioethics*, edited by Alireza Bagheri, Jonathan D. Moreno, Stefano Semplici. Cham: Springer.

Demény, Enikő. 2016. "The principle of vulnerability and its potential applications in bioethics". I *Ethics & Bioethics (in Central Europe)* 6 (3/4): 181–186.

Donati, Paolo. 1984. "Le trasformazioni del rapporto comunicativo nella relazione interpersonale medico-paziente". *Rassegna Italiana di Sociologia* 4: 547–571.

Dowrick, Christopher. 1997. "Rethinking the doctor-patient relationship in general practice". *Health and Social Care in the Community* 5: 11–14.

Evans, Adrienne, Sarah Riley and Martine Robson. 2020. "Postfeminist healthism: Pregnant with anxiety in the time of contradiction". *Jura Gentium* 17 (1): 95–118.

FAME [Federación de Asociaciones de Matronas de España]. 2021. "Manifiesto FAME contra la violencia obstétrica en España". 19 July. https://matronasextremadura.org/manifiesto-fame-contra-la-violencia-obstetrica-en-espana/ (last accessed September 22, 2025).

Flaskerud, Jacquelyn H., and Betty J. Winslow. 1998. "Conceptualizing vulnerable population's health-related research". *Nursing Research* 47 (2): 69–78.

Foucault, Michel. 1963. *Naissance de la Clinique: Une Archéologie du Regard Médical.* Paris: Presses Universitaires de France.

Foucault, Michel. 1975. *Surveiller et punir. Naissance de la prison.* Paris: Gallimard.

Foucault, Michel. 1979. *Naissance de la biopolitique.* Paris: Hautes Etudes Seuil.

García, Alarcón, and Rodrigo Hernán. 2012. “A bioética na perspectiva latino-americana, sua relação com os direitos humanos e a formação da consciência social de futuros profissionais”. *Revista Latinoamericana de Bioética* 12 (2): 44–51.

Garcia, Lorraine M. 2024. “Obstetric violence in the United States and other high-income countries: an integrative review”. *Sexual and Reproductive Health Matters* 31 (1): 1–26.

Grady, Christine. 2015. “Enduring and emerging challenges of informed consent”. *New England Journal of Medicine* 372 (9): 855–862.

Ha, Fong J. and Nancy Longnecker. 2010. “Doctor-patient communication. A review”. *The Ochsner Journa*l 10. Pp. 38-43.

Hagopian, Chelsea O. P. 2024. “From informed to empowered consent”. *Nursing Philosophy* 25 (1): e12475.

Haimes, Erica. 2002. “What can the social sciences contribute to the study of ethics? Theoretical, empirical and substantive considerations”. *Bioethics* 16 (2): 89–113.

Hall, Budd L., and Rajesh Tandon. 2017. “Decolonization of knowledge, epistemicide, participatory research and higher education”. *Research for All* 1 (1): 6–19.

Harris, John. 2003. “In praise of unprincipled ethics”. *Journal of Medical Ethics* 29 (5): 303–306.

Hedgecoe, Adam M. 2004. “Critical bioethics: Beyond the social science critique of applied ethics”. *Bioethics* 18 (2): 120–143.

Hoberman, John. 2012. *Black and Blue: The Origins and Consequences of Medical Racism.* Berkeley, CA: University of California Press.

Hurst, Samia. 2010. “What ‘Empirical turn in bioethics’?”. *Bioethics* 24 (8): 439–444.

Illich, Ivan. 1976. *Medical Nemesis: The Expropriation of Health.* New York: Pantheon.

Jardim, Danúbia Mariane Barbosa, and Celina Maria Modena. 2018. “Obstetric violence in the daily routine of care and its characteristics”. *Revista LatinoAmericana de Enfermagem* 26: e3069.

Jolly, Yasmin, Mamuda Aminu, Florence Mgawadere, Nynke van den Broek. 2019. “‘We are the ones who should make the decision’. Knowledge and understanding of the rights-based approach to maternity care among women and healthcare providers”. *BMC Pregnancy Childbirth* 19: 42–49.

Kingma, Elselijn. 2021. “Harming one to benefit another: The paradox of autonomy and consent in maternity care”. *Bioethics* 35: 456–464.

Leal, Maria do C., Ana Paula Esteves Pereira, Rosa Maria Soares Madeira Domingues, Mariza Miranda Theme Filha, Marcos Augusto Bastos Dias, Marcos Nakamura-Pereira, Maria Helena Bastos, Silvana Granado Nogueira da Gama. 2014. “Intervenções obstétricas durante o trabalho de parto e parto em mulheres brasileiras de risco habitual”. *Cadernos de Saúde Pública* 30: S17–S47.

Leite, Tatiana H., Emanuele Souza Marques, Rachel Geber Corrêa, Maria do Carmo Leal, Bheatriz da Costa Diniz Olegário, Rafaelle Mendes da Costa, Marilia Arndt Mesenburg 2024. “Epidemiologia da violência obstétrica: uma revisão narrativa do contexto brasileiro”. *Ciência & Saúde Coletiva* 29: e12222023.

Lima, Kelly Diogo de, Camila Pimentel, and Tereza Maciel Lyra. 2021. “Disparidades raciais: uma análise da violência obstétrica em mulheres negras”. *Ciência & Saúde Coletiva* 26 (Supl. 3): 4909–4918.

Lorenzo, Cláudio, and Volnei Garrafa. 2011. “Ensayos clínicos, Estado y sociedad: ¿dónde termina la ciencia y empieza el negocio?”. *Salud Colectiva* 7 (2): 166–170.

Luna, Florencia. 2012. “Elucidating the concept of vulnerability: Layers, not labels”. *International Journal for Feminist Approaches to Bioethics* 2 (1): 121–39.

Marmot, Michael. 2015. *The Health Gap. The Challenge of An Unequal World.* London: Bloomsbury.

Martín-Badia, Júlia, Obregón-Gutiérrez, Noemí, and Goberna-Tricas, Josefina. 2021. “Obstetric Violence as an Infringement on Basic Bioethical Principles. Reflections inspired by focus groups with midwives”. *International Journal of environmental research and public health* 18 (23): 12553.

Martínez-Galiano, Juan-Miguel, Julián Rodríguez-Almagro, Ana Rubio-Álvarez, Inmaculada Ortiz-Esquinas, Ana Ballesta-Castillejos, and Antonio Hernández-Martínez. 2023. "Obstetric Violence from a Midwife Perspective". In: *Int. J. Environ. Res. Public Health* 20, 4930.

Massó-Guijarro, Ester. 2023. "La violencia obstétrica como injusticia epistémica: el parto en disputa". *Salud Colectiva* 19: e4464.

Matos, M. Gouvea de, Andrea Seixas Magalhães, and Terezinha Féres-Carneiro. 2021. "Violência Obstétrica e Trauma no Parto: O Relato das Mães". *Psicologia: Ciência e Profissã*o 41: e219616.

MPF [Ministério Público Federal]. 2019. "MPF recomenda ao Ministério da Saúde que atue contra a violência obstétrica em vez de proibir o uso do termo". 10 July. https://www.mpf.mp.br/sp/sala-de-imprensa/noticias-sp/apos-recomendacao-do-mpf-sp-ministerio-da-saude-reconhece-liberdade-do-uso-do-termo-violencia-obstetrica (last accessed September 22, 2025).

Musschenga, Albert W. 2005. "Empirical Ethics, Context-Sensitivity, and Contextualism". *Journal of Medicine & Philosophy* 30 (5): 467–490.

Myser, Catherine. 2003. "Differences from Somewhere: The Normativity of Whiteness in Bioethics in the United States". *AJOB* 3 (2): 1–11.

Nelson, James L. 2000. "Moral teachings from unexpected quarters. Lessons for bioethics from the social sciences and managed care". *The Hastings Center Report* 30 (1): 12–17.

Newnham, Elisabeth and Mavis Kirkham. 2019. "Beyond autonomy: Care ethics for midwifery and the humanization of birth". *Nursing Ethics* 26: 2147–2157.

O'Neill, Onora. 1996. *Towards Justice and Virtue.* New York: Cambridge University Press.

Oliveira, Mayra de Castro and Magno Conceição das Merces. 2017. "Percepções sobre violências obstétricas na ótica de puérperas". *Revista de Enfermagem UFPE on-line* 11 (6): 2483–2489.

Oppel, Richard A. Jr., Robert Gebeloff, Rebecca K. K. Lai, Will Wright, and Mitch Smith. 2020. "The Fullest Look Yet at the Racial Inequity of Coronavirus". *New York Times*, 05 July. https://www.nytimes.com/interactive/2020/07/05/us/coronavirus-latinos-african-americans-cdc-data.html (last accessed September 22, 2025).

Osorio, Juan H. 2011. "Evolution and changes in the physician-patient relationship". *Colombia Médica* 42 (3): 400–405.

Pasche, Dário Frederico, Maria Esther de Albuquerque Vilela, Cátia Paranhos Martins. 2010. "Humanização da atenção ao parto e nascimento no Brasil: pressuposto para uma nova ética na gestão e no cuidado". *Revista Tempus Actas Saúde Coletiva* 4 (4): 105–117.

Perez, Emilia B. 2022. "Nacer en casa. Una reflexión sobre bioética y derechos humanos". *Cuadernos de Bioética* 33 (107): 67–86.

Ramallo-Castillo, Rocio M., Manuel Lozano Vidal, Isabel Durán Castellanos, Isabel Corrales Gutiérrez. 2024. "Violencia obstétrica, una visión actual. Definición, percepción por parte de profesionales y propuestas de mejora. Revisión narrativa". In *Ginecol Obstet Mex* 92 (2): 85–96.

Raymundo, Marcia Mocellin and Claudio Lorenzo. 2023. "The whiteness of bioethics and racism in healthcare". In *Bioethics and Racism. Practices, Conflicts, Negotiations and Struggles*, edited by Carlo Botrugno, Marcia Mocellin Raymundo and Lucia Re. Berlin: De Gruyter.

Rendtorff, Jacob D. 2002. "Basic Ethical Principles in European Bioethics and Biolaw: Autonomy, Dignity, Integrity and Vulnerability". *Medicine, Health Care and Philosophy* 5 (3): 235–244.

Rogers, Wend, Catriona Mackenzie, Susan Dodds. 2012. "Why Bioethics Needs a Concept of Vulnerability". *International Journal for Feminist Approaches to Bioethics* 5 (2): 11–38.

Santana, A. de Teixeira, Telmara Menezes Couto, Keury Thaisana Rodrigues dos Santos Lima, Patricia Santos de Oliveira, Aiara Nascimento Amaral Bomfim, Lilian Conceição Guimarães Almeida, Lúcia Cristina Santos Rusmando. 2024. "Racismo obstétrico, um debate em construção no Brasil: percepções de mulheres negras sobre a violência obstétrica". *Ciência & Saúde Coletiva* 29 (9): 1–8.

Silverman, David. 1987. *Communication and Medical Practice: Social Relations in the Clinic.* London: Sage.
Simpson, Madeleine and Christine Catling. 2016. “Understanding psychological traumatic birth experiences: A literature review”. *Women and Birth* 29 (3): 203–207.
Szasz, Thomas. 2007. *The Medicalization of Everyday Life.* Syracuse, NY: Syracuse University Press.
Turner, Leigh. 2004. “Bioethics needs to rethink its agenda”. *British Medical Journal* 328 (7432): 175.
Turner, Leigh. 2005. “Bioethics, Social Class, and the Sociological Imagination”. *Cambridge Quarterly of Healthcare Ethics* 14: 374–378.
Vacaflor, Carlos H. 2016. “Obstetric violence: a new framework for identifying challenges to maternal healthcare in Argentina”. *Reproduction Health Matters* 24 (47): 65–73.
UN Agenda 2030. “Sustainable Development Goals.” https://unosd.un.org/content/sustainable-development-goals-sdgs (last accessed September 22, 2025).
WHO 2014. “The prevention and elimination of disrespect and abuse during facility-based childbirth.” https://iris.who.int/bitstream/handle/10665/134588/WHO_RHR_14.23_eng.pdf (last accessed September 22, 2025).
WHO 2018. “Intrapartum care for a positive childbirth experience.” https://www.who.in t/reproductive-ehealth/publications/intrapartum-care-guidelines/en/ (last accessed September 22, 2025).
Wilkie, Laurie A. 2003. *The Archaeology of Mothering: An African-American Midwife’s Tale.* New York: Routledge.
Zanardo, G. Lemos de Pinho, Magaly Calderón Uribe, Ana Hertzog Ramos De Nadal, and Luísa Fernanda Habigzang. 2017. “Violência obstétrica no Brasil: uma revisão narrativa”. *Psicologia & Sociedade* 29: e155043.
Zwijsen, Sandra A. 2011. “Ethics of using assistive technology in the care for community-dwelling elderly people: An overview of the literature”. *Aging & Mental Health* 15: 419–427.

Ester Massó Guijarro

Decolonizing Bioethics, Feminizing Public Health: Obstetric Violence as Epistemic Injustice

> Many women around the world experience disrespectful, abusive, or neglectful treatment during childbirth.
> —*WHO 2014*

Abstract: This chapter critically examines obstetric violence through the lens of epistemic injustice, situating its analysis within decolonial, feminist, and narrative bioethics frameworks. Drawing on a qualitative systematic literature review and phenomenological reflection, I explore the evolution of legal and social responses — from Venezuela's pioneering 2007 legislation to emerging Spanish laws — and highlight the ontological debates surrounding the concept's naming. A central focus is the interplay between testimonial and hermeneutical injustice, as articulated by Miranda Fricker, and the embodied experiences of birthing women, particularly in the work of Sara Cohen Shabot. The chapter argues for retaining the term "obstetric violence" as an insurgent, insurrectionary concept that simultaneously describes and condemns systemic harm. It concludes by advocating a decolonized, intersectional, and feminist public health paradigm that integrates bioethical theory with transformative praxis.

1 Introduction: the interregnum of obstetric violence

> The crisis consists precisely in the fact that the old is dying and the new cannot be born; in this interregnum a great variety of morbid symptoms appear.
> —*Gramsci 1999, 556*

In 2007, Venezuela made a bold global statement by passing the world's first law against obstetric violence.

All fiction is a foundation. Legal cartographies are also cognitive fictions, first and foremost, like any construct aimed at human emancipation. This chapter seeks,

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among other things, to offer a critical reflection on how this vast and necessary fiction has increasingly become an epistemic tool and a critical banner — a true barricade founded in the empirical reality of countless subaltern subjects (birthing and postpartum women) across the world, and how, through it, a new reality has been founded. Yet we remain within the interregnum so aptly described by Gramsci as typical of times of crisis: a time when we need to call out the denialism of obstetric violence and when work like this, alongside the efforts of many others, is still urgently needed.

Venezuela issued this bold challenge in 2007 (Pérez D'Gregorio 2010). The challenge was directed at the world — the world of women, mothers, Popper's world of life, obstetrics (among others), and philosophy.

Following Venezuela, a string of Latin American countries began to develop and implement laws against obstetric violence, through a truly pioneering process that deserves genuine recognition. A new world had been born, though still in embryonic form within the old one that had yet to die. This is why we turn here to the interregnum of obstetric violence, both as a hermeneutic concept and as a political critique.

Obstetric violence is not only a political issue; it is also about naming — about the labels we assign to things (realities, phenomena) and, consequently, how we come to recognize them. It is, among other things, tied to the epistemic-political capital of rights-bearing individuals — a central concern of this research.

Fortunately, there is now a growing body of research, emerging from diverse fields and perspectives, on obstetric violence. It is clear that this has become a contested concept in contemporary discourse. More recently, efforts have begun to frame it within the lens of epistemic injustice, where it is increasingly seen as a paradigmatic case. This chapter centers on that connection, recognizing that, although still a relatively new area of inquiry, the analysis of violence as epistemic injustice already includes significant contributions. The connection between these two concepts is, in my view, powerfully intuitive: the union of these theoretical terms — each controversial in its own right — seemed inevitable. One is insurgent in nature; the other, widely successful and applied across various fields.

My work, then, delves into the connection between these two concepts — applying the lens of epistemic injustice to the pervasive problem of obstetric violence, with all its conceptual and practical controversies. It aims to construct a multifaceted perspective on this contested notion and, above all, on the interregnum in which it currently resides. In this effort, I argue that a critical hermeneutic engagement with the concept of epistemic injustice, particularly through the lens of feminist phenomenological philosophy, is essential, and, in my view, among the most illuminating approaches developed to date.

Finally, I want to assert the importance of framing this analysis of obstetric violence within the domain of bioethics (specifically, from the standpoint of critical bioethics, which will be advocated throughout this work). If we understand bioethics as "a multidisciplinary epistemological field focused on reconciling biological knowledge with human values" (Petra et al. 2024, 1), then the moral and political concern over the harm caused by obstetric violence is, without question, inextricably linked to what biological knowledge has revealed to us. For this reason, it is also crucial to work toward the integration of these domains of knowledge, actively moving away from false epistemic dichotomies and harmful political polarizations.

This chapter aims to explore these issues through the following structure: after this general introduction, the next section outlines the theoretical and epistemological framework, situating these reflections within a narrative bioethics that is critical, intersectional, feminist, and ultimately decolonial. The subsequent section addresses the concept of obstetric violence itself, with particular emphasis on its manifestations in Spain. The final section examines the relationship between obstetric violence and epistemic injustice, approached through the lens of feminist phenomenology. The chapter concludes with reflective remarks and a list of references.

2 Theoretical-epistemological framework: narrative, decolonial, and intersectional bioethics for feminist public health

This chapter is grounded in two key approaches: narrative bioethics at the methodological level, and decolonial bioethics — or rather, the imperative to decolonize bioethics — at the epistemological level, approached through an intersectional and feminist lens. This perspective necessarily implies a commitment to feminist public health. For greater clarity, the discussion is divided into two sub-sections.

2.1 The value of narrative and (auto)ethnography in narrative bioethics

With regard to narrative bioethics, this is understood within the broader narrative paradigm as part of "a group of ethical approaches that explore the potential of narrated experience, imaginative capacity, and interpretive contexts" (Domingo and Feito 2020, 1). This framework emphasizes a distinctly Latin American perspective (Manchola-Castillo 2014), recognizing the region's central role in confronting obs-

tetric violence and advancing the decolonial turn in bioethics. This perspective is also informed by the philosophy of narration developed by contemporary feminist thinker Adriana Cavarero (1997).

These perspectives are central and foundational to my broader research on childbirth, which is developed through a philosophical, anthropological, and ethnographic lens. They also form the experiential groundwork of this chapter, which, while constituting an independent and autonomous piece, is primarily analytical and phenomenological in nature. Within this ethnographic approach (as will become clear, ethnography is often the preferred method in many of the studies cited here), autoethnography has also been a crucial research method in my work. Since 2008, as both a lactivist mother of two and a researcher, I have been continuously engaged in participant observation across a range of formal and informal groups, as well as in various social and academic settings related to experiences of matriactivism.

This approach is supported by the work of other scholars in high-impact journals who also draw upon their autobiographical experiences in a self-consciously autoethnographic mode — Sara Cohen Shabot being a paradigmatic example. This falls within what is often referred to as militant research — one of many ways to name the intertwining of the personal (including the embodied and the sexual) with the political, and, above all, its increasing legitimation within academic contexts.

But why, ultimately, is it so important to pay attention to — and to decolonize — narrative in this context? Because it entails recognizing, on epistemic, practical, and political levels, the narratives of women — of birthing women — that have so often been denied, silenced, and marginalized. This is the core epistemological intersection between obstetric violence and epistemic injustice, which will be explored in greater depth in the final section. This is why, as I will argue next, a feminist perspective is essential: it urges us to listen to both women and ourselves. Equally important is the decolonial perspective, which compels us to listen to, and unearth, even those narratives that have been silenced and discredited often as a result of complex forms of discrimination (related to gender, class, and race), as intersectionality reminds us.

Methodologically, this chapter is based on a qualitative systematic literature review, complemented by classical phenomenological-philosophical reflection, aimed at generating grounded theory. The primary research was conducted using the Web of Science and Scopus databases, alongside academic platforms such as Academia.edu, ResearchGate, and Google Scholar. For the specific section that examines the intersection of obstetric violence and epistemic injustice, the key search terms were precisely those — *obstetric violence* and *epistemic injustice* — in both Spanish and English. The aim was not to exhaustively review each term indepen-

dently, given the vast body of literature each already entails, but rather to focus on their intersection. As is customary in my work, grey literature and netnography have also served as valuable sources of knowledge and insight.

2.2 Decolonizing, feminizing…and intersectionalizing bioethics

Why, in this context, do I consider it relevant to decolonize bioethics (or engage in its decolonial turn), to feminize it (from the perspective of feminist public health), or to apply an intersectional lens to it? Because each of these approaches serves as a sharp analytical tool and a critical, revisionist framework that compels us to consider silenced narratives and unrecognized forms of oppression, especially the stories of women concerning their experiences with the medical field related to reproduction, and therefore gynecological and obstetric care.

Both the lens of intersectionality and that of decoloniality — or the decolonial turn — are useful in refining and strengthening the bioethical perspective applied here. Like any field of knowledge, bioethics is not exempt from sociopolitical dimensions that must be critically examined. Authors such as Petra et al. (2024) already employ an intersectional approach — more specifically, one grounded in "anti-oppressive, anticapitalist, feminist, and antiracist perspectives," focused on sexual and reproductive rights.

Some works and approaches bring these frameworks — decoloniality and intersectionality — together. A growing number of scholars challenge the deeply embedded Western-centric foundations of bioethics as a discipline, rooted in its post–World War II origins in North America. Latin America stands out notably for its leading role in the most critical reflections on bioethics from decolonial and intersectional perspectives, just as it does in developing legislation addressing obstetric violence. What follows is a brief critical narrative review from within these frameworks.

The prominent role of Latin America in decolonial bioethics is hardly surprising, given the region's foundational contributions to the very concepts of "coloniality" and "decoloniality." Beyond the well-established roots of postcolonial thought in this area, and even further back, one must acknowledge the (often overlooked) intellectual debt to Frankfurt School thought and Critical Theory. Indeed, Lorenzo et al. (2024) explicitly synthesize Frankfurt School philosophy with decolonial studies to ground what they term a *critical decolonial bioethics* — a framework that underpins my own reflections.

This chapter is situated, following the established distinction outlined by Lorenzo et al. (2024), within both *empirical* bioethics (which draws on the social sciences to strengthen ethical analysis) and *critical* bioethics, which not only employs

research methods but is also grounded in established social theories. The latter seeks greater epistemological depth and aims to overcome the decontextualization that characterizes many classical approaches.

Traditional approaches in bioethics are thus being questioned from multiple critical perspectives. Scholars have pointed out that these traditions often rest on "abstract ideals of impartiality, universal citizenship, and absolute autonomy" and stress the need to confront them with "situated knowledge and the recognition of the matrix of intersectional domination" (Ortúzar and Rodríguez 2024, 1). What is being called for is a critical, intersectional bioethics — one that is representative and participatory, promotes care and relational autonomy, and actively works to overcome the repeated patterns of epistemic injustice.

Flor do Nascimento and Garrafa (2010) go as far as to advocate for an Intervention Bioethics (IB), aimed at ethically and practically politicizing the way we engage with bio-techno-scientific, health, social, and environmental conflicts. Similarly, Oliveira et al. (2017) explicitly propose a decolonial perspective on bioethics as part of the broader expansion of Latin American epistemic, political, and aesthetic projects, beyond Eurocentric hegemonic frameworks. They challenge the legitimization of epistemicide and call for bioethical pluralism as a path toward other ways of thinking.

Martínez Dueñas (2023) also raises the question of whether a decolonial intercultural bioethics is possible. Along these lines, Fayemi and Macaulay-Adeyelure (2016) question whether the export of bioethics, in its fully Western form, to non-Western developing states may constitute a case of ethical imperialism or bioethical neocolonialism. This issue is particularly relevant in sub-Saharan Africa, where their work is focused. They ultimately argue that the dominant trend in bioethics across the region amounts to an unintended imperialist project — more a structural consequence than a deliberate effort. As such, they advocate for an urgent decolonizing trajectory for bioethics in Africa: one that supports a "bioethics in Africa," rather than simply an "African bioethics."

Salamanca (2015) argues that the decolonial project, the *Buen Vivir* framework, and bioethics each contribute meaningfully to addressing contemporary issues rooted in the legacy of modernity — such as power relations, poverty, environmental degradation, consumerism, the sense of community, the struggle for survival, and other equally or even more pressing challenges. He contends that these issues can be approached and reimagined in a dialogical and complementary way through the perspectives and contributions of these three fields. Yáñez (2017) also explores the articulation between biopolitics and coloniality in the context of Latin American bioethics.

As for intersectionality itself, Brünig et al. (2024) have conducted an insightful systematic review of how this "itinerant" concept has become central in bioethical

research. They show how its epistemic use — as a form of critical praxis — supports key functions such as revealing health inequities, improving data collection, and fostering reflexivity, thereby enhancing the relevance of research outcomes for the communities involved.

Finally, Couto et al. (2019) present a valuable review of the current state of theoretical and methodological integration of intersectionality in public health, highlighting it as a promising analytical tool for understanding and addressing the global challenge of health inequalities. At the same time, many scholars stress the need to reconceptualize public health — so closely tied to bioethics — through a distinctly feminist lens. This call for a feminist public health perspective will be revisited in the conclusion, as part of a broader argument for placing the fight against obstetric violence at the center of the international public health agenda.

3 Obstetric violence: a brief overview and the situation in Spain

3.1 Names, laws, and beyond

In 2020, the United Nations Committee on the Elimination of Discrimination against Women (CEDAW) condemned Spain "for failing to act with due diligence to protect the rights of a woman and her daughter to quality, violence-free obstetric care" (UN 2020).

In response to the growing wave of citizen complaints and activist movements speaking out against obstetric violence, the Illustrious Official College of Physicians of Madrid (2022) ultimately issued an official statement that openly and explicitly rejected the term "obstetric violence" (SEGO 2018). In fact, in Spain in particular — and more broadly across Europe — the debate remains highly contentious, even at the level of its very existence (an *ontological* level debate, we might say): does obstetric violence, under that name, actually exist? This reality is fervently defended by subversive and radically feminist organizations such as "El Parto es Nuestro," which in 2016 explicitly identified it as a form of structural violence. From this organization also emerged the current Observatory of Obstetric Violence in Spain, created to address and combat this specific form of violence targeting women and newborns, which, as noted earlier, has already been recognized by the UN's CEDAW, contrasting sharply with the denial expressed by Spain's medical establishment.

However, and as has already been pointed out from within the scientific community:

> Spain seems to have a serious problem with public health and respecting human rights in obstetric violence. Offering information to women and requesting their informed consent are barely practiced in the healthcare system, so it is necessary to profoundly reflect on obstetric practices with, and request informed consent from, women in Spain (Mena-Tudela et a. 2020, 9).

All of this occurs even though the practices actually defined as constitutive of obstetric violence are prohibited, "since they involve the violation of fundamental rights recognized in the Spanish Constitution. These relate to physical and moral integrity (Article 15), personal freedom (Article 17), and privacy (Article 18)" (Brigidi 2023).

As noted at the outset, one of the central controversies surrounding obstetric violence concerns ontological-naming questions: how should it be named? Calling it "violence" in connection with obstetrics is unsettling, especially for the medical establishment. Indeed, CEDAW did not use the exact term "obstetric violence" in the ruling mentioned earlier but rather referred to "violence related to obstetric practices," which, in logical and expressive terms, amounts to the same thing.

However, despite everything, language should serve to solve problems, not to create new ones or worsen those that already exist. Should we look for another name, or perhaps soften this one? (cf. Lévesque and Ferron-Parayre 2021). Something less harsh? But harsh for whom? (Because the mother–baby dyads are already harmed by the time they reach this dialectical stage, while we continue to debate.)

On the other hand, the inflated or excessive use of a concept can render it vague, perhaps even useless. When something starts to mean everything (a kind of catch-all), it risks meaning nothing at all. Is this, perhaps, what is happening with obstetric violence? Is any incident — any medical error or poor practice — being labeled as such? Are we calling violence something that might simply be malpractice, as occurs in many other fields? Or worse, are we misusing the term, given that calling something "violence" may imply intentionality? Might this attribution not apply to healthcare professionals, whose role and purpose, after all, is healing? This is, in fact, a common objection raised by the biomedical profession in its critique of the concept. Yet it is epistemically unconvincing: it would be like claiming we should not use the term gender-based or intimate partner violence, simply because the intended purpose of a relationship is mutual care and affection.

All of these are, in any case, undoubtedly legitimate questions. Let us take a brief look at the history of the issue: first, how obstetric violence is defined (that is, how it is named), and second, how it is addressed and resisted (that is, how it is subverted), both through legislation and through public awareness — in other words, across multiple levels of action.

The evolution of — and toward — the concept of obstetric violence is, without question, a powerful and paradigmatic example of the theory and practice of language as well as of pragmatic insurrection (I will return to my notion of conceptual insurrection in the conclusion). It is also an example of how this naming has gained ground in political agendas and grassroots movements — true barricades formed by mothers and their children — radical, transformative actors who, in many ways, have been more genuinely subversive than many other, more widely studied and visible social movements. These are the voices that have called out obstetric violence as a deeply personal and political harm.

Only very recently in Europe — and in a pioneering move, though met with considerable resistance from the medical profession — the region of Catalonia in Spain has enacted legislation explicitly addressing obstetric violence. The law recognizes that obstetric violence can harm physical and mental health, as well as sexual and reproductive health. It also emphasizes a key dimension: "the prevention of or hindrance to access to truthful information necessary for autonomous and informed decision-making" (Mena-Tudela et al. 2022, 1). The law also formalizes the establishment of the Observatory of Obstetric Violence, as mentioned earlier.

This definition is crucial to the reflective aims of my work, as it refers specifically to information, to the right to truthful and necessary information, and its withholding or denial as a root cause of obstetric violence. This connects directly to epistemic injustice — a distinct and genuine form of injustice that concerns information (its access and processing), cognition itself, and how these are recognized, or not.

Given the broad scope and widespread academic recognition of the term, I will assume a general familiarity with its meaning and cannot, for reasons of space, offer a more detailed discussion here. I will simply cite its foundational reference: Miranda Fricker (2007), who defines epistemic injustice (in its two main forms, testimonial and hermeneutical) as occurring when a person's ability to make sense of their social experiences and to convey knowledge is undermined (cf. Massó Guijarro 2021).

3.2 Obstetric violence: formulating a concept under fire

Returning to the issue of obstetric violence, we know it can occur either through deficient or excessive medical care, and both forms are frequently seen across all continents. It is true that in very low-income countries, obstetric violence often stems from a lack of adequate resources. Yet both expressions are two sides of the same coin, and arguably, both reflect a fundamental trait of the Anthropocene's hypertechnologized drift: the systemic failure to adequately care for a universal and critical human process. Birth (like death) concerns the entire human community, not

only birthing women, though they alone are more than sufficient reason for ethical and political engagement.

The need for a theoretical framework that reflects the complexity of the phenomenon has long been recognized and has yielded important developments. Bellón (2015) highlights the contributions of biopolitical and feminist critique (which I will return to later), emphasizing how the control of medical care during childbirth — and thus the struggle over the possession of legitimized knowledge — plays a central role in contemporary obstetrics.

In the study by Smith-Oka et al. (2022), based on ethnographic research in Mexico and South Africa, two key arguments emerge regarding obstetric violence: first, that structural inequalities in different global contexts are primarily gender-based and lead to similar patterns of obstetric violence; and second, that ethnography is a powerful method for giving voice to women's stories. This brings us once again to the importance of narrative and its philosophical grounding, precisely as a means to subvert epistemic injustice, both testimonial and hermeneutical. Such subversion is deeply tied to healing: to giving voice, to listening, to respecting voices that have been historically dismissed. According to the authors, connecting these two insights — the contextual similarities and the role of ethnography — offers a temporal model for understanding how women across the world anticipate, experience, and respond to obstetric violence: before, during, and after the clinical encounter. All of this, in turn, calls for legal articulation — for a paradigm shift in the legal field that maps out a regulatory cartography of rights (Brigidi 2023).

Descriptive approaches — particularly those aligned with the ethnographic style of Smith-Oka et al. (2022) — are well-suited to show, name, and embody experiences (*embodiment*, in its classical English sense). Medeiros et al. (2022), in their qualitative study, examine obstetric violence and its various expressions from the perspective of postpartum women in the Brazilian context. They conclude that such violence is recurrent in hospital care, reflecting deeper gendered inequalities and power imbalances between healthcare professionals and service users. Ultimately, they underscore the need for greater visibility of the issue, supported by comprehensive, multilevel training on the subject (see also Rodríguez and Martínez Gandolfib 2021).

García (2018) also explores obstetric violence as a form of gender-based violence, drawing from an ethnographic study of institutional abuse during pregnancy and childbirth in Spain, as well as the perceptions of both patients and professionals. Arguedas (2016) also contributes to this discussion by analyzing obstetric violence and obstetric knowledge/power in Costa Rica through the critical lens of feminist epistemology and decolonial feminism. Llobera et al. (2019) apply a phenomenological approach in their qualitative study focused on the Spanish context.

Castrillo (2016) proposes two interrelated axes of analysis: on the one hand, the application of a socio-anthropological model of violence to the specific case of obstetric violence; on the other, the intersection of objective definitions (academic, legal, political) and subjective ones, to address the complexity of the issue. As Castirllo (2016, 43) rightly notes, "the shift in social sensitivities regarding various forms of violence (which has led to changes in legitimacy) explains the current debate over the definition of obstetric violence." In other words, what was once neither visible nor acknowledged — nor even understood — as violence (as has occurred historically in other domains lacking a defined analytical concept), is now being recognized as such. And this recognition is now being extended to the field of obstetrics itself. As we will see, this is a crucial development for how the concept is taken up in philosophy and hermeneutics, particularly at the charged intersection between obstetric violence and epistemic injustice.

Sadler et al. (2016) have also made significant contributions to the understanding and description of the structural dimension of obstetric violence, both in general terms and concerning its specific manifestations in Chile. Despite considerable attention to the issue in recent decades, excessive rates of medical intervention and persistent disrespect toward women during childbirth remain widespread consequences of that same structural violence. This underscores, among other things, the need for and importance of activism in support of respectful childbirth.

This structural issue — arising from a system that is itself broken and applicable to other contexts of bodily biopolitics, such as social hypogalactia as a syndemic (Massó Guijarro 2024)— is central and will be addressed later in my argument.

4 Obstetric violence as epistemic injustice: the combustive intersection

This final section focuses on analyzing the selected literature that explicitly links obstetric violence with epistemic injustice. These connections appear across a range of fields and disciplines, but particularly relevant to our perspective is the work produced in recent years by Israeli scholar Sara Cohen Shabot, within the domains of philosophy and women's studies. Her contributions are especially significant for their autoethnographic dimension — a perspective I strongly embrace, as previously mentioned. In her work (published in top-tier journals), Cohen Shabot speaks openly and literally about her own childbirths, treating her lived experience as a legitimate source of knowledge. In my research on breastfeeding — and by extension, on childbirth, since breastfeeding is necessarily linked to pregnancy and its embodied, phenomenological manifestations — I have often held back from

speaking explicitly about my personal experience. Therefore, as a researcher, I find it encouraging and affirming to encounter Cohen Shabot's powerful work.

I am particularly drawn to Cohen Shabot's work because she is one of the few authors, perhaps the only one, who approaches this issue from within the tradition of *phenomenological philosophy* (most existing studies originate from other disciplinary perspectives). What makes her contribution especially compelling is that she explicitly frames her phenomenological reflection as *feminist*. At a time when the term "feminism" is being continuously deconstructed and reconstructed — populated by even opposing hermeneutic frameworks, burdened by ideological cosmetics that are sometimes far from harmless (and certainly not effective) and limited by normative constraints that, in some cases, verge on the scholastic, it is refreshing to encounter a thinker who grounds her phenomenological reflection in feminism — *because she does so from the standpoint of women's bodies, specifically the bodies of birthing women:* bodies that *give birth and (re)produce* other human beings.

In this sense, Cohen Shabot (2020a, 2020b) addresses obstetric violence head-on, first and foremost as a form of structural gender-based violence that compromises bodily autonomy and agency. It manifests through both psychological and physical violence, enacted by medical professionals against birthing women. As she rightly notes, the phenomenon has largely been studied through the lens of the social and health sciences (as is also the case with reproductive processes more broadly), leaving key theoretical and conceptual questions underexplored. Cohen Shabot places special emphasis on the notion of embodied vulnerability as the condition within which obstetric violence occurs. This vulnerability, she argues, has gone unrecognized, and precisely because of this, it can be destructive to subjectivity, as it prevents support and undermines relationships between women, their lived bodies, their environments, and their interdependence.

In her analysis, Cohen Shabot draws directly on Beauvoir's framework of the embodied subject, understood as a being essentially constructed phenomenologically through its relationships. This perspective helps to clarify the genuine harm that occurs in obstetric violence: "The oxymoronic body of childbirth is notably susceptible to violence mainly because it is not alone: because we [...] birth with others" (Shabot 2020a, 10).

Cohen Shabot (2020a; 2020b) also develops a crucial argument through the concept of *hermeneutical* injustice: many women, she notes, lack the epistemic resources necessary to recognize certain practices during childbirth as violent. For example, vaginal examinations — whose utility has even been questioned by the WHO — are an unnecessary and invasive technique that breaches bodily intimacy. This lack of epistemic resources is shaped by patriarchy — both gyneco-obstetric and societal — which is deeply linked to sexual availability and commodification,

processes that normalize such violence. To deepen the phenomenological understanding of this problem, Cohen Shabot turns to Judith Butler's distinction between "recognition" and "apprehension", which helps to explain why certain acts are often not recognized as violent, even though they are *apprehended* — and thus suffered — as such by those who experience them. The high prevalence of postpartum neurosis and depression is one indicator of this suffering, among others, and we must not overlook the impact on health professionals themselves (cf. Olza 2014).

Another fundamental issue is the role of shame, specifically "gender shame," in relation to obstetric violence (Cohen Shabot et al. 2018). In their feminist and gender-informed philosophical analysis of obstetrics, the authors show how shame, among other factors, contributes to the normalization of obstetric violence. It perpetuates and spreads through mechanisms of blame that work to paralyze women in their decision-making during childbirth, rendering them more passive and therefore less able to resist or confront such violence. This is particularly evident in the case of women who advocate for more humanized birth experiences and are met with threats or fear tactics from medical personnel, often through insinuations or overt scolding about "putting the baby at risk," even when such claims are unfounded.

Notably, in the context of home births (Martínez-Mollà et al. 2019), women consistently emphasize a sense of autonomy, freedom, and the absence of blame (see also Bandelli in this volume). This is tied to freedom of movement and embodied agency — being able to scream if they wish, use the bathroom, eat or drink, or engage in sexual activity alone or with a partner. All of this contrasts sharply with what Cohen Shabot et al. (2018) describe: the parturient body cast as "dirty," "overly sexual," and "not sufficiently feminine," in opposition to the "re-educated" body of the good mother — passive, feminine, and obedient (see also Loughlin et al. 2022 on stigma, respect, and blame in clinical contexts, from a philosophical perspective).

It is also striking, as Cohen Shabot et al. (2018) point out, that these "unruly" mothers are often confronted with the well-being of their baby as the top priority, expected to behave as altruistic mothers at the expense of their own preferences, and portrayed as potentially putting the baby at risk. This framing suggests, falsely, that the well-being of mother and baby are separate or even opposed realities, presenting the situation as a zero-sum game. It reflects a flawed, individualistic Western perspective that treats mother and child as two disconnected entities when, in fact, as noted earlier, their interests are almost always intrinsically and structurally aligned.

This connects directly with an earlier analysis by Cohen Shabot (2016), in which she explores obstetric violence as a form of structural and gender-based violence. There, she develops a foundational phenomenological reading of embodied oppression and the pervasive sense of infantilization experienced by birthing women. Her

analysis offers a compelling justification for why this phenomenon is distinct from other forms of medical violence, objectification, or dehumanization.

Following Iris Marion Young's analysis of female existence under patriarchy, Cohen Shabot (2016) explains how birthing women (their bodies in labor), are often perceived as the antithesis of the myth of femininity. Contrary to the ideal of feminine passivity, these bodies are powerfully active and (re)productive. In doing so, they disrupt the normative mandate of bodily passivity and pose a serious threat to the hegemonic forces of patriarchy. Obstetric violence functions to domesticate these bodies, imposing a traditional, oppressive form of "femininity" (unlike home births, where women are free to move, act, and choose, and where some actively seek out precisely to avoid institutional obstetric violence; cf. Martínez-Mollà et al. 2019). The insurgent potential of childbirth in particular, and motherhood more broadly, is vividly expressed in lactivist mothering movements, among others (Massó Guijarro 2015).

This also closely aligns with the analysis of Ballesteros (2022), who emphasizes the positive impact of being able to participate in and influence decision-making processes — an essential component of autonomy — in any health context, and especially in childbirth. She highlights what has been termed the "stigmatizing dilemma:" on the one hand, birth is socially framed as highly risky; on the other, women in labor face testimonial injustice, as their accounts are dismissed or undervalued in comparison to the presumed authority and objectivity of medical professionals. Thus, when women do not obey medical instructions, they risk being stigmatized as either irrational or selfish — a dichotomy echoed in Cohen Shabot's analysis.

Chadwick (2020; 2021), in a line of inquiry similar to Cohen Shabot's, addresses obstetric violence as a practice of silencing and marginalization, and shows how the very term itself fosters a dissenting, resistant lexicon. She explains that "obstetric violence" has emerged as a significant tool — situated between legal advocacy and activism — in the global pursuit of obstetric and, more broadly, maternal care that is humane, equitable, and respectful.

Chadwick views obstetric violence not merely as a descriptive term or legal category, but as an "epistemic intervention" — one that challenges the normalization of both language and practices deemed harmful or undesirable: "the language of obstetric violence also constitutes a refusal of epistemic frames that silence, diminish, erase, and devalue alternative and embodied forms of reproductive knowledge and agency" (Chadwick 2020, 1).

Finally, Cohen Shabot (2019; 2021) also focuses her analysis on testimonial injustice as a specific form of epistemic injustice systematically directed at birthing women, who are, quite literally, "not believed" in the delivery room — neither during nor after labor. This disbelief stems from a dual bias: one related to their

status as women, and another tied to their subordinate position in relation to medical authority. This double marginalization constitutes a form of discrimination that can and should be examined through an intersectional lens.

In connection with this, and following Cohen Shabot's self-referential example — and by way of closing — I must say that one of the things that most surprised me (still very much a product, at the time, of the gyneco-obstetric patriarchal paradigm) was something that happened while speaking with my midwives in preparation for a home birth. I asked them: "How will I know when to push? Will you tell me?" And they always replied: "You'll know." And indeed, I did.

They would ask if I felt the urge and tell me to push *when I felt it was right*. I believe that few experiences in my life have been as empowering as that one — the moment of "Push when you're ready" — in giving birth to my children.

5 Final words: conceptual insurrection, or unruly concepts

> Sometimes it is enough to change the words to understand
> things better, to make the world appear differently
> —*Jorge Larrosa*

Obstetric violence resembles a many-headed hydra: it is an issue that can — and must — be addressed from multiple fronts and platforms, as it constitutes a complex, multilevel problem. It concerns mothers and babies. Therefore, it concerns human beings — *every* human being, in the moment of being born. As such, it is a matter of human rights, of public health (feminist and thus universal), and of bioethics — a bioethics that must be decolonized, intersectional, narrative, and feminist.

One fundamental question that inevitably arises in discussions about obstetric violence — and about the supposed lack of intentionality on the part of those who perpetrate it — is: why are so many good people engaging in harmful practices? It is crucial, in response, to emphasize the systemic and paradigmatic nature of patriarchy, which normalizes and legitimizes certain practices, even rendering them invisible. This is not about accusing individuals, or at least not always, nor about judicializing every process.

There is a particularly illuminating concept in philosophy that helps us make sense of this. It was coined by Hannah Arendt (2006), a Jewish philosopher who, like many others, was forced into exile to survive and spent years stateless, by conviction, in her case. Arendt developed her idea after observing how so many

good, educated people — respectable neighbors, parents — collaborated with the Nazi regime, even serving as key agents of genocide, as was the case with Adolf Eichmann, a high-ranking bureaucrat in the Third Reich.

The concept is *the banality of evil*. In a broken ("sick") system, perverse in some or many of its practices, evil occurs naturally, without our even noticing it, often because we must cooperate with it in order to survive or preserve social homeostasis — a tendency inherent to individuals and communities alike. This phenomenon has been observed in many contexts, including Apartheid-era South Africa. Nelson Mandela (1995) made the same observation when he befriended his Afrikaner jailers on Robben Island — men who were racist toward him, yet in their everyday lives were, in many ways, decent human beings.

What is needed, then, is a transformation of many elements of this patriarchal system (biopolitical magma). We must demobilize its mechanisms so that harm does not continue to occur, even when carried out by good people and well-intentioned professionals.

I have sought to place particular emphasis on the concept of obstetric violence — specifically through its critical framing as a form of epistemic injustice — drawing on feminist phenomenology and questioning, ultimately, whether its use as a term remains conceptually appropriate. It is worth remembering that, as philosophy suggests, concepts are *tools for thought* but also *instruments for action*. In the case of obstetric violence, we might consider it what philosophy refers to as a thick moral concept, as opposed to a thin ethical one, carrying both descriptive and evaluative meaning simultaneously. When we use the term "obstetric violence," we are not only describing a reality; we are also asserting that it is avoidable and that it must be rejected. Subversion is built into the word. For that reason, I propose thinking of obstetric violence as an insurrectionary concept — an unruly notion.

In my view, it is essential to preserve the specific term "obstetric violence" — even if that means continuing to debate it, refine it, and complicate it, as much as necessary, within the contested terrain of competing legitimacies and plural voices. Not to create new, false dichotomies — a zero-sum battle between two imagined sides (medical professionals vs. the general public, in this case women and their babies), as that framing is misleading — but rather to help us understand more clearly. There is great power in naming, in narration, in the stories we tell — and how we tell them. The insurgent potential of childbirth like that of breastfeeding, is profound. Because childbirth is not merely a medical act or a biological event, just as the human species is not *merely* biological. As I have said elsewhere, *we give birth to biographies* (Massó Guijarro 2021a, 2021b).

I find it both intriguing and unsettling to note the profound symmetry between the excessive intervention (medicalization, technological overuse) seen in obstetric violence, and the broader trajectory of the world: the systemic degradation of eco-

systems, now called the climate emergency, which has brought about a true global crisis. A threat to life itself. This abuse of the planet, driven precisely by an *excess* of civilization, as understood through the Enlightenment myth of progress and its neoliberal capitalist logic, finds its corollary in how childbirth is managed in human societies. In this context, a reflection that is not merely ethical but *bioethical*, in the fullest sense of the term, becomes urgent and non-negotiable. Indeed, obstetric violence has already been recognized as a matter of global public health, due to its widespread prevalence and alarming severity (Edward and Kibanda 2022).

Finally, with regard to emerging directions in global health, I argue for the urgent need to feminize public health — or, put differently, to establish a feminist public health model, as I have previously noted. Feminist political philosophy insists on the necessity of reconstructing political institutions around more inclusive and just ideals. This aligns with the approaches of decolonial feminism and ecofeminism in the realm of global health and supports advocacy for an intersectional (decolonial, feminist) perspective on bioethics. Within that framework, a (bio) ethical commitment to childbirth must be seen as both urgent and universal.

We must loosen the reins on our concepts when necessary — this is why we speak of unruly words. We must allow them to carry out their own insurrection. For a much broader, more integrative, decolonial, and — above all — feminist bioethical paradigm of health, it is essential to use the term "obstetric violence" clearly and unapologetically, so long as we remain in that interregnum described at the outset. We must continue to name it — to politicize it, to legitimize it epistemically, and above all, to confront it in practice, through active resistance.

To the barricades.[1]

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1 I thank my children and their father, for being with me back then on the other side of (obstetric) violence and (epistemic) injustice, and for standing with me now on the barricades.

References

Arendt, Hannah. 2006. *Eichmann in Jerusalem: A Report on the Banality of Evil.* London: Penguin Classics.

Arguedas, Gabriela. 2016. “Reflexiones sobre el saber/poder obstétrico, la epistemología feminista y el feminismo descolonial, a partir de una investigación sobre la violencia obstétrica en Costa Rica”. In *Antología del pensamiento crítico costarricense contemporáneo*, edited by Montserrat Sagot & David Díaz Arias. CLACSO Stable. https://www.jstor.org/stable/j.ctvtxw1wh.31 (last accessed 22 September 2025).

Ballesteros, Victoria. 2022. “A Stigmatizing Dilemma in the Labour Room: Irrationality or Selfishness?” *Journal of Evaluation in Clinical Practice* 28: 875–882. https://doi.org/10.1111/jep.13747.

Bellón, Silvia. 2015. “La violencia obstétrica desde los aportes de la crítica feminista y la biopolítica”. *Dilemata* 18: 93–111. https://www.dilemata.net/revista/index.php/dilemata/article/view/374 (last accessed 22 September 2025).

Brigidi, Serena. 2023. “El marco jurídico como cambio de paradigma. Los orígenes del Observatorio de la Violencia Obstétrica en el Estado español”. Observatorio de la Violencia Obstétrica. https://observatorioviolenciaobstetrica.es/los-origenes-del-observatorio-de-la-violencia-obstetrica-en-el-estado-espanol/ (last accessed 22 September 2025).

Brünig, Lisa et al. 2024. “The Concept of Intersectionality in Bioethics: A Systematic Review”. *BMC Medical Ethics* 25: 64. https://doi.org/10.1186/s12910-024-01057-5.

Castrillo, Belén. 2016. “Dime quién lo define y te diré si es violento. Reflexiones sobre la violencia obstétrica”. *Sexualidad, Salud y Sociedad* 24: 43–68. http://dx.doi.org/10.1590/1984-6487.sess.2016.24.03.a.

Cavarero, Adriana. 1997. *Filosofia della narrazione. Tu che mi guardi, tu che mi racconti*. Milano: Feltrinelli.

Chadwick, Rachelle. 2020. “Practices of Silencing: Birth, Marginality and Epistemic Violence”. In *Childbirth, Vulnerability and Law: Exploring Issues of Violence and Control*, edited by Camilla Pickles y Jonathan Herring, 30–48. Oxford: Routledge. https://www.taylorfrancis.com/chapters/edit/10.4324/9780429443718-3/practices-silencing-rachelle-chadwick (last accessed 22 September 2025).

Chadwick, Rachelle. 2021. “Breaking the Frame: Obstetric Violence and Epistemic Rupture.” *Agenda* 35 (3): 104–115. doi:10.1080/10130950.2021.1958554.

Cohen Shabot, Sara. 2016. “Making Loud Bodies 'Feminine': A Feminist-Phenomenological Analysis of Obstetric Violence”. *Human Studies* 39: 231–247. https://doi.org/10.1007/s10746-015-9369-x.

Cohen Shabot et al. 2018. “Domesticating Bodies: The Role of Shame in Obstetric Violence”. *Hypatia* 33 (3): 384–40. https://doi.org/10.1111/hypa.12428.

Cohen Shabot, Sara. 2019. “‘Amigas, Sisters: We Are Being Gaslighted’: Obstetric Violence and Epistemic Injustice”. In *Childbirth, Vulnerability and Law: Exploring Issues of Violence and Control*, edited by Camilla Pickles and Jonathan Herring, 14–291. Abington: Routledge. https://www.taylorfrancis.com/chapters/edit/10.4324/9780429443718-2/amigas-sisters-re-being-gaslighted-sara-cohen-shabot (last accessed 22 September 2025).

Cohen Shabot, Sara. 2020a. “We Birth with Others: Towards a Beauvoirian Understanding of Obstetric Violence”. *European Journal of Women’s Studies* 16 (1). https://doi.org/10.1177/1350506820919474.

Cohen Shabot, Sara. 2020b. “Why 'Normal' Feels So Bad: Violence and Vaginal Examinations during Labour – A (Feminist) Phenomenology”. *Feminist Theory 0* (0): 1–21. https://doi.org/10.1177/1464700120920764.

Cohen Shabot, Sara. 2021. “You Are Not Qualified — Leave It to Us: Obstetric Violence as Testimonial Injustice”. *Human Studies* 44: 635–653. https://doi.org/10.1007/s10746-021-09596-1.

Couto, Marcia Thereza et al. 2019. “La perspectiva feminista de la interseccionalidad en el campo de la salud pública: revisión narrativa de las producciones teórico-metodológicas”. *Salud Colectiva* 15. doi: 10.18294/sc.2019.1994

Domingo, Tomás, and Lidia Feito. 2020. *Bioética narrativa*. España: Escolar y Mayo.

Edward, Majani M., and Zakia Kibanda. 2022. “Obstetric Violence: A Public Health Concern”. *Health Science Reports* 6 (1): e1026. https://10.1002/hsr2.1026.

Fayemi, Ademola Kazeem, and O. C. Macaulay-Adeyelure. 2016. “Decolonizing Bioethics in Africa”. *BEOnline* 3 (4): 68–90. https://doi.org/10.20541/beonline.2016.0009.

Flor do Nascimento, Wanderson, and Volnei Garrafa. 2010. “Nuevos diálogos desafiadores desde el sur: colonialidad y Bioética de Intervención”. Revista *Colombiana de Bioética* 5 (2): 23–37. https://www.redalyc.org/articulo.oa?id=189218186003 (last accessed 22 September 2025).

Fricker, Miranda. 2007. *Epistemic Injustice: Power and the Ethics of Knowing*. Oxford: Clarendom Press.

García, Eva M. 2018. *La violencia obstétrica como violencia de género: Estudio etnográfico de la violencia asistencial en el embarazo y el parto en España y de la percepción de usuarias y profesionales*. Doctoral Thesis, Universidad Autónoma of Madrid. https://repositorio.uam.es/handle/10486/684184 (last accessed 22 September 2025).

Gramsci, Antonio. 1999. *Prison notebooks*. London: ElecBook.

Lévesque, Sylvie, and Audrey Ferron-Parayre. 2021. “To Use or Not to Use the Term 'Obstetric Violence': Commentary on the Article by Swartz and Lappeman”. *Violence Against Women* 27 (8): 1009–1018. https://doi.org/10.1177/1077801221996456.

Llobera Cifre, Rosa et al. 2019. “Violencia obstétrica. La perspectiva de mujeres que la han sufrido”. *Investigaciones Feministas* 10 (1): 149–184. http://dx.doi.org/10.5209/INFE.60886.

Lorenzo, Claudio et al. 2024. “Decolonial critical bioethics and access to treatment for hemophilia in the Americas”. *Revista Latinoamericana De Bioética*, 24(2), 27–38. https://doi.org/10.18359/rlbi.6433.

Loughlin, Michael, et al. 2022. “Philosophy and the Clinic: Stigma, Respect and Shame”. *Journal of Evaluation in Clinical Practice* 28: 705–710. https://doi.org/10.1111/jep.13755.

Manchola-Castillo, Camilo. 2014. Por una bioética distinta: narrativa y latinoamericana. *Revista Redbioética/UNESCO* 2 (10): 70–80. https://redbioetica.com.ar/wp-content/uploads/2018/11/Art7-Manchola-R10.pdf (last accessed 22 September 2025).

Mandela, Nelson. 1995. *Long Walk to Freedom: The Autobiography of Nelson Mandela.* New York: Back Bay Books.

Martínez Dueñas, William Andrés. 2023. “¿Es posible una bioética intercultural decolonial?”. *Jangwa Pana* 21(3): 174–175. https://doi.org/10.21676/16574923.5119.

Martínez-Mollà, Teresa M., Siles, José and Solano, María del Carmen. 2019. “Evitar la violencia obstétrica: Motivo para decidir el parto en casa”. *Musas* 4(2): 53–77. https://doi.org/10.1344/musas2019.vol4.num2.4.

Massó Guijarro, Ester. 2015. “Lactivismo contemporáneo en España: ¿Una nueva marea sociopolítica?”. *Journal of Spanish Cultural Studies* 1(16): 193–213. https://doi.org/10.1080/14636204.2015.1069074.

Massó Guijarro, Ester. 2021a. “Infancia y pandemia: Crónica de una ausencia anunciada”. *Salud Colectiva* 17. https://doi.org/10.18294/sc.2021.3303.

Massó Guijarro, Ester. 2021b. “Sacando pecho: Narrando la vida”. In *Maternidades, experiencias y narraciones: Una mirada a través de los campos de saberes*, edited by Serena Brigidi & Coral Cuadrada, 39–64. Tarragona: Editorial Publicacions URV. https://llibres.urv.cat/index.php/purv/catalog/view/479/497/1112.

Massó Guijarro, Ester. 2024. “Lactancia materna y violencia obstétrica: en el camino de una soberanía lactante”. *MEDICA REVIEW* 12 (1): 10–23. https://doi.org/10.62701/revmedica.v12.5417.

Medeiros, Rita de Cássia da Silva et al. 2022. “No lloraste mientras lo hacías: La violencia obstétrica y sus expresiones”. *Revista Estudos Feministas* 30 (3): e71008. https://doi.org/10.1590/1806-9584-2022v30n371008.

Mena-Tudela, Desirée et al. 2020. “Obstetric Violence in Spain (Part I): Women’s Perception and Interterritorial Differences.” *International Journal of Environmental Research and Public Health* 17 (21): 7726: https://doi.org/10.3390/ijerph17217726.

Mena-Tudela, Desirée, et al. 2022. “Breastfeeding and Obstetric Violence during the SARS-CoV-2 Pandemic in Spain: Maternal Perceptions”. *International Journal of Environmental Research and Public Healt*h 19: 15737: https://doi.org/10.3390/ijerph192315737.

Oliveira, Marcos de Jesús et al. 2017. “Pluralismo bioético: contribuições latino-americanas para uma bioética em perspectiva decolonial”. *Revista Bioética* 25 (1): 52–60. https://doi.org/10.1590/1983-80422017251166.

Olza, Ibone. 2014. “Estrés postraumático secundario en profesionales de la atención al parto. Aproximación al concepto de violencia obstétrica”. *Cuadernos de Medicina Psicosomática y Psiquiatría de Enlace* 111: 79–83. https://dialnet.unirioja.es/servlet/articulo?codigo=4906961 (last accessed 22 September 2025).

Ortúzar, María Gabriela and Cintia Rodríguez. 2024. “Bioética interseccional en América Latina: agenciamiento político, autonomía relacional y cuidados para la vida”. *Rev. Cadernos de Campo* 24 (2): 2359–2419. https://doi.org/10.47284/cdc.v24iesp.2.19567.

Pérez D’Gregorio, Rogelio. 2010. “Obstetric violence: A new legal term introduced in Venezuela”. *Int J Gynecol Obstet* 111 (3): 201–202. https://doi.org/10.1016/j.ijgo.2010.09.002.

Petra, Priscila Cardia et al. 2024. “(Re)pensar la bioética: análisis interseccional de los derechos sexuales y reproductivos”. *Revista Bioética* 32. https://doi.org/10.1590/1983-803420243516pt.

Rodríguez Mira, Javier and Alejandra Martínez Gandolfib. 2021. “La violencia obstétrica: una práctica invisibilizada en la atención médica en España”. *Gac Sanit* 35(3): 211–212. https://doi.org/10.1016/j.gaceta.2020.06.019.

Sadler, Michelle et al. 2016. “Moving beyond disrespect and abuse: addressing the structural dimensions of obstetric violence”. *Reproductive Health Matters* 24 (47): 47–55. https://doi.org/10.1016/j.rhm.2016.04.002.

Salamanca, Leonardo. 2015. “Buen vivir, decolonialidad y bioética. Discusiones, aportes y articulaciones”. *Polisemia* 10 (17): 86–94. https://doi.org/10.26620/uniminuto.polisemia.10.17.2014.

SEGO [Sociedad Española de Ginecología y Obstetricia]. 2018. “Violencia obstétrica: Un concepto legalmente delictivo, moralmente inadecuado, científicamente inaceptable”. https://us18.campaignarchivecom/?e=e52bacb293&u=fbf1db3cf76a76d43c634a0e7&id=5a7 (last accessed 22 September 2025).

Smith-Oka, Vania et al. 2022. “Obstetric Violence in Their Own Words: How Women in Mexico and South Africa Expect, Experience, and Respond to Violence”. *Violence Against Women* 28 (11): 2700–2721. https://doi.org/10.1177/10778012211037375.

UN [Oficina del Alto Comisionado de Naciones Unidas (Derechos Humanos)]. 2020. “España necesita combatir la violencia obstétrica, dicen expertos de la ONU”. 9 March. https://www.ohchr.org/es/2020/03/spain-needs-combat-obstetric-violence-un-experts (last accessed 22 September 2025).

Yáñez Ríos, Randy. 2017. *Bioética en Latinoamérica: articulaciones entre bioética, biopolítica y colonialidad*. Master Thesis, Universidad of Chile. https://repositorio.uchile.cl/handle/2250/153409 (last accessed 22 September 2025).

Sara Dal Monico

Gynecological and Obstetric Violence: Framing the Phenomenon under International Human Rights Law

Abstract: The purpose of this chapter is to frame the issue of gynecological and obstetric violence from a human rights law perspective. Considering the lack of a comprehensive legally binding definition, this contribution serves as a starting point to reflect further on the notion and enhance scholarly debate on the matter. Ultimately, it argues in favor of the recognition of gynecological and obstetric violence as a form of gender-based violence, positing that attempts at drafting a definition should embrace a human rights-based and intersectional approach focused on the gendered element.

1 Introduction

Despite the growing attention, at the international and regional levels, devoted to gynecological and obstetric violence, the phenomenon remains undefined from a legal perspective. Though a few notable attempts at providing a legal definition can be accounted for in domestic legal systems, the international legal system and in particular human rights law have not yet been able to fill such legal void. The purpose of this chapter is to address the issue of gynecological and obstetric violence from a human rights perspective, deconstructing the phenomenon and evaluating its impact on the human right to freedom from inhuman or degrading treatment, on women's right to sexual and reproductive health and on the right to be free from discrimination. It also acknowledges that gynecological and obstetric violence is based on, and perpetuates, gender stereotyping. Far from being able to provide a comprehensive legally binding definition within these pages, this contribution serves as a starting point to foster discussion on the matter, arguing in favor of the recognition of gynecological and obstetric violence as a form of gender-based discrimination which can lead to gender-based violence against women. Furthermore, it contends that attempts at a definition should embrace a human rights-based and intersectional approach.[1]

1 This contribution focuses on the impact of gynaecological and obstetric violence on women's rights. Nonetheless, it should be acknowledged that, as a phenomenon deeply rooted in gender stereotypes, it can affect non-binary and trans people as well.

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2 Unveiling the complex nature of gynecological and obstetric violence

As Pickles (2022, 632) warns, "naming is not a neutral phenomenon," and "violence" is certainly not a neutral term. The choice of terminology, especially concerning the word "violence," has sparked lively debates, with health professionals opposing it strongly, on the one side, and some victims, on the other side, who would use words such as "torture" and "dehumanization" to describe what they have experienced. Framing the "negligent care, omissions, indirect causing of harm, and physical and psychological harms too" (Pickles 2022, 632) taking place in the wider context of sexual and reproductive health services as a form of violence can prove effective. However, there are some challenging aspects to consider. Pickles notes that, at times, women and childbearing persons who have suffered from it struggle to put a name to their experience or do not perceive it as a form of violence (Pickles 2024). The term "violence" is also opposed, as mentioned, by healthcare professionals, who refrain from naming these practices as a form of violence. A more nuanced and careful approach was also adopted by the World Health Organization (WHO), which in 2015 released a statement concerning the "disrespect and abuse" spreading— across facility-based childbirth (WHO 2015). Speaking about violence may lead to the related perception of individuals who have experienced it as *mere victims*, perpetuating conceptions of helplessness and pity towards them which exacerbate stereotypes and their condition of vulnerability.

However, there is power in naming what one has suffered. There is power in recognizing that even though what individuals have experienced is a form of violence, they survived it, reclaiming their own agency in the process. There is also power in realizing that others have suffered what you have, and that the experience of violence does not lead to being a mere victim. The importance of recognizing the form of violence in gender-based phenomena puts the spotlight — especially from an international human rights law perspective — on the inaction of the State in addressing such phenomena (De Vido 2021). It also gives voice to those who have been subjected to practices embedded in social stigma — such as gynecological and obstetric violence — and highlights the lack of consent which underlies any act of violence suffered. From an international legal perspective, it also situates the conduct of the State in the realm of violence against women and characterizes it as a serious violation of women's human rights. According to Pickles: "'Obstetric violence' [...] reflects an 'epistemic intervention' [...] that forces us to confront the fact that the gynaecologist's office or the birthing room are not separate spheres removed from societal relations of power, human rights violations, legacies of colonialisation, and systemic prejudices" (Pickles 2022, 632).

In April 2024, upon request of the FEMM Committee of the European Parliament (EP) — the Committee on Women's Rights and Gender Equality — a report was issued titled *Obstetric and Gynaecological Violence in the European Union (EU): Prevalence, legal frameworks and education guidelines for prevention and elimination* (Brunello and others 2024). The report, authored by several researchers, aims to provide an overview of how the phenomenon of gynecological and obstetric violence occurs across the 27 Member States of the European Union, of the level of understanding and the awareness of the issue and, significantly, of how the domestic legal system of EU Member States frame it. The authors describe gynecological and obstetric violence as a form of gender-based violence and recognize that, despite the difficulty in accessing and collecting data on the issue from the EU Member States, gynecological and obstetric violence is found across the EU (Brunello and others 2024, 9–12).

What emerges from the report is that gynecological and obstetric violence is neither new, nor recent, and that every Member State is affected by it. Women throughout the EU have experienced and continue to experience gynecological and obstetric violence. Despite its overall scope, awareness is still developing, mainly thanks to the contributions of scholars from several disciplines as well as of efforts to define the notion.[2] One of the reasons why it is difficult to pinpoint this phenomenon is indeed the lack of a widely accepted (and legally binding) definition. The absence of an agreed-upon notion — not only at domestic level but also at the regional and international levels — has detrimental effects both on the victims, who struggle to correctly identify their experiences, and on potential perpetrators, including health professionals, who might fail to understand how to avoid engaging in gynecological and obstetric violence-related behaviors.

Gynacological and obstetric violence is a complex phenomenon, rooted in the patriarchal structure of societies as well as in medicine and in the medical sector, "a systemic problem of institutionalized gender-based violence" (Diaz-Tello 2016, 1). The Council of Europe (CoE) Rapporteur for the Committee on Equality and Non Discrimination stated that it "is the result of the continued existence of a patriarchal culture within the medical sector, particularly in the training given to health care staff, and of persistent gender stereotypes in society" (Blondin 2019). According to the FEMM Committee Report: "as a social and systemic phenomenon, obstetric and gynaecological violence is situated at the convergence of two structural crises: discrimination based on gender and the under-resourcing of healthcare systems and institutions" (Brunello and others 2024). Both attempts to address the roots of

2 Among scholarly contributions to the phenomenon of gynecological and obstetric violence, see: Pickles and Herring 2019; Chadwick 2023; Diaz-Tello 2016; García Moreno and Heidari 2016; Kukura 2018; Perrotte 2010; Pickles 2022; Quattrocchi 2019; Bernardini and Dal Monico 2024.

gynecological and obstetric violence share two characteristics: first, the finding that this phenomenon is deeply rooted in gender stereotypes — it is a form of gender-based discrimination and violence — and second, that it involves the medical or healthcare field, meaning it is experienced in a specific context that can exacerbate women's vulnerable condition.

Though the "where" and the "who" of gynecological and obstetric violence can be identified, one more aspect contributes to the difficulty of pinpointing the phenomenon. Both the FEMM Committee Report and the Report of the Rapporteur for the Committee on Equality and Discrimination refer to it as gynecological and obstetric violence. The 2024 Case Study Analysis conducted on four EU Member States by several authors for the European Commission on the issue speaks of obstetric violence (Rozée and others 2024). In this essay, the expression "gynecological and obstetric violence" is preferred to the more common expression "obstetric violence," because it is an umbrella term able to convey the multi-faceted and complex nature of the phenomenon, which extends this form of violence to all reproductive health-services, whereas obstetric violence may allude to experiences more centered around childbirth (Pickles 2024, 616).[3] It hence may not address similar forms of violence which happen in the wider context of reproductive healthcare services, such as abortion. Gynecological and obstetric violence does not only occur in the delivery room, but indicates a much more complex pattern of abuse, both physical and verbal, occurring before, during and after a pregnancy, in the wider context of reproductive and sexual health-related services (Bernardini and Dal Monico 2024).

2.1 Looking for a definition: international, regional and national efforts

At the international level within the UN context, gynecological and obstetric violence was acknowledged by both the WHO and the Special Rapporteur on Violence against Women in the report on a human-rights based approach to mistreatment and violence against women in reproductive health services. The latter defines obstetric violence as: "the kind of violence experienced by women during facility-based childbirth" (Šimonović 2019). The WHO also addressed the issue of the widespread mistreatment of women during childbirth in medical facilities in its 2015 statement by condemning the practice and framing it as a violation of their

3 The definition provided by Pickles refers to obstetric violence as a social phenomenon and as violence and abuse during childbirth. However, many women refer to abortion-related gynaecological and obstetric violence.

rights to life, health and bodily integrity as well as freedom from discrimination (WHO 2015). Alongside physical abuse, WHO included the "profound humiliation and verbal abuse, coercive or unconsented medical procedures (including sterilisation)" (WHO 2015), as well as lack of confidentiality and of fully informed consent.

At the regional level, attempts at tackling gynecological and obstetric violence can be found in reports[4] and soft law and only partially in a hard law instrument. The 2011 Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence includes the criminalization of female genital mutilation (Art. 38) and of forced abortion and forced sterilization (Art. 39).[5] Though not expressly recognized as forms of gynecological and obstetric violence and only scratching the surface of such a complex and multi-faceted phenomenon, three relevant practices have been included in a hard law instrument as forms of violence against women which States are under an obligation to criminalize. Among soft law instruments, it is worth mentioning Resolution 2306(2019) adopted by the Parliamentary Assembly of the Council of Europe (PACE), which explicitly refers to gynecological and obstetric violence and defines it as "a form of violence that has long been hidden and is still too often ignored" (PACE 2019), hinting at the social stigma that still surrounds the issue and stressing its non-consensual nature. Although the Resolution does not provide a definition, it calls on the Member States of CoE to take measures to address gynecological and obstetric violence-related behaviors within their healthcare systems, both public and private. Gynecological and obstetric violence was also partially tackled by Resolution 2020/2215(INI) of the European Parliament, though aimed at addressing the broader issue of sexual and reproductive health rights in the EU. Among the measures specifically aimed at tackling gynecological and obstetric violence, the European Parliament invites Member States to act by "reinforcing procedures that guarantee respect for free and prior informed consent and protection from inhuman and degrading treatment in healthcare settings" (EP 2022) and calls on the European Commission to take action concerning this specific form of violence against women.

Some notable efforts can be found in national legal systems, with Latin American countries being forerunners in criminalizing obstetric violence in domestic legislations. One initial significant attempt at framing this form of violence was made at the Conference on the Humanization of Childbirth held in Fortaleza, Brazil, in 2000, where 12 Latin American countries met and funded the RELACAHUPAN–Red Latino-

4 Obstetric violence was mentioned by the Follow-Up Mechanism established under the Convention on the Prevention, Punishment and Eradication of Violence against Women (MESECVI) in 2012. See OAS MESECVI 2012.

5 See also Alaattinoğlu 2023; Mestre i Mestre 2023.

americana y del Caribe para la Humanización del Parto y Nacimiento: a network and platform for activists, researchers and healthcare providers to meet and discuss child-birth related issues.[6] A few years later, in 2007, building on the achievements of the Conference, Venezuela passed the Organic Law on Women's Right to a Violence-free Life, which included the first legally binding definition of obstetric violence (not *gynecological* and obstetric violence). According to Venezuelan law, obstetric violence can be defined as:

> The appropriation of a woman's body and reproductive processes by health personnel, in the form of dehumanising treatment, abusive medicalization and pathologization of natural processes, involving a woman's loss of autonomy and of the capacity to freely make her own decisions about her body and her sexuality, which has negative consequences for a woman's quality of life (OAS MESECVI 2012).

Two years later, Argentina adopted Law No. 26.485 – "Ley de Proteccion Integral A Las Mujeres." The article provides a list of forms of violence against women and in Article 6, letter e), it includes a definition of obstetric violence. In 2018, Uruguay amended its civil and criminal code by adopting a reform of Law No. 17.514 on violence against women based on gender. The previous law, which dated back to 2002, was amended by Law No. 19580, expanding the criminalized forms of gender-based violence against women to include gynecological and obstetric violence, providing a definition focused on women's loss of autonomy on decisions concerning their own body.[7]

Some noteworthy steps have also been taken in the European legal framework. In 2023 an attempt was made in France to pass a specific law criminalizing gynecological and obstetric violence — this time including also the *gynecological* element in the name. The French draft proposal is a pivotal starting point in Europe, for several reasons. In the explanatory memorandum accompanying the proposal, it recognizes gynecological and obstetric violence as a form of gender-based violence against women and acknowledges the imbalance of power in the relation between patient and medical staff, thus exacerbating the condition of vulnerability of the patients in those moments. It also provides a comprehensive picture of what constitutes gynecological and obstetric violence which is not limited to mere *physical* conducts, but also includes slurs, name-calling and verbal abuse.[8] Furthermore,

6 On the issue of gynecological and obstetric violence and attempts to define it, see: Pickles 2022; Quattrocchi 2019; Larrea et al. 2021; Sadler et al. 2016; Ferrão et al. 2022; Chadwick 2023; Brennan 2019.
7 Ley No. 19580, Ley De Violencia Hacia Las Mujeres Basada En Genero. Modificacion A Disposiciones Del Codigo Civil Y Codigo Penal. Derogacion De Los Arts. 24 A 29 De La Ley 17.514, 9 January 2018.
8 Proposition de loi n° 982 (2023).

the proposed definition of the crime of gynecological and obstetric violence highlights how it infringes upon human dignity, by creating a hostile and intimidatory condition for the patient, who is consequently put in a position to act contrary to their will, i.e. without voluntary given consent.

While the French attempt still remains a draft proposal, in 2025 Portugal adopted Law No. 33/2025, "Law to promote the right during pregnancy and childbirth."[9] The law introduces obligations for the government to raise awareness concerning obstetric violence in the context of sexual education, in order to promote respect for "sexual and reproductive autonomy and the elimination of gender-based violence" (Article 3) thus underlying the gendered nature of the phenomenon, as well as an obligation to provide specific training on the matter. Law No. 33/2025 also provides a definition, though it refers to *obstetric* violence only. Obstetric violence is defined as a both physical and verbal, exercised by health professionals on the body and reproductive parts of women. Unlike other existing definitions, the law clearly states that obstetric violence is carried out on women and "on other pregnant individuals" (Article2). The definition also stresses that obstetric violence amounts to inhuman treatment, however it does not include references to consent, which are present in the French proposal.

The Spanish region of Catalonia also offers a noteworthy example in this regard. Law no. 17/2020,[10] adopted by the Autonomous Community of Catalonia on the eradication of sexist violence, includes obstetric violence as well as other forms of violence towards the sexual and reproductive rights of women. The focus of the definition — again referring only to obstetric violence — is the inability to take conscious, autonomous and informed decisions about one's sexual and reproductive processes and choices. The definition also lists various conducts amounting to obstetric violence.[11] This definition encompasses many innovative elements, such as widening the practice to assisted reproduction and focusing on autonomy. Moreover, according to Article 4, paragraph 2), letter d), it extends obstetric violence to gynecological and obstetrical practices which do not respect "the decisions, the body, the health and emotional processes of women."

Despite these few — yet noteworthy — attempts, the international, regional and national frameworks concerning gynecological and obstetric violence offer

9 Lei no. 33/2025 de 31 de março, promove os direitos na gravidez e no parto e alter a Lei no. 15/2014 de 21 de março, 31 March 2025.

10 Ley 17/2020, de 22 de diciembre, de modificación de la Ley 5/2008, del derecho de las mujeres a erradicar la violencia machista, 22 December 2020.

11 Such as: forced sterilizations and abortions, but also forced pregnancies; preventing access to abortion or to methods for preventing sexually transmitted diseases and HIV, as well as to assisted reproduction methods.

a scattered and fragmented scenario. However, identifying and agreeing upon a definition, especially from a legal perspective, is certainly a crucial step in addressing this phenomenon. Aside from ensuring that all forms of gynecological and obstetric violence are tackled — thus not only the physical, but also the verbal and psychological abuse — a comprehensive definition should take into account the element of free and informed consent (or better, the lack of it) which is a core issue in the context of violations of sexual and reproductive rights of women.

3 Framing gynecological and obstetric violence as a violation of human rights

Gynecological and obstetric violence is a multi-layered phenomenon, which can include physical, psychological and verbal abuse and mistreatment. It is comprised of several practices (Šimonović 2019),[12] some of which, if performed with the patient's consent, do not necessarily lead to gynecological and obstetric violence. For instance, an abortion, a C-section, or even a sterilization procedure (to name a few), if carried out with the voluntary, informed and unconditioned consent of the patient, are normally administered procedures within hospitals and healthcare facilities. The European Court of Human Rights (ECtHR) stated in *V.C. v. Slovakia* and in *N.B. v. Slovakia* that the forced sterilization of the two applicants following the delivery of their children (even though they had been led to signing some documents to undergo the procedure — in a language they did not speak fluently, without the support from a translator, and heavily drugged to mend the pain) amounted to substantive violations of their rights under Articles 3 (freedom from inhuman or degrading treatment) and 8 (right to private and family life) of the European Convention of Human Rights (ECHR).

The violation of the right to private and family life, as well as the violation of the right to be free from inhuman or degrading treatment, are only two examples of human rights violations gynecological and obstetric violence can amount to. The following pages will focus on how human rights courts and treaty bodies have dealt

12 In her report the Special Rapporteur enumerates a number of practices which can amount to gynaecological and obstetric violence, such as symphysiotomy; episiotomy; forced sterilizations and forced abortions; being tied or cuffed to a hospital bed during childbirth or abortion; unnecessary caesarean sections or deliveries; overuse of oxytocin to induce contractions; exposing patients to unexperienced medical staff during labour; manual fundal pressure to facilitate childbirth; sharing patients' health information without regard for privacy or consent; profound humiliations; verbal abuse and sexist remarks.

with some cases of gynecological and obstetric violence, highlighting the human rights violations found.

In the cases brought to the ECtHR, though the Court never specifically addressed the issues as gynecological and obstetric violence, the violations concerned the prohibition of torture and inhuman or degrading treatment and to the right to private and family life. Gynecological and obstetric violence infringes upon the dignity of women, protected under Article 3 ECHR, and renders them unable to perform decisions concerning their own body and reproductive health, amounting to violations of Article 8 (Dal Monico 2024, cf. also Dal Monico forthcoming). However, what the Court did not identify in that context was a violation of Article 14 ECHR, dealing with non-discrimination — even though the two patients, young women of Roma ethnic origin, were subjected to those procedures due to a bias towards people of Roma origin. Indeed, in her dissenting opinion judge Mijović firmly disagreed with the Court's decision not to engage in a broader reasoning on Article 14, which reduced the case to an individual dimension, not addressing the systematic discrimination of Roma women in Slovakian hospitals.[13] Though the Court did not find the actions of the medical staff in both *N.B.* and *V.C.* as deliberately aimed at ill-treating the patients, the non-consensual nature of the acts, as well as the physical and psychological damages caused to them, were perceived as being severe enough to meet the threshold for inhuman treatment.[14]

Cases of gynecological and obstetric violence amounting to inhuman or degrading treatment were decided also by the InterAmerican Court of Human Rights (IACtHR), which has adopted a more extensive approach in its appraisal of gynecological and obstetric violence-related cases, compared to its European counterpart. In the 2016 case *I.V. v. Bolivia*, it dealt with forced sterilization. I.V. was a young woman of Peruvian nationality, who obtained the refugee status together with her partner and daughters in Bolivia after fleeing from Peru. In 2000, being pregnant with her third child, she was admitted to the Women's Hospital in La Paz after experiencing the spontaneous rupture of the membranes, in her 38th week of pregnancy. Since her child was in a transversal position and she had not entered into labour at that point, the medical staff decided to perform a C-section. During the procedure, after her third child was born, the medical staff performed a tubal ligation to which she had not given consent. The medical staff had her husband sign a form, prior to the surgery, to authorize the C-section. The form was not signed by I.V. So, even

13 Dissenting opinion of Judge Mijovic in the case of V.C. v. Slovakia, No. 18968/07, ECtHR (Former Fourth Section), 8 November 2011.

14 For a feminist critique of Article 3 ECHR with specific reference to the cases of gynaecological and obstetric violence, see Dal Monico forthcoming.

if she was conscious as she underwent the operation under epidural anesthetic, they went looking for her husband during the procedure to have him authorize the sterilization, but they could not find him. In her file, the doctors wrote that she had given verbal consent to the sterilization while in surgery, but, in front of the domestic Courts, she firmly denied having ever agreed to it, as she only learned what had been done to her a few days later.

Eventually, the Court stated that Bolivia had violated Articles 5.1 (right to humane treatment) in particular in regards to the non-consensual nature of the sterilization; 7.1 (right to personal liberty); 11.1 (right to privacy); 13.1. (right to freedom of thought and expression) of the American Convention, as well as Article 7(a) of the Belém Do Pará Convention, which enshrines the right for women to be free from violence. The Court's evaluation demonstrates the impact that gynecological and obstetric violence practices can have on human rights, as well as the necessity to assess such cases with an intersectional approach and bearing in mind the gender-based nature of the phenomenon. Indeed, the Court noted how multiple factors of discrimination converged intersectionally in this case, also with regard to access to justice, highlighting how the patient's gender, socio-economic condition and refugee status were key factors in the discrimination she suffered (Dal Monico 2024).

The IACtHR addressed the issue of gynecological and obstetric violence, with a (tentative) intersectional approach, also in *Manuela et al. v. El Salvador*, by recognizing how the applicant's socio-economic and cultural background exacerbated her condition of vulnerability, whereby she was discriminated against by the hospital staff, who verbally abused and degraded her. Manuela was subjected to different practices amounting to gynecological and obstetric violence: she was shackled to her bed without necessity, she had her medical information disclosed without consent, and she was verbally abused by the staff who believed she had induced the abortion herself.[15]

The contribution of human rights treaty bodies and human rights courts is of paramount importance in framing how gynecological and obstetric violence impacts other human rights. In the absence of a specific legally binding definition or of the establishment of a right to be free from gynecological and obstetric violence in human rights law, such efforts in drawing the boundaries and establishing the content of such violations are a crucial means towards the eradication of the

15 The young woman was admitted to the hospital in severe pain as a consequence of a natural abortion, but she was suspected of having procured it herself, which is illegal in El Salvador. For this reason, she was reported to the police by the medical staff and arrested. While under arrest, she was shackled to her bed, though her condition was so critical — Manuela was also suffering from an undiagnosed Non-Hodgkin lymphoma — that prevented her from moving at all.

phenomenon. The specific contribution of the CEDAW Committee in this regard was also crucial in establishing two features at the basis of gynecological and obstetric violence: that it is a form of gender-based violence against women and that it amounts to a violation of women's human rights (among others, their right to reproductive health) (Bernardini and Dal Monico 2024). Furthermore, the CEDAW Committee's assessment of gynecological and obstetric violence has also proved instrumental in establishing that the practice entails forms of gender stereotyping.

In *S.F.M. v. Spain*, the CEDAW Committee found a violation of the applicant's rights under Articles 2(b)(c)(d) and (f), 3, 5 and 12 of the CEDAW Convention.[16] The applicant claimed that she had to undergo certain procedures to which she had not consented, such as early induced labour through oxytocin, forced lithotomy position during childbirth and an episiotomy alongside repeated (unnecessary) digital vaginal exams (a total of 10 in less than 48 hours, leading to her daughter contracting E. coli bacteria upon delivery and being taken away to undergo treatment right after birth — resulting in a week long separation from her mother). Moreover, the stereotypes that were at the basis of the mistreatment she suffered at the hospital were also prolonged during administrative and judicial proceedings, violating her right to be free from discrimination. The Committee stated that:

> the author maintains that she received the poor care that is the subject of the present complaint precisely because of the persistent gender stereotypes related to motherhood and childbirth: first the health personnel and then the judges took the view that women should follow doctors' orders because they are incapable of making their own decisions (CEDAW 2020a, 8).

Furthermore, the domestic judges' appraisal of the author's account of the events, discrediting her suffering as a mere "matter of perception" revealed "a gender-stereotyped depiction of women as hysterical, mad and prone to exaggeration and whining."

In *N.A.E. v. Spain*, the Committee acknowledged the same breach of the applicant's fundamental rights enshrined in the CEDAW Convention. In this case, the applicant claimed also to have been induced into early labour through oxytocin, to have undergone ten digital vaginal examinations; to have undergone a caesarean section without her consent; being strapped down and prevented from holding her

16 Specifically, Article 2 establishes State parties' obligations to: (b) eliminate discrimination against women by adopting appropriate legislative measures; (c) establish legal protection on an equal basis with the rights of men; (d) refrain from engaging in any act or practice of discrimination. Article 3 concerns the obligation to adopt measures to ensure the advancement of women in the economic, social, and cultural fields on the basis of equality with men. Article 5 concerns gender stereotyping and prejudices, imposing the obligation to eradicate such patterns, while Article 12, as mentioned, concerns obligations in relation to the right to health.

newborn child, denied food and clarifications concerning what was being done to her. She also reported several incidents where, instead of meeting her requests for explanations, she was faced with demeaning and infantilizing comments such as: "calm down little girl" (CEDAW 2022, 3).[17] In the Committee's views, Spain had violated its obligation to take all appropriate measures to modify or abolish laws and regulations as well as customs and practices resulting in forms of discrimination against women and considered that "stereotyping affects the right of women to be protected against gender-based violence, in this case obstetric violence" (CEDAW 2022, 17). It also recognized that the applicant's right to sexual and reproductive health was violated, including the access to safe and high quality maternity free from discrimination (Bernardini and Dal Monico 2024).

A third case was brought against Spain in 2023, *M.C.P.D. v. Spain*, where the applicant alleged being repeatedly denied medications to ease the pain for a hiatal hernia she was suffering from and forced to dilate in the lithotomy position against her wishes. Ultimately, she was forced to undergo a C-section without her consent and without actual medical necessity, as she reported having overheard the medical staff saying that all the delivery rooms were full, hence the choice of a C-section. In its decision, the Committee stressed how often in similar cases of gynecological and obstetric violence, caesarean deliveries are performed without actual medical necessity, but mostly due to economic or time related reasons.

4 Missed opportunities at the international and regional levels: how to approach gynecological and obstetric violence moving forward?

Some considerations can be drawn with regard to how human rights courts and the CEDAW Committee have dealt with cases of gynecological and obstetric violence. Again, it is worth stressing that, in the absence of a legally binding definition at the international or regional levels, the efforts of courts and treaty bodies are crucial in defining the contours of gynecological and obstetric violence in human rights law. However, these efforts show precisely how such a legal void may lead to differences in how gynecological and obstetric violence is approached by courts.

In the cases decided by the CEDAW Committee and by the IACtHR, the gender-based nature of gynecological and obstetric violence clearly emerges. In considering

17 The author was 25 years old at the time.

the cases brought against Spain, the Committee highlighted how the nature of the stereotyping that the applicants were subjected to affected their right to be protected from gender-based violence, in relation not only to gynecological and obstetric violence but also to accessing remedies, in order to seek justice for what they had suffered. For instance, in *M.D.P.C v. Spain*, the Committee highlighted that:

> the administrative and judicial authorities of the State party applied stereotypical and therefore discriminatory notions of gender, for example, by assuming that it is the doctor who decides whether or not to perform a caesarean section, without exploring alternatives, explaining the reasons to the patient or seeking her informed consent, even though the author had expressed her opposition to the procedure (CEDAW 2020b, 16).

Another relevant aspect shared by the reasoning of both of the IACtHR and the CEDAW Committee lies in the recognition of the violation of the applicants' right to health. At the international level, the right to health is enshrined in Article 12 of CEDAW and in all three cases concerning Spain, the Committee identified a violation of the right to health.[18] In the Interamerican context, the right to health is not expressly enshrined within the Convention, yet the case law of the IACtHR has included health within the scope of Article 26 of the American Convention (ACHR), which concerns progressive development and obliges State Parties to adopt measures "with a view to achieve progressively [...] the full realization of the rights implicit in the economic, social, educational, scientific, and cultural standards set forth in the Charter of the Organization of American States." In *Manuela et al.*, the IACtHR established a violation of Article 26 ACHR by El Salvador, hence a violation of the right to health, stating: "The right to sexual and reproductive health forms part of the right to health."[19] The ECtHR came to similar conclusions with regard to the violation of the applicants' right to reproductive health in both *V.C.* and *N.B.*, identifying a violation of Article 8 ECHR. The ECHR does not include a provision specifically aimed at the protection of the right to health, and has expanded the parameters of Article 8, concerning the right to private and family life, to include health-related matters and particularly cases concerning reproductive rights.[20] Yet, the ECtHR failed to recognize the gendered nature of this form of violation (Alaattinoğlu 2023) by not considering the discrimination suffered by the applicants.

Contrary to the CEDAW Committee and the IACtHR's approaches to gynecological and obstetric violence, which also indicate an intersectional appreciation of how

18 See CEDAW 2020a, para. 7.6; CEDAW 2022, para. 15.9; CEDAW 2020b, para. 7.14.

19 IACtHR 2021, 55. On the human right to health in the Interamerican system see Tripo 2023. Specifically on women's right to health, see De Vido 2021.

20 See also ECHR 2023.

different factors converge to exacerbate conditions of vulnerability and lead to further discriminations, the gender-based nature of gynecological and obstetric violence has not been so expressly acknowledged by the ECtHR, which did not recognize that the applicants' socio-economic and cultural backgrounds had played a significant role in what they experienced (Dal Monico 2024). Although the ECtHR did get to a conclusion similar to that of the IACtHR concerning forced sterilization, stating that it amounts to inhuman treatment, the overall approach of the Interamerican Court, which relied also on the Belém Do Pará Convention to interpret States' obligations in cases of gender-based violence against women, shows a more extensive appreciation of the phenomenon, which affects women because of their gender and because of a stereotyped perception of how a woman about to be a mother should act. Cook and Cusak (2010) stressed how pervasive false stereotypes in the health sector portray women as incapable of making rational decisions, which leads to disrespectful and patronizing attitudes as well as infantilization by the medical staff.

Recognizing how stereotypes are entrenched in gynecological and obstetric violence practices and its gender-based nature, which can lead to discrimination, would allow for a more comprehensive appraisal of the phenomenon and constitute a first step towards its eradication. As mentioned, gynecological and obstetric violence is an umbrella term which includes practices ranging from forced episiotomies and sterilizations to humiliating and debasing comments and verbal abuse, which share the element of being a form of gender-based discrimination and violence against women. The inclusion in the Istanbul Convention of forced sterilization and forced abortions, two practices which can amount to gynecological and obstetric violence, is a crucial step in the recognition of gender-based violence against women in the health sector. Moreover, the ECtHR could refer to the Istanbul Convention to interpret the ECHR law in cases of gender-based violence against women, including gynecological and obstetric violence (De Vido 2020).[21] Such a gender-sensitive approach would prove particularly relevant in cases of gynecological and obstetric violence. The practice often leads not only (and not necessarily) to physical damage, but also to psychological and emotional scarring and human rights violations which should be approached as forms of gender-based discrimination and violence.

21 The IACtHR, by applying the Belém Do Pará Convention, could interpret State obligations in cases of violence against women and conceptualize transformative reparations.

5 Conclusions

The lack of a legally binding definition of gynecological and obstetric violence at the international and regional levels leaves a legal void that regional courts of human rights and treaty bodies have to fill, resulting in fragmented approaches. In particular, there is a risk of not recognizing gynecological and obstetric violence as a gender-based phenomenon, which is deeply embedded in societal conceptions and stereotypes on how women should behave, what they should do and how they should act as mothers. Moreover, the deeply seeded notion in the health sector that the doctor-patient relation is heavily imbalanced in favor of the doctor, who is the "rational" one in the binomial, contributes to gynecological and obstetric violence. Further attempts at defining the practice from a legal perspective at the national, regional and international levels should then strive to recognize it as a gender-based discrimination that can amount to gender-based violence.

Future attempts should also focus on the notion of *consent*. Indeed, acts amounting to gynecological and obstetric violence share the underlying lack of the patient's informed and voluntary consent. Consent should be *voluntary*, meaning that no patient should be put in a position where they feel forced to accept certain practices, and it should come from the patient themselves — not from the husband, partner or a relative[22]; it should be *informed*, meaning that information should always be made available to the patient in a way that is accessible and understandable and the patient should be in a physical and mental state that allows them to understand what they are being told[23]; finally, the consent should be given prior to the performing of the acts. This would necessarily lead to redefining the doctor-patient relation as one based on consent and not on mere trust because "the doctor knows best" (Popowicz 2021), reshaping the imbalance of power and diverting from systemic prejudices (cf. also De Vido 2021).

22 See: *I.V. v. Bolivia.*

23 *Cf. V.C. v. Slovakia* and *N.B. v. Slovakia.* In both cases, the applicants did not understand the language and were not provided with a translator. Also, due to the pain they were suffering, the applicants were heavily medicated thus unable to give their valid consent.

References

Alaattinoğlu, Daniela. 2023. "Article 39 – Forced abortion and forced sterilization" in *Preventing and Combating Violence Against Women and Domestic Violence: A Commentary to the Istanbul Convention*, edited by Sara De Vido and Micaela Frulli. Edward Elgar Publishing Limited.

Bernardini, Lorenzo, and Sara Dal Monico. 2024. "A Way Forward: Criminal Law as a Possible Remedy in Addressing Gynaecological and Obstetric Violence?" in *Researching the boundaries of sexual integrity, gender violence and image-based abuse*, edited by Gert Vermeulen, Nina Peršak and Stéphanie De Coensel. Maklu Publishers.

Blondin, Maryvonne. 2019. "Obstetrical and Gynaecological Violence." Doc. 14965. https://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-EN.asp?fileid=28108 (last accessed March 24, 2025).

Brennan, Karen. 2019. "Reflections on Criminalising Obstetric Violence. A Feminist Perspective." In *Childbirth, Vulnerability and Law. Exploring Issues of Violence and Control*, edited by Camilla Pickles and Jonathan Herring. Routledge.

Brunello, Silvia, Gay-Berthomieu, Magali, Smiles, Beth, Bardho, Eneidia, Schantz, Clémence and Virginie Rozee 2024. "Obstetric and Gynaecological Violence in the EU – Prevalence, legal frameworks and educational guidelines for prevention and elimination." PE 761-478. https://www.europarl.europa.eu/thinktank/en/document/IPOL_STU(2024)761478 (last accessed March 24, 2025).

CEDAW 2020a. *S.F.M. v. Spain.* https://juris.ohchr.org/casedetails/2710/en-US (last accessed March 24, 2025).

CEDAW 2020b. *M.D.P.C v. Spain.* https://juris.ohchr.org/casedetails/3754/en-US (last accessed March 24, 2025).

CEDAW 2022. *N.A.E. v. Spain.* https://juris.ohchr.org/casedetails/3144/en-US (last accessed March 24, 2025).

Chadwick, Rachelle. 2023. "The dangers of minimizing obstetric violence" *Violence Against Women* 29 (9): 1899–1908, doi: 10.1177/10778012211037379.

Cook, Rebecca and Simone Cusak. 2010. *Gender Stereotyping*. University of Pennsylvania Press.

Dal Monico, Sara. 2024. "Di Violenza Ostetrica E Ginecologica, Vulnerabilità Ed Intersezionalità: Prospettive Emergenti Nella Giurisprudenza Della Corte Europea Dei Diritti Umani E Della Corte Interamericana Dei Diritti Umani." In *Pluralità & Diritto, Alle radici del giuridico*, edited by Rosa Palavera, Nicola Pascucci and Anna Sammassimo. Urbino University Press.

Dal Monico, Sara. forthcoming. "Gynaecological and Obstetric Violence: meeting the threshold of ill-treatment? A feminist reading of Article 3 of the European Convention on Human Rights" *GenIUS*. https://www.geniusreview.eu/ (last accessed March 24, 2025).

De Vido, Sara. 2020. "The Istanbul Convention as an Interpretative Tool at the European and National Levels" in *International Law and Violence against Women*, edited by Johanna Niemi, Lourdes Peroni and Vladislava Stoyanova. Routledge.

De Vido, Sara. 2021. *Violence against Women's Health in International Law*. Manchester University Press.

Diaz-Tello, Farah. 2016. "Invisible Wounds: Obstetric Violence in the United States". *Reproductive Health Matters* 24 (847): 56–64. https://doi.org/10.1016/j.rhm.2016.04.004.

ECtHR 2011. *V.C. v. Slovakia*, https://hudoc.echr.coe.int/fre#{%22itemid%22:[%22001-107364%22]} (last accessed March 24, 2025).

ECtHR 2012. *N. B. v. Slovakia*, https://hudoc.echr.coe.int/eng#{%22itemid%22:[%22001-111427%22]} (last accessed March 24, 2025).

European Parliament (EP). 2022. "European Parliament Resolution of 24 June 2021 on the situation of sexual and reproductive health and rights in the EU, in the frame of women's health." (2020/2215(INI)). *Official Journal of the European Union*, C 81, 18 February 2022.

Ferrão, Ana Cristina, Sim-Sim, Margarida, Almeida, Vanda Sofia and Maria Otília Zangão. 2022. "Analysis of the concept of obstetric violence: scoping review control" *Journal of Personalized Medicine* 12 (7): 1–11. https://doi.org/10.3390/jpm12071090.

García Moreno Claudia, and Shirin Heidari. 2016. "Gender-based Violence: a barrier to Sexual and Reproductive Health and Rights." *Reproductive Health Matters* 24 (47): 1–4. https://doi.org/10.1016/j.rhm.2016.07.001.

IACtHR 2016. *I. V. v. Bolivia*, https://www.corteidh.or.cr/docs/casos/articulos/seriec_329_ing.pdf (last accessed March 24, 2025).

IACtHR 2021. *Manuela et al. v. El Salvador*. https://www.corteidh.or.cr/docs/casos/articulos/seriec_441_ing.pdf (last accessed March 24, 2025).

Kukura, Elizabeth. 2018. "Obstetric Violence." *The Georgetown Law Journal* 106: 721–801. https://ssrn.com/abstract=3167375.

Larrea, Sara, Prandini Assis, Mariana and Camila Ochoa Mendoza. 2021. "Hospitals have some procedures that seem dehumanising to me: experiences of abortion related obstetric violence in Brazil, Chile and Ecuador." Agenda 55 (3): 54–68. https://doi.org/10.1080/10130950.2021.1975967.

Mestre i Mestre, Ruth. 2023. "Article 38 – Female Genital Mutilation" in *Preventing and Combating Violence Against Women and Domestic Violence: A Commentary to the Istanbul Convention*, edited by Sara De Vido and Micaela Frulli. Edward Elgar Publishing Limited.

OAS MESECVI. 2012. "Second Hemispheric Report on the Implementation of the Belém Do Pará Convention." https://www.oas.org/en/mesecvi/docs/mesecvi-segundoinformehemisferico-en.pdf (last accessed March 24, 2025).

Parliamentary Assembly of the Council of Europe (PACE). 2019. "Resolution 2306(2019) on Obstetric and Gynaecological Violence." Doc. 14965. https://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-EN.asp?fileid=28236 (last accessed March 24, 2025).

Perrotte, Violette, Chaudhary, Arun and Annekathryn Goodman. 2010. "'At Least Your Baby Is Healthy': Obstetric Violence or Disrespect and Abuse in Childbirth Occurrence Worldwide: A Literature Review." *Open Journal of Obstetrics and Gynecology*, 10: 1544–1562 https://doi.org/10.4236/ojog.2020.10110139.

Pickles, Camilla. 2022. "'Obstetric Violence', 'Mistreatment' and 'Disrespect and Abuse': Reflections on the Politics of Naming Violations During Facility-based Childbirth." *Hypathia* 38: 628–649. https://doi.org/10.1017/hyp.2023.73.

Pickles, Camilla. 2024. "Everything is Obstetric Violence Now: Identifying the Violence in "Obstetric Violence" to Strengthen Socio-legal Reform Efforts." *Oxford Journal of Legal Studies* 44 (3): 616–644. https://doi.org/10.1093/ojls/gqae016.

Pickles, Camilla, and Jonathan Herring, eds. 2019. *Childbirth, Vulnerability and Law. Exploring Issues of Violence and Control*. Routledge.

Popowicz, Dylan M. 2021. ""Doctor knows best": on the Epistemic Authority of the Medical Practitioner." *Philosophy of Medicine* 2 (2): 1–23. https://doi.org/10.5195/pom.2021.49.

Quattrocchi, Patrizia. 2019. "Obstetric Violence Observatory: Contributions of Argentina to the International Debate," *Medical Anthropology* 28 (8): 762–776, https://doi.org/10.1080/01459740.2019.1609471.

Rozée, Virginie, Schantz, Clémence, van der Waal, Rodante, van der Pijl, Marit, Holubová, Barbora, Villarmea, Stella and Adela Recio Alcaide. 2024. "Case studies on Obstetric Violence: experience, analysis and responses." Publications Office of the European Union. https://doi.org/10.2838/712175.

Sadler, Michelle, Santos, Mário, Ruiz-Berdún, Dolores, Rojas, Gonzalo Leiva, Skoko, Elena, Gillen, Patricia and Jette A Clausen. 2016. "Moving beyond disrespect and abuse: addressing the structural dimensions of obstetric violence" *Reproductive Health Matters* 24 (47): 47–55, https://doi.org/10.1016/j.rhm.2016.04.002.

Šimonović, Dubravka. 2019. "Report of the Special Rapporteur on violence against women, its causes and consequences on a human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence." UN Doc. A/74/137. https://docs.un.org/en/A/74/137 (last accessed March 24, 2025).

Tripo, Francesco. 2023. "The Human Right to Health in the Inter-American Human Rights System: An Analysis of its Enforceability." *Diritti Umani e Diritto Internazionale* 1: 35–70, https://doi.org/10.12829/107094.

WHO (World Health Organization). 2015. "The prevention and elimination of disrespect and abuse during facility-based childbirth." https://iris.who.int/bitstream/handle/10665/134588/WHO_RHR_14.23_eng.pdf?sequence=1 (last accessed March 24, 2025).

Camila Giugliani

Obstetric Violence: A Matter of Gender, Race and Class

Abstract: This chapter presents an overview of obstetric violence, mainly from a Latin American perspective. Concepts, definitions, legal aspects, and statistics are described to support the assertion that obstetric violence is a matter of gender, race and class. Obstetric racism is defined, along with the consequences of obstetric violence. Reflections about the dispute involving the terms are shared. Finally, ideas to prevent and eliminate obstetric violence are presented.

1 Introduction: concepts, definitions and legal aspects

Obstetric violence has existed for centuries, but only recently has been named as such. In 2007, the Venezuelan law defined it as:

> any conduct, action or omission carried out by the health team, directly or indirectly, in the public or private sphere, characterized by the appropriation of the woman's body and reproductive processes by the health professional, which is expressed through dehumanized care, abuse of medicalization and pathologization of natural processes, resulting in loss of autonomy and the ability to freely decide about one's body and sexuality, negatively affecting one's quality of life (Leite 2024, 2).

This was a very important precedent for the world, and awareness was raised around this subject and its particularities.

In 2010, Bowser and Hill (2010, 1) authored a USAID report proposing the term "disrespect and abuse in facility-based childbirth." This definition included seven dimensions: physical abuse; non-consented care; non-confidential care; non-dignified care; discrimination based on specific patient attributes; abandonment of care; and detention in facilities. With this definition signed by the Harvard School of Public Health, the subject gained more visibility worldwide, pushing the World Health Organization (WHO) to speak out. The publication *The prevention and elimination of disrespect and abuse during facility-based childbirth* came out in 2014, highlighting the importance of the topic and the urgency to take action (World Health Organization 2014, 1).

In 2015, based on these previous definitions and on a set of quali-quantitative research, the term "mistreatment of women during childbirth in health facilities"

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was proposed by Bohren et al. (2015, 1). The dimensions presented in this definition were: physical abuse; sexual abuse; verbal abuse; stigma and discrimination; inadequate health care; failure to meet professional standards of care; poor rapport between women and providers; and health system conditions and constraints.

So, the term "obstetric violence" emerged in Latin America, as a result of the hard work and mobilization of women's movements. This is an important observation to understand the power relations that influence the use and acceptance of these terms. There is notably greater resistance to the term "obstetric violence," and this deserves our attention. More reflections on this will be shared in section 5 of this chapter.

But these definitions share a few convergent points about obstetric violence: it occurs exclusively in the context of health facilities; it is most frequently perpetrated by health professionals; and it combines interpersonal acts (physical or verbal abuse) with institutional or systemic aspects (overburdened maternity wards or inadequate structures or human resources) (Leite et al. 2024, 2). To these, we can add other relevant characteristics that should be considered common to all definitions: obstetric violence is a form of gender-based violence and it includes not only childbirth, but pregnancy, post-partum and abortion care.

Another aspect that is worth mentioning is that some acts are unanimously identified as disrespectful and abusive (e.g. explicit physical violence), while others are subtler because they are naturalized in the institutional culture, either by health professionals or by women themselves (e.g. routine procedures that are not based on best current evidence, like C-sections without clear necessity, the Kristeller maneuver, and episiotomy) (Freedman et al. 2014, 916). This is important, because it often makes obstetric violence unclear if not fully invisible to women.

Finally, drawing from all these definitions, it is clear that obstetric violence is a structural problem impacting women's lives, involving health professionals, institutions and systems as a whole.

Unlike Venezuela, Argentina and Mexico, a specific federal law that typifies obstetric violence is still absent in most Latin-American countries (Medeiros and Nascimento 2022, 2). But there are meaningful initiatives, like the Network on Humanization of Delivery and Childbirth, created in 1993 in Brazil, that drove legal changes in obstetric care: the companion law was issued in 2005, and the transparency requirement regarding C-section rates in maternity wards or for individual professionals was introduced in 2015. In Brazil, like in many other countries, the culture and organization of health systems favor an interventionist and medicalized obstetric care. Deliveries occur mainly in tertiary hospitals and are assisted almost exclusively by physicians, even in usual risk situations, rarely involving midwives or obstetric nurses (Paiz et al. 2024, 4).

Some examples of obstetric violence in its different dimensions include: the health team making jokes, such as, "When you made this baby, you didn't cry, did

you?" and other offensive or threatening comments; deprivation of food and water; unnecessary interventions; unconsented procedures; immobilization in bed; obligation to stay in the lithotomy position; violation of the right to privacy and confidentiality; impossibility of asking questions; and being refused the presence of a companion throughout the whole childbirth process. It is well known that having a companion is protective, and denying this increases loneliness, insecurity, and pain for women in the birthing or abortion process (Medeiros and Nascimento 2022, 5).

2 How common is obstetric violence?

Because obstetric violence is a complex phenomenon, it is difficult to assess. In addition to its multiple definitions, there are also diverse instruments to measure its occurrence. In Brazil, various studies have shown a prevalence varying from 18% to 44% during the most recent pregnancy or delivery, and from 25% to 62% across a woman's lifetime (Leite et al. 2024, 4).

However, it is very common that many dimensions of obstetric violence go unrecognized. The largest Brazilian survey on pregnancy and childbirth, *Birth in Brazil*, which included 24,000 women, indicated a prevalence of 44% of women having suffered obstetric violence in their last delivery. However, this same research showed that 81% of women had noted the complete or partial absence of a companion. Regarding interventions in the birth process, 56% of women reported having undergone an episiotomy, and 37% the outlawed Kristeller maneuver (Leite et al. 2020, 395). Another large cohort study conducted in Brazil, including 745 women, evidenced this same kind of disparity: while 62% affirmed having suffered at least one act of obstetric violence, only 8 % perceived themselves as victims of any kind of violence, abuse or mistreatment (Dornelas et al. 2022, 535). In a further cross-sectional study with 287 participants, 12.5% said yes to the single question "Have you felt, at any moment, disrespected, humiliated or mistreated by a health professional?" However, when using an instrument compiling several acts that are considered as obstetric violence, this prevalence increased to almost 24% (Paiz et al. 2022, 9). This shows that the prevalence of practices that violate the woman's rights is superior to its recognition when measured through the women's perspective. These findings demonstrate that there is a big distance between the women's perspective and the formal definition of obstetric violence according to technical and scientific documentation. Ultimately, this means that women who are exposed to unnecessary, obsolete, outlawed, and painful practices, more often than not, do not identify them as acts of violence.

Most research about obstetric violence is conducted in the context of childbirth, yet it is estimated that women suffer even more violence during abortion care. National research in Brazil showed a prevalence around 54% of obstetric violence in women having gone through an induced abortion throughout life, compared with 25% in childbirth (Fundação Perseu Abramo 2010, 191). In countries where abortion is criminalized, obstetric violence in these cases may be more frequent (Leite et al. 2024, 6).

3 Obstetric violence as an expression of sexism, racism and classism

In 2002, Alyne Pimentel, a Black woman living in a vulnerable area of Rio de Janeiro, Brazil, died in consequence of obstetric violence (and obstetric racism, as will be detailed below). She was 28, had a 5-year old child, and was six months pregnant with her second child. After being transferred between hospitals, she lost her life due to institutional and systemic negligence, ultimately causing a hemorrhage that was not detected and treated on time. Alyne's death led to the first condemnation by a United Nations body holding a State—Brazil—responsible for a preventable maternal death. In reference to this case, the Brazilian policy to reduce maternal and neonatal deaths, previously called "Stork Network," was renamed the "Alyne Network" in 2024 (Brazil Ministry of Health 2024). This marks a governmental commitment to face the problem of obstetric violence and fight for its elimination.

Alyne's case is also emblematic because it illustrates which women are more prone to experiencing obstetric violence: poor, Black or Brown, indigenous, and less educated (Leal 2014) women. National statistics show that maternal mortality is more than twice as high among Black women compared to White women (Brazil Ministry of Health 2023). This is certainly not a coincidence. Obstetric violence is recurrent in hospital care and expresses inequalities and oppressions in gender relations as well as between health professionals and patients.

Because of wide racial disparities in obstetric care, the term obstetric racism was coined to denote "the intersection between obstetric violence and medical racism," including all health professionals, not only physicians (Davis 2018, 260). According to Dmowska et al. (2023, 210), "the concept of obstetric violence must be interrogated in relation to racism, as obstetric violence has origins not only in gender-based violence, but also in racialized and racializing violence." In this sense, obstetric racism specifically refers to the dehumanizing and neglectful treatment of non-White patients.

The research *Birth in Brazil*, already mentioned in section 2, showed that Black women had a higher risk of inadequate prenatal care, of being denied a companion, of being transferred between hospitals, and of receiving less local anesthesia for episiotomy (Leal et al. 2017, 1). Based on robust analyses with almost 24,000 women from all regions of the country, the authors state that there is clear and worrying evidence of race/color inequalities in prenatal and birth conditions for Brazilian women.

Qualitative studies conducted in Brazil have illustrated some of the most frequent scenes of obstetric racism: Black women are left waiting for longer without analgesia because they are considered "stronger," and they are ordered to take off their hair (Lima et al. 2021, 5). In the Unites States, a qualitative research examined Black, Latina, and Asian mothers' traumatic birth experiences and the role of obstetric racism in shaping these experiences (Dmovska et al. 2023, 209). According to the interviewed mothers, there were four racialized and gendered stereotypes their providers assigned to them: 1) they were uneducated (unintelligent or uninformed); 2) they were negligent (uncaring toward their child or themselves); they were considered as sexually irresponsible individuals who fail to properly care for their children; 3) they were (in)tolerant to pain (either weak or tough)[1]; and 4) they were dramatic (overreactive or unreasonably anxious). This study revealed how obstetric racism can be a key component of traumatic childbirth experiences.

The roots of obstetric racism are very ancient and deep. In the United States, enslaved women were used as reproductive objects: rape, deprivation of knowledge about contraception, gynecologic experimentation without anesthesia, and coerced reproduction are some examples. Moreover, forced sterilization of Black women was a common strategy in the 20th century, with some estimates suggesting that as many as 70,000 people were involuntarily sterilized by government-sponsored family-planning programs (Kozhimannil, Hassan and Hardeman 2022, 1538). In Brazil, enslavement was only officially abolished in 1888, leaving unhealed wounds for the whole of society, especially for the Black and Brown population.

In the search for abortion care, Black women are the most exposed to individual, social and structural barriers. A study with 2,649 women in the Northeast of Brazil demonstrated that Black and Brown women were more frequently afraid of being mistreated or more often did not have enough money for transportation, compared to White women (Goes et al. 2020, 1). These findings evidence a direct link between obstetric racism and unsafe abortion: if people suspect that they will

1 This aligns with research showing that Black and Latina women are undertreated for pain in obstetric settings.

be mistreated, discriminated or stigmatized at a health facility, they will avoid seeking care altogether and face abortion alone.

The World Health Organization, in its *Abortion Care Guideline*, states that:

> it is imperative that the access to abortion care be equitable, and that quality of care does not differ based on gender, race/color/ethnicity, religion, social class, level of education, place of residence, or the presence of any disability (World Health Organization 2022, 1)

To conclude this section, the racism of health professionals and institutions delays the decision of women to search for health care and makes access to facilities difficult, preventing these women from receiving adequate treatment, either for childbirth or abortion (Goes et al. 2020, 10).

4 Consequences of obstetric violence

The consequences for a woman who has experienced obstetric violence are many. Post-partum depression, anxiety and post-traumatic stress disorder are amongst the most common (Leite et al. 2020, 391). Delay in attending health services after delivery and difficulties in breastfeeding were also noted. As presented in section 3, maternal mortality is greater for Black women compared with White women, and obstetric violence/obstetric racism play a role in this causation.

Obstetric violence contributes to maternal morbidity and mortality in different ways. First, through the additional risk associated to aggressive management of vaginal births. Second, through using the aggressive management of vaginal births as a form of coercion to elective C-sections, increasing their occurrence and resulting risks. Third, through neglect of women who express suffering (crying, screaming, moaning) or who insistently ask for help. Fourth, through hostility against professionals and women who are seen as dissenting from the hegemonic model of care. Fifth, through neglect, delay, or outright denial of care for women undergoing abortion, particularly when team suspects or assumes that the abortion was induced. Lastly, by precluding the presence of a companion (Diniz et al. 2015, 380).

Negligence is one of the known factors associated with both near-miss events (defined as cases in which a pregnant or recently delivered woman survives a complication during pregnancy, childbirth or within 42 days after termination of pregnancy) and maternal mortality, as in the case of Alyne Pimentel illustrated above. Negligence is also a dimension of obstetric violence, so there seems to be a clear connection between these points (Diniz et al. 2015, 380).

The North-American study on obstetric racism, mentioned in section 3 (Dmovska et al. 2023, 216), discusses how the trauma that resulted from mothers'

experiences of obstetric racism had three central consequences for them: long-term mental health effects (postpartum anxiety, depression, and symptoms of post-traumatic stress disorder); decreased trust in healthcare and fear of having their needs dismissed (which dissuades them from seeking medical care); and a reduced desire to have future children.

5 Obstetric violence: a term in dispute

To start with, a couple of questions: why is the term "obstetric violence" so unwelcome in medicine? Why do physicians feel so targeted by it?

Reflections about these questions should consider several factors. In the first place, the importance of naming. Does naming these situations as "obstetric violence" or "mistreatment" change anything? Probably yes. Leila Katz (2020, 623), in her paper "Who is afraid of obstetric violence?," writes: "Naming it obstetric violence and understanding it as gender-based violence will ensure appropriate interventions to prevent this violation of women's rights." And it also honors every woman who has suffered obstetric violence or is at risk of going through it.

Why then is the medical category so resistant to the name "obstetric violence?" Many medical councils in Brazil have already publicly manifested their rejection of the term, arguing that it targets obstetricians in a belligerent way, encouraging legal processes that potentially harm physicians. This is important to consider: for this reason, the Brazilian Network on Humanization of Delivery and Childbirth has chosen to essentially use affirmative terms, like humanization of birth. This would presumably create a better environment for discussions and taking action. But what about the history of this term? How about women's struggles? How about their lives and suffering? This is the history of obstetric violence. It comes from Latin American women's voices. It has a sociopolitical construction and it confronts power relations. It calls the violation of human and reproductive rights "violence." And it has been validated by academics and institutions all around the country, as exemplified by the Brazilian Association of Collective Health, which recognizes obstetric violence as a public health matter. However, the Brazilian Ministry of Health, under the extreme right government in power in 2019, has declared the term inappropriate, arguing that health professionals do not have the intention of harming or causing damage. This ministerial position was reverted in 2022.

When the medical category denies this term, it silences these voices and this history. It denies the existence of those who are suffering: Black and indigenous women, as well as those advocating for other models of care, like midwives and traditional birth attendants. It fails to recognize that this is a public health problem.

It says that medical power should not be questioned. To clarify, it is important to say that the term "obstetric violence" is not specific to physicians or obstetricians, but encompasses all health professionals acting in birth or abortion care, and includes systemic failures. This assumption is also very informative, because it shows how obstetric care in Brazil is centralized around the figure of the doctor. Therefore, if we are to think of alternative terms, this process has to be done with real dialogue and respectful recognition of women's voices and histories. No one has the right to erase their knowledge and wisdom in the construction of the term *obstetric violence*.

6 The way forward: how to prevent/eliminate obstetric violence?

What to do? Recognizing the problem (and naming it appropriately) is the first step. Then, it is a matter of investing heavily in education to confront all forms of gender-based violence. This includes community education but especially professional training to ensure good practices in antenatal, childbirth, post-partum and abortion care. This encompasses training in person-centered care; involving the women's support network; encouraging the use of delivery/birth plans; having good continuity of care in the process from antenatal to post-partum care; being responsible for sharing quality information; ensuring effective and respectful communication in all situations; creating an environment where women feel at ease to ask questions; not harassing women having an induced abortion; and not discriminating against women because of their color, ethnicity, social class, or educational background. Not discriminating, indeed, is not enough. It is necessary to be aware of the structural nature of racism and other violences, and be careful not to reproduce it.

Action is needed from the individual to the systemic level. Governments and health systems must be held accountable. The World Health Organization (2014) has called for greater support from governments for research and action on disrespect and abuse, and for programs that ensure that all women have access to respectful, competent and caring maternity health care services. The WHO statement also emphasizes that States should develop policy initiatives on the importance of respectful maternal care and calls all stakeholders (women, communities, healthcare providers, managers, health professional training, education and certification bodies, professional associations, governments, health systems stakeholders, researchers, civil society groups and international organizations) to be part of these efforts. This statement represents an important progress in recognizing the problem of disrespectful and abusive treatment during childbirth in facilities at the global level. Nonetheless, there are some gaps to be filled: violations in abortion

care are not mentioned, nor is the term “obstetric violence” used in recognition to this as an expression of gender-based violence.

Obstetric violence is a symptom of reproductive injustice, and this should be the bottom line to guide strategies to face this problem. Reproductive justice, proposed by authors and activists such as Loreta Ross, Dorothy Roberts, and Sueli Carneiro, has three pillars: 1) the right to have children under the conditions of choice; 2) the right not to have children by using contraception, abortion or abstinence; and (3) the right to care for one's children in safe and healthy environments, free from violence by individuals or the state (Carvalho and Elias 2024, 9). The prism of reproductive justice recognizes the singularities and specificities of women, and how their lives are affected by racism, classism, patriarchy, and other oppressions. Therefore, action for reproductive justice is intersectional in nature.

In conclusion, we need action on all levels: individual (women living in dignity who can learn about their rights and claim them); professional (training of health professionals in sexual and reproductive rights and good practices in prenatal, childbirth, and abortion care, since the undergraduate level; incentives to the training of midwives and obstetric nurses); community (epidemiological surveillance and formal complaints); legal (specific laws that typify obstetric violence); institutional (health facilities that are structured and organized to respect the rights of women); and systemic (health systems and policies that protect women from obstetric violence and that promote respectful care). Beyond that, strategies to confront obstetric racism include: increased access to doulas services, increased racial/ethnic diversity among obstetric providers (because patient-physician racial concordance may increase patients’ trust, satisfaction, service utilization, and involvement in decision-making), and improvements to medical education curricula, such as training in anti-racism and cultural humility (Dmovska et al. 2023, 2017).

The tragic story of Alyne Pimentel must not happen again.

References

Bohren, Meghan A., Joshua P. Vogel, Erin C. Hunter, et al. 2015. “The mistreatment of women during childbirth in health facilities globally: A mixed-methods systematic review”. *PLOS Med* 12 (6): e1001847. https://doi.org/10.1371/journal.pmed.1001847.

Bowser, Diana, and Kathleen Hill. 2010. “Exploring evidence for disrespect and abuse in facility-based childbirth: Report of a Landscape Analysis.” *United States Agency for International Development*. https://content.sph.harvard.edu/wwwhsph/sites/2413/2014/05/Exploring-Evidence-RMC_Bowser_rep_2010.pdf (last accessed March 30, 2025).

Brazil Ministry of Health. 2023. “Morte de mães negras é duas vezes maior que de brancas, aponta pesquisa”, November 11. https://www.gov.br/saude/pt-br/assuntos/noticias/2023/novembro/morte-de-maes-negras-e-duas-vezes-maior-que-de-brancas-aponta-pesquisa (last accessed March 31, 2025).

Brazil Ministry of Health. 2024. “Rede Alyne: conheça a história da jovem negra que deu nome ao novo programa de cuidado integral à gestante e bebê”, 20 September. https://www.gov.br/saude/pt-br/assuntos/noticias/2024/setembro/rede-alyne-conheca-a-historia-da-jovem-negra-que-deu-nome-ao-novo-programa-de-cuidado-integral-a-gestante-e-bebe (last accessed March 31, 2025).

Carvalho, Layla P., and Maria L.G.G.R. Elias. 2024. “Justiça reprodutiva nos debates sobre a esterilização de mulheres e sobre o vírus Zika.” *Revista Sociedade e Estado* 39 (1): e49724. https://doi.org/10.1590/s0102-6992-20243901e49724.

Davis, Dána A. 2018. “Obstetric Racism: The Racial Politics of Pregnancy, Labor, and Birthing.” *Medical Anthropology* 38 (7): 560–573. https://doi.org/10.1080/01459740.2018.1549389.

Diniz, Simone G., Heloísa de O. Salgado, Halana F.de A. Andrezzo, et al. 2015. “Abuse and disrespect in childbirth care as a public health issue in Brazil: origins, definitions, impacts on maternal health, and proposals for its prevention.” *Journal of Human Growth and Development* 25 (3): 377–384. http://dx.doi.org/10.7322/jhgd.106080.

Dmowska, Amelia, Priya Fielding-Singh, Jodi Halpern, and Ndola Prata. 2023. “The Intersection of Traumatic Childbirth and Obstetric Racism: A Qualitative Study.” Birth 51 (1): 209–217. https://doi.org/10.1111/birt.12774.

Dornelas, Adélia C.V.R., Lívia D.S. Rodrigues, Marina P. Penteado, et al. 2022. “Abuse, disrespect and mistreatment during childbirth care: contribution of the Ribeirao Preto cohorts, Brazil.” *Ciência & Saúde Coletiva* 27 (2): 535–544. https://doi.org/10.1590/1413-81232022272.01672021.

Freedman, Linn P., Kate Ramsey, Timothy Abuya, et al. 2014. “Defining disrespect and abuse of women in childbirth: a research, policy and rights agenda.” *Bulletin of the World Health Organization* 92 (12): 915–917. https://doi.org/10.2471/BLT.14.137869.

Fundaçao Perseu Abramo. 2010. “Mulheres Brasileiras e Gênero nos Espaços Público e Privado”, May 5. https://fpabramo.org.br/publicacoes/wp-content/uploads/sites/5/2017/05/pesquisa-integra_0.pdf (last accessed: March 30, 2025).

Goes, Emanuelle F., Greice M.S. Menezes, Maria-da-Conceição C. Almeida , et al. 2020. “Racial vulnerability and individual barriers for Brazilian women seeking first care following abortion.” *Cadernos de Saúde Pública* 36 Sup 1:e00189618. https://doi.org/10.1590/0102-311X00189618.

Katz, Leila. 2020. “Who is afraid of obstetric violence?” *Revista Brasileira de Saúde Materno Infantil* 20 (2): 623–626. http://dx.doi.org/10.1590/1806-93042020000200017.

Kozhimannil, Katy B., Asha Hassan, and Rachel R. Hardeman. 2022. “Abortion access as a racial justice issue.” *The New England Journal of Medicine* 387 (17): 1537–1539. https://doi.org/10.1056/NEJMp2209737.

Leal, Maria do Carmo, Ana Paula E. Pereira, Rosa M.S.M. Domingues, et al. 2014. “Intervenções obstétricas durante o trabalho de parto e parto em mulheres brasileiras de risco habitual” Obstetric interventions during labor and childbirth in Brazilian low-risk women”. *Cadernos de Saúde Publica* 30 (Supl. 1): S1–S16. https://doi.org/10.1590/0102-311x00151513.

Leal, Maria do Carmo, Silvana G. N. da Gama, Ana Paula E. Pereira, Vanessa E. Pacheco, , Cleber N. do Carmo, , and Ricardo V. Santos, 2017. “The color of pain: racial iniquities in prenatal care and childbirth in Brazil.” *Cadernos de Saúde Pública* 33 (Sup 1): e00078816. https://doi.org/10.1590/0102-311X00078816.

Leite, Tatiana H., Ana Paula E. Pereira, Maria do Carmo Leal, and Antônio A. M. da Silva. 2020. “Disrespect and abuse towards women during childbirth and postpartum depression: findings from Birth in Brazil Study.” *Journal of Affective Disorders* 273: 391–401. https://doi.org/10.1016/j.jad.2020.04.052.

Leite, Tatiana H., Emanuele S. Marques, Rachel G. Corrêa, et al. 2024. “Epidemiology of obstetric violence: a narrative review of the Brazilian context.” *Ciência & Saúde Coletiva* 29 (9): 1–13. https://doi.org/10.1590/1413-81232024299.12222023.

Lima, Kelly D de., Liana Lewis, and Tereza M. Lyra I,. 2021. “O escuro das cores, na pele afrodescendente, herdeira das dores: dimensões do racismo no contexto de assistência ao parto.” *Physis: Revista de Saúde Coletiva* 31(1): e310119. http://dx.doi.org/10.1590/S0103-73312021310119.

Medeiros, Rita de Cássia da S., and Ellany G. C. do Nascimento. 2022. “You didn’t cry while doing it: obstetric violence and its expressions.” *Revista de Estudos Feministas* 30 (3): e71008. https://doi.org/10.1590/1806-9584-2022v30n371008.

Paiz, Janini C., Stela M. de J. Castro, Elsa R.J. Giugliani, et al. 2022. “Development of an instrument to measure mistreatment of women during childbirth through item response theory.” *PLOS ONE* 17 (7): e0271278. https://doi.org/10.1371/journal.pone.0271278.

Paiz, Janini C., Alice S. Souto, Ana Cláudia M. Martins, , Sarah M. dos Santos Ahne, Mônica Baréa and Camila Giugliani. 2024. “Obstetric violence: between women’s perception and childbirth care practices.” *Revista Brasileira de Medicina de Família e Comunidade* 19 (46): 3852. https://doi.org/10.5712/rbmfc19(46)3852.

World Health Organization. 2014. “The prevention and elimination of disrespect and abuse during facility-based childbirth”. https://www.who.int/publications/i/item/WHO-RHR-14.23 (last accessed March 30, 2025).

World Health Organization. 2022. “Abortion Care Guideline.” https://www.who.int/publications/i/item/9789240039483 (last accessed March 31, 2025).

Giulia Stolfi

The Prevention of Obstetric Violence: The Humanization of Childbirth in Brazil

Abstract: The purpose of this chapter is to analyze the measures taken in Brazil to prevent obstetric violence. The initiatives promoted in public facilities, inherent in the implementation of the humanized childbirth model, aim to improve maternal health through care centered on the respect and protagonism of women. The humanization of childbirth, drawing on the contributions of professionals and activists and the critique of the medicalized and technocratic model of childbirth, has provided a decisive impulse for the transformation of obstetric care through a holistic approach that considers childbirth not only as a biological, but also as a psychosocial event. The paradigm shift, which affects both healthcare systems and the professionals involved, is not limited to eliminating certain practices, but rather aims to promote structural, ethical and cultural change, reducing cases of obstetric violence and ensuring a better childbirth experience while respecting women's human rights.

1 Obstetric violence in Brazil

With the increasing use of medical technologies since the second half of the twentieth century, Brazil has been affected by numerous transformations in the field of childbirth. The view of childbirth as a pathological and unnecessarily painful event gained ground starting from the earliest decades of the twentieth century; it was so that the practice of external intervention began, modifying the normal processes associated with childbirth. The figure of the physician soon took on a salvific value, in that he could deliver the woman without her being aware of it, using anesthetic techniques such as the administration of morphine, scopolamine and dolatine, which induced deep sedation, also known as twilight sleep. The physician then proceeded to extract the fetus from the mother's body through the use of high forceps (Sandelowski 1984). This method, already employed in Europe and the United States, had in Brazil its most prominent represantive in Magalhães, who developed his own formulation of the drug by mixing morphine and caffeine (Diniz 2005, 628). The technique was later abandoned, due to the high incidence of maternal morbidity and mortality associated with it, but the medical view of the female body as an inanimate object on which to operate remained unchanged, with lasting consequences in the medical practice of childbirth. The motionless, unconscious body became the symbol of women's passive suffering in childbirth (Rich 1995).

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During the second half of the twentieth century, childbirth — at first still experienced at home and assisted by other women (*parteiras*) — was moved to the hospital, which was seen as a more secure setting. Hence, in most industrialized countries, a "technocratic" model of childbirth emerged, characterized by a planned series of sequential interventions, as in an assembly line, monitoring, altering, accelerating or delaying the physiological progress of childbirth (Davis-Floyd 2001). In Brazil's public facilities, an invasive and violent mode of assisting birthing women was outlined. Women were tied to beds, forced to the supine position and subjected to cascade medical interventions, deprived of their personal belongings and isolated from family members, surrounded by unknown medical personnel. This scenario was often replaced by the practice of caesarean section proposed by obstetricians as a less traumatic and safer method of delivering the newborn (Diniz 2005, 629).

According to *Nascer no Brasil*, one of the most important researches conducted at the Federal level (Ensp-Fiocruz 2014), an operational model of childbirth, characterized by numerous invasive interventions, is widespread in Brazilian healthcare facilities. It includes labor induction, amniotomy, episiotomy, and the Kristeller maneuver, performed even in cases of physiological and low-risk childbirth, often in the absence of informed consent. Furthermore, in public and private healthcare, there is an alarming "epidemic of C-sections." In 2024, caesarean delivery accounted for 59.6% of total births (Ministério da Saúde 2024), in stark contrast to the guidance provided by the WHO that caesarean deliveries should not exceed 10–15% (WHO 1985). The rate of caesarean sections in private healthcare is estimated to be much higher. According to Agência Nacional de Saúde Suplementar (2022), it has reached record figures, standing at around 81,78%, mainly related to the high use of elective or planned caesarean.

The prevalence of this model in private facilities is influenced by economic, cultural and social factors. Scheduled cesarean is preferred by professionals for reasons of practicality and economic opportunity; women, on the other hand, often opt for scheduled cesarean because it is faster, despite evidence that elective caesarean affects the health of the newborn, low birth weight, development of lung capacity, and incidence of diseases such as diabetes (Ensp-Fiocruz 2014, 3). It should also be pointed out that many women prefer to turn to private clinics for planned delivery, because it is well known that giving birth in a public facility means they are more likely to experience a painful and traumatic childbirth. However, according to the Ministério da Saúde, not all women have easy access to paid care. In fact, about 71% of Brazil's population uses public healthcare to receive medical care, while those who can afford a private clinic are a minority. This disparity reinforces inequalities in access to appropriate services and puts women at greater risk of experiencing obstetric violence during childbirth. This risk is mostly associated

with greater vulnerability factors linked to disadvantaged socioeconomic conditions, ethnicity and race among the others (Leal et al. 2023).

Medicalization in childbirth has not led to positive results in terms of decreasing maternal deaths, even though safety in childbirth was one of the pivotal reasons that pushed health policies in this direction. Conversely, massive interventionism worsened the conditions of childbirth by making it riskier and violent. In fact, the problem of high maternal morbidity and mortality rates in the country (Bessa et al. 2023) is also compounded by the systematic violence acted against women in childbirth. According to Fundação Perseu Abramo, which fostered the debate on obstetric violence in Brazil, one in four women in Brazil is a victim of obstetric violence, with physical and verbal aggression, mistreatment, and unconsented interventions that are detrimental to the women's integrity and dignity rights (Fundação Perseu Abramo 2013). Behaviors such as: preventing the parturient from being accompanied by a trusted person; use of infantile names and humiliating diminutives; painful or unnecessary procedures; lack of privacy; and continuous vaginal examinations even by more than one person are also recorded (Castro et al. 2023; Costa et al. 2022; Martins et al. 2022; Medeiros and Nascimento 2022; Ferreira et al. 2025). Since the 1990s, movements, associations, and women's groups have mobilized by making explicit demands for adequate policies to ensure more humane and dignified birthing conditions for women (Rede Parto do Principio 2012), recognizing obstetric violence as a structural and institutional phenomenon, traceable to the abuse of medicalization, sexism, and medical authoritarianism. From these premises, a broad movement developed to change childbirth care from the perspective of humanization and women's reappropriation of the normal physiological processes of childbirth.

2 The movement for humanized childbirth

In response to the problem of excessive medical interventionism, beginning in the 1970s, a broad movement for the humanization of childbirth was formed in Brazil. While Leboyer's (2009) volume was being published in Europe, Brazilian gynecologist and obstetrician José Galba de Araújo initiated a pioneering project to humanize childbirth care in the State of Ceará, in collaboration with the government and the Ministry of Health. The goal was to improve childbirth care in rural areas of Ceará by providing appropriate care through differentiated treatment, based on the peculiarities of the region. In fact, Galba — who had done his studies in the United States, but always maintained a strong connection with his homeland — had realized that to improve maternal and newborn health, Brazil could not simply

replicate the program of other countries, but had to implement a solution that combined scientific medicine and respect for local traditions (Ministério da Saúde 2005, 9).

The project was initiated at Assis Chateaubriand Maternity Hospital through the creation of a school for traditional birth attendants, the *parteiras*. The latter have always carried out activities in Brazil to help and support parturients, through traditional, empirical and orally handed down knowledge. Galba de Araújo provided the *parteiras* with additional training through the teaching of basic procedures, such as the use of scissors and tiomersal to cut and treat the umbilical cord. Among other things, the project included the implementation of linking the home-based work of the *parteiras* with the maternity services present in Ceará, to strengthen local healthcare coverage. Galba de Araujo contributed to the adoption of effective measures to improve maternal and newborn health, while respecting the traditions and skills of the *parteiras*, becoming an example of a caring and respectful approach toward the culture of childbirth in Brazil. For his insight and great sensitivity, Galba de Araújo is recognized as one of the most influential figures in the movement for the humanization of childbirth, so much so that in 1999 the Ministry of Health established an award named after him that recognizes the contribution of health units integrated in the SUS public network that develop outstanding actions in promoting humanization in women's healthcare (Rede Feminista de Saúde 2002, 16).

To honor Galba de Araujo, in 1985 the WHO chose Fortaleza to hold its Conference on Appropriate Technology for Birth. This represented one of the most important moments in the establishment of a humanization movement in childbirth care, as for the first time it established the need to limit unnecessary and harmful practices for mother and child. The Conference, organized by the Pan American Health Organization (PAHO) and the World Health Organization (WHO), gave rise to the paper *Appropriate Technology for Birth*, published in the prestigious journal *The Lancet* (WHO 1985). More than fifty representatives of gynecologists, obstetricians, pediatricians, epidemiologists, sociologists, psychologists, economists, administrators, feminists and activists attended the Conference. On that occasion, WHO affirmed the necessity of quality care so that all women have the right to receive appropriate treatment. It also considered the importance of social, emotional and psychological aspects as part of perinatal assistance.

A series of recommendations were developed in the document such as: providing policies to implement appropriate technologies in public and private services; monitoring the adequacy of childbirth care; informing women about alternative modes of delivery, so as to encourage free and informed choice; encouraging the coexistence of informal systems of perinatal care with the formal system, maintaining a collaborative approach for the benefit of mother and child; fostering communication between obstetricians, midwives, women and families; and assigning responsibility

for physiological delivery to competent professionals, such as midwives or skilled attendants (WHO 1985, 436).

The general recommendations were followed by more specific ones on advised practices and those to be avoided. The former included: allow the parturient to be accompanied by a trusted person during delivery and postpartum; encourage ambulation during labor supporting the parturient to assume the most comfortable position; promote the presence of the baby with the mother. Conversely, the following practices are not recommended: conducting electronic fetal monitoring (except in cases of increased risk to the fetus); performing procedures without clinical indication, such as enema and trichotomy; forcing the parturient into the back position; resorting to cesarean section except in cases of necessity; performing episiotomy, induction of labor and artificial rupture of membranes; administering drugs, analgesics or anesthetics unless there is a real need (WHO 1985, 437). The indications formulated in 1985 are still highly relevant today.

Only ten years later, the report *Care in Normal Birth. A Practical Guide* (WHO 1997) was published, developed by a technical working group composed of experts from each WHO regional committee, with oversight from WHO's Maternal and Newborn Health/Safe Motherhood Unit and Family and Reproductive Health. This represented a milestone in the formation of a new approach in childbirth care, as the WHO, for the first time, stipulated that obstetric and gynecological practices must be evidence-based, that is, scientifically proven. In assessing the scientificity of gynecological and obstetric practices, the WHO used the Cochrane Pregnancy and Childbirth Database, placing greater emphasis on unrecommended practices. In doing so, it founded the basics of evidence-based medicine (MBE) in the field of childbirth and birth care. The WHO defined normal childbirth as "spontaneous at onset, low risk, and remaining so throughout labor and delivery," while highlighting how the recommendations made also apply to high-risk women, since very often the delivery still occurs with a normal course. The goal of normal childbirth care is "to achieve a healthy mother and child with the least possible level of intervention that is compatible with safety." Therefore, intervention is required only when there is "a valid reason to interfere with the natural process" (WHO 1997, 121).

The figure of the midwife is identified as the one best suited to assist a woman during a physiological pregnancy and childbirth. Her responsibilities include risk assessment and recognition of complications, in the absence of which there is no need to call on the obstetrician, who, instead, is deputed to treat the pathology alone. A woman with a low-risk pregnancy may opt for delivery at home or in a birth center, as a low-risk childbirth "needs no intervention but encouragement, support and a little tender loving care" (WHO 1997, 122). Through this new perspective, greater emphasis was placed on physiology, highlighting the unscientific basis of the connection between childbirth and pathology.

During those years, the feminist movement also mobilized for the promotion of women's rights in childbirth. One of the landmarks in the humanization of childbirth was the formation of the Rede pela Humanização do Parto e do Nascimento (ReHuNa), founded in 1993, in Campinas, São Paulo State. Here, concerned and indignant women and activists gathered to discuss what they called the "current situation of birth in our society." As a result of that meeting, the Carta de Campinas (Rede Feminista de Saúde 2002, 26) was drafted, containing the main critical points about the interventionist model of childbirth, as well as programmatic points about desirable interventions to ensure respectful childbirth conditions for women, in line with the recognition of women's rights, autonomy and the recognition of childbirth as a physiological event. As described by Rattner et al., ReHuNa:

> promotes and claims the practice of humanized care during childbirth in all its phases, from the prominence of the woman, the mother/child dyad, and evidence-based medicine [...] This mission has been gradually incorporated into the daily practice of individuals, professionals, groups, and entities affiliated with the network and eager to improve quality of life, well-being, and childbirth. For ReHuNa members, the need for paradigm shift in the organization of services and delivery of care to effectively meet the needs of the birthing woman, her baby, and her family is evident (Rattner et al. 2010).

The ReHuNa movement also played a decisive role in the establishment of a Latin American network, promoting the organization of the International Conference on the Humanization of Childbirth and Birth, held in Fortaleza in 2000, with the contribution of the Japan International Cooperation Agency (JICA), which had already initiated a collaboration with the Brazilian Ministry of Health through a program for the humanization of childbirth in Ceará, called "Projeto Luz" (Umenai 2001). In the Declaration formulated as part of the Conference, a new paradigm emerges based on the recognition of childbirth as a psychosocial event that therefore invests the human, spiritual and existential dimensions of the woman. From this perspective, humanization is an important step in the development of a society centered on respect, care and acceptance.

At that time, the Latin American and Caribbean Network for the Humanization of Childbirth (RELACAHUPAN) was founded, with the goal of fostering change in the model and practices of childbirth throughout the Latin American region. Currently, RELACAHUPAN encompasses seventeen countries, carrying out a coordinating action in the region, strengthening initiatives in the improvement of services and programs with a holistic approach, creating the conditions to reduce risks and improve healthcare coverage, as a function of women's right to be informed and respected at every stage of the pregnancy-puerperal cycle (López 2010, 223).

In the Latin American context, the battle for human, sexual and reproductive rights in childbirth has also been relevant in the work of the Committee for Latin America and Caribbean for the defense of women's rights (CLADEM), an NGO founded in 1987 in San José of Costa Rica. CLADEM is among the first to have extensively described the condition of women in childbirth and the systematic violation of women's rights, in the document *Silencio y Cumplicidad: Violencia contra la Mujeres en los Servicios Públicos de Salud en el Perú* (CLADEM 1998). Here, CLADEM highlighted the abuse and mistreatment of Peruvian women, mentioning physical, verbal, and psychological abuse, normalization of invasive and violent practices, humiliation, and disrespect in childbirth services, resulting in violations of international norms on combating gender-based violence codified as part of the Cairo Conference on Population and Development (UNFPA 1994) and the Fourth World Conference on Women in Beijing (UN 1995). A few years later, a new policy-formative terminology would emerge (Quattrocchi 2019) describing the forms of abuse and mistreatment that occur in the delivery room as “obstetric violence”. A legal definition was provided in Venezuela (Ley n. 38.668/2007) and Argentina (Ley 26.485/2009).

3 Laws and policies on humanizing childbirth care

For about the past two decades, institutions in Brazil have shown increasing awareness of the need to ensure a more respectful childbirth for women by launching initiatives to improve childbirth care with a focus on greater humanization. Initially, the government's effort had focused on humanization in the sense of improving public health, with the main goal of decreasing maternal and neonatal mortality and morbidity rates due to lack of resources, lack of appropriate childbirth facilities, and overuse of medical intervention. Subsequently, however, humanization policies have taken on a polysemous (Diniz 2005) and broader meaning, encompassing a perspective more focused on women’s protagonism in childbirth and sexual and reproductive rights.

The institutional commitment made at government and ministerial level represents a particularly virtuous example with respect to the implementation of this model in health policies, also in the international and global context. The policies adopted reflect the principles underpinning the humanized model of childbirth, which promotes a demedicalized, evidence-based approach, centered on the woman's needs and wants, as well as the psychosocial (Diniz et al. 2018, 20) and relational dimensions related to childbirth, with a focus on the importance of continuity of care and greater involvement of midwives, *doulas* and *parteiras* (Pitta et al.

2024). Such interventions are relevant in promoting a humanized culture of childbirth and represent one of the main strategies in preventing the phenomenon of obstetric violence, through a change that invests medical institutions at a structural level, redefining their protocols, models and practices.

The adoption of policies specifically aimed at fostering the humanization of childbirth can be made to coincide with the provision of the Prenatal and Birth Humanization Program (PHPN), established by the Ministry of Health through Ordinance/GM no. 569 of 6/01/2000 (Ministério da Saúde 2000). The primary objective was to ensure improved access to care, coverage of social and healthcare services, and quality of obstetric care in pregnancy, childbirth, and puerperium. The PHPN was based on the need to promote the right to adequate care for mother and child, while reducing maternal and neonatal morbidity and mortality rates.

In 1999, the Ministry of Health launched another initiative to reduce the number of cesarean sections with the creation of the Centro de Parto Normal (CPN), a healthcare unit that provides quality care in physiological childbirth through an autonomous facility designed for low-risk parturients who do not require hospitalization. CPNs are spaces adapted to accommodate women in a more familiar and comfortable environment, with the possibility of being followed by a midwife, respecting the normal physiological processes of childbirth and minimizing the impact of external interventions (Azevedo et al. 2023).

CPNs are complemented by the Casa da Gestante, Bebê e Puérpera (CGBP), a care unit designed for pregnant women at higher risk. This has the main objective of providing care for pregnant, birthing and *postpartum* women with intermediate care, intervening medically only in cases of proven need. The space constitutes a middle ground between home and hospital and aims to ensure more adequate care in situations where more supervision and proximity to referral services are needed, but without neglecting the importance of a respectful and welcoming environment (Marques et al. 2020, 5).

An important milestone in defining a humanized model of childbirth occurred with the Lei do Acompanhante (Lei n. 11.108/2005), which establishes the right of the parturient to have a person she trusts — the partner or other person of her choosing — during pregnancy, delivery, and *postpartum*. This standard emphasizes the importance of the involvement of the birthing woman's affections in a moment that requires closeness but is too often experienced in isolation. The right to have a trusted person close by is also among the practices recommended by the WHO to promote the pregnant woman's well-being.

Laws promoting improved obstetric care include Lei n. 11.634/2007, which recognizes the pregnant woman’s right to have contact with the healthcare personnel of the facility from the beginning of her pregnancy, with the corresponding obligation by healthcare personnel to assist the woman throughout her pregnancy, delivery,

and *postpartum*. For the purpose of personalized and respectful care, it is important for healthcare personnel to know the pregnant woman's health condition from the beginning; in addition, it is also crucial for the woman to establish a relationship of knowledge and trust with the obstetric personnel who will follow her through the pregnancy and delivery. The purpose of the rule is to curb the frequent cases of refusal of admission by some facilities due to lack of bed availability. In this way, the law aims to ensure continuity in childbirth care, through the formation of a bond between the pregnant woman and the facility since prenatal checkups, reinforcing the obligation of public and private facilities to provide care (Rede Parto do Principio 2012, 131).

Among the most relevant humanization initiatives there is Rede Cegonha, a set of actions promoted by the Ministry of Health, with the aim of ensuring women the right to reproductive planning and humane and respectful care during pregnancy, childbirth, and puerperium within SUS facilities (Ministério da Saúde 2011). Rede Cegonha is part of the government's strategies to qualify healthcare in pregnancy, childbirth and puerperium, expanding access to services and providing continuity of care, countering medicalization excess, and valuing a supportive and relational approach.

The Rede Cegonha Program was later expanded to assess the validity of actions taken at the ministerial level through initiatives such as Avaliação das Boas Práticas na Atenção ao Parto e Nascimento em Maternidades da Rede Cegonha, promoted by the Ministry of Health in collaboration with Fundação Oswaldo Cruz and Universidade Federal do Maranhão. The evaluation aimed to build shared responsibility among involved agents, by analyzing practices and work organization, and to assess the implementation level of best obstetric practices according to Ministry of Health standards (Ensp-Fiocruz 2017).

More recently, the Brazilian government has invested resources in strengthening Rede Cegonha, in view of the 2030 Agenda goals, to improve maternal and child health. The government has provided for increased coverage of public care services, access to obstetric care with highly trained staff, and psychological care services for pregnant women in SUS facilities. Finally, the government has invested in the construction of new maternity hospitals through the Novo Pac Saúde program aiming to provide adequate facilities and coverage in obstetric care in peripheral areas and in the most economically disadvantaged regions, with priority given to the most socially vulnerable segments of the population (Ministério da Saúde 2025).

Public policies promoting the humanization of childbirth in Brazil have emphasized the importance of professional figures who are not recognized or considered ancillary in the medical care model, thus promoting an alternative and transformative model of maternity care, centered on support for the parturient and useful in preventing trauma related to obstetric violence. The initiatives taken

to promote the presence, inclusion and attribution of a central role to midwives, *doulas* and *parteiras* on the birthing scene are a significant example of the institutional relevance attributed to them, despite obstacles and resistance from the medical profession (Sampaio et al. 2018, 112).

There is currently a wide-ranging debate about the recognition of the role of *doula* in promoting humanized childbirth as a figure of support, accompaniment and advocacy for the pregnant woman, in pregnancy, childbirth, puerperium and breastfeeding. Many studies have shown that the presence of a *doula* is associated with increased chances of spontaneous birth, reduced medical interventions, reduced number of cesarean sections, positive childbirth experience, and reduced incidence of depressive disorders in the *postpartum* (Azevedo et al. 2023, 11).

The recognition of the role of the *doula* first developed through some pioneering initiatives that introduced this professional in some public facilities, such as that of Hospital Sofia Feldman, in Belo Horizonte, in the State of Minas Gerais, initiated in 1997 through the "Doulas Voluntárias" project (Leão and Bastos 2001). The experience turned out to be very positive with the subsequent extension of the experiment to other facilities, later culminating with the inclusion of *doulas* in public policies as part of good care practices. The profession was then recognized in 2013 by the Ministério do Trabalho e Emprego in the Classificação Brasileira de Ocupações. Subsequently, some Municipal and State Laws have provided for the presence of *doulas* in childbirth in public and private facilities, establishing the possibility for the parturient to request a *doula* in childbirth.[1]

There is currently a bill being debated in the Câmara Federal (PL 3946/2021) that provides for the regulation of the *doula*'s profession as crucial for physical and emotional support to expectant women, in pregnancy, childbirth and *postpartum*. The Draft Law establishes the right of the pregnant woman to avail herself of the *doula* in all maternity hospitals, birthing homes and all healthcare establishments, public or private (Art. 6), considering this figure as central in the implementation of a multidisciplinary model of support to the woman in the pregnancy-puerperal cycle (Art. 5). The purposes related to the humanization of childbirth are made explicit in the concluding notes:

> With the increasing focus on humanizing childbirth, the role of the *doula* has gained paramount importance. This does not replace the care of family members or the assistance of healthcare

1 Some State laws are those of Tocantins (Lei 3.113/2016), Santa Catarina (Lei 16.869/2017), Rôndonia (Lei 3.657/2015), Rio de Janeiro (Lei 7314/2016), Pernambuco (Lei 15.880/2016), Paraíba (Lei 10.648/2016), Amazonas (Lei 4.072/2014), Ampá (Lei 1,946/2015), Ceará (Lei 16837/2019), Goiás (Lei 20,072/2018), Mato Grosso (Lei 10,675/2018), Mato Grosso do Sul (Lei 5,440/2019), Rio Grande do Norte (Lei 10,611/2019), Alagoas (Lei 8,129/2019), Sergipe (Lei 9393/2024).

> professionals, but plays a diversified role, bridging the gap between the pregnant woman and the healthcare team. The support provided by the *doula* through information, dialogue and guidance can promote a peaceful childbirth, since the doubts and fears of the woman can be more easily understood and overcome if they are shared with a reliable person, willing to listen and welcome them. [...] We therefore believe it is necessary to pass a national law that recognizes the work of doulas, in order to ensure that in our country all mothers can count on the support of this professional, whose skills contribute to the humanization of childbirth.

The *doula* is ascribed the following responsibilities: encouraging the expectant mother in finding evidence-based information about pregnancy, childbirth and puerperium; encouraging and supporting the expectant mother in identifying a facility to turn to during the prenatal phase and childbirth; assisting the parturient in choosing the most comfortable positions during labor; providing the parturient with information about pharmacological and nonpharmacological methods of pain relief (such as water birth and massage); promoting the maintenance of a cozy, quiet and confidential environment during childbirth; performing a pedagogical function with respect to breathing techniques during labor; promoting and encouraging the attendant's participation in childbirth and birth through his active involvement; supporting and sustaining the woman in puerperium and breastfeeding (Art. 4).

On the other hand, policies of humanization of childbirth have led to the valorization and rehabilitation at an institutional level of the figure of the *parteira*, a traditional figure recognized and deeply rooted in the Brazilian cultural and social context who has always provided assistance to women in home birth, relying on knowledge handed down orally and learning through direct experience. The marginalization and progressive exclusion of the *parteira* from medical practices related to childbirth has coincided with the hospitalization and delegation of obstetric care to institutional medical knowledge, resulting in the devaluation of skills considered archaic. Nevertheless, the *parteira* still represents a point of reference for childbirth care in many areas of Brazil, not only because of the lack of sufficient healthcare coverage in the territory, but also for cultural and ethnic reasons, especially in indigenous communities, *quilombolas* and *ribeirinhas* (Ministério da Saúde 2023). Galba de Araujo had already understood the importance of the *parteira* because of the fundamental role she played in the female community. The effort to humanize childbirth has also been realized through the implementation of *parteira*s in the national healthcare system, through its inclusion in the Programa Trabalhando com Parteiras Tradicionais (PTPT), a program within the Programa de Assistência Integral à Saúde Mulher (PAISM). PTPT is based on the implementation of a plan to cover obstetric care that takes into account the country's cultural, geographic, and socioeconomic diversities, also including the assistance of the qualified *parteira*. The Program has provided for the involvement of *parteiras* in local hospitals and primary care services through State and Municipal secretariats, who are also

deputized to create registries of practicing *parteiras* in the territory. The PTPT also includes actions to raise awareness among healthcare professionals toward the relevance of the *parteira* (Pitta et al. 2024).

Rede Cegonha has also included the work of *parteiras* as a community health element in childbirth care. The introduction of parteiras into SUS policies represents a strategy to integrate and enhance women's traditional knowledge about childbirth, making it central to the construction of an alternative model on childbirth, through the recovery of ancient knowledge, feminine dimension, community relations, and humanizing practices based on respect and care, which are opposed to the technological, biomedical, and Western model of childbirth (Castro and Erviti 2014). It is precisely the humanization paradigm that has prompted the recovery of a heritage of knowledge and practices considered useless and outdated. Thus, there is an effort by institutions in promoting an integrative approach aimed at making two models coexist in a complementary way, despite the challenges that this innovative vision still requires.

4 Preventing obstetric violence: obstacles and challenges

In 2014, through the statement *The prevention and elimination of disrespect and abuse during facilitative-based childbirth*, the WHO, while not naming it, highlighted the problem of the global prevalence of obstetric violence, pointing out how many women in various geographic settings experience mistreatment, abuse, and neglect by healthcare workers during childbirth. On that occasion, the WHO reaffirmed the right of every woman to receive appropriate care, including the right to dignified and respectful care during pregnancy and childbirth, and the right to live free from violence and discrimination, framing abuse and violence in childbirth as a violation of internationally sanctioned and recognized basic human rights (WHO 2014). In order to prevent obstetric violence in childbirth care, the WHO made a series of recommendations to governments, healthcare workers, managers, service providers, professional associations, researchers, international organizations (NGOs), civil society, and women's groups. To this end, the WHO recommended that key players: initiate and support programs aimed at improving maternal health by providing quality care centered on respectful and competent care (this includes ensuring that the birthing woman receives support and advocacy; a trusted partner or person during delivery; access to food and fluids; confidentiality; information about her rights; and respect for informed consent); promote policy initiatives on the importance of respectful maternal care by developing appropriate programs to improve

the organization and management of healthcare systems and ensuring compensatory mechanisms; provide support and training to healthcare workers to ensure that women are treated respectfully, also involving women and the civil community in this process; implement processes to monitor the quality of birth services, identifying and documenting incidents of disrespect and abuse; and finally, implement preventive measures at a local level, with the involvement of stakeholders. The WHO then reiterated the importance of birthing care based on a holistic, human rights-centered model in the WHO recommendations guidelines: *Intrapartum care for a positive childbirth experience* (2018).

As we have seen, progressively appropriate policies have been implemented in Brazil to prevent obstetric violence through a conspicuous investment in: strengthening and improving public healthcare services; providing statistical data on the conditions of childbirth; implementing facilities for physiological and low-risk childbirth; reducing medical interventions; providing support networks for women in pregnancy, childbirth and puerperium; integrating a respectful and humanized model of childbirth; including professional figures who foster the implementation of a relational and empathic model; promoting home delivery.

This is also accompanied by an increased awareness of women that has developed through the numerous campaigns promoted by feminist associations and movements, which has led to greater visibility of the phenomenon of obstetric violence and to the recognition of mechanisms that are often internalized and normalized by both women and healthcare personnel. Strategies to prevent obstetric violence also include the formulation of an individualized birth plan, which allows the pregnant woman to orient herself through common practices and treatments (especially in hospitalized childbirth) by providing or withholding her consent in relation to possible interventions at an earlier stage of pregnancy. In this process, the parturient can be supported and guided by a midwife, *doula* or primary care physician. This also serves to establish a dialogue with the professionals who can guide the parturient in her choice, also to clarify doubts and obtain information about risks and benefits in relation to each procedure (Ministério da Saúde 2017, 15). Another important intervention relates to the extension and coverage of healthcare services, which considers a strengthening of the public childbirth care network as a crucial element in preventing obstetric violence (Azevedo et al. 2023).

Many challenges still exist to achieve a satisfactory level of appropriate care in childbirth. These include specific training for obstetricians, midwives and, in general, healthcare personnel, who should be informed about women's human rights in childbirth, discrimination and stereotypes that affect the medical profession and obstetric violence in its manifestations in order to avoid repeating incorrect habits. In addition, it is necessary to insist on training healthcare personnel on evidence-based medicine and practices, also changing outdated protocols based on standardization

of care, focusing, instead, on the personalization of the birth pathway. Then, it is also important to ensure adequate working conditions, investing in staff and resources in public health services (Silva et al. 2021).

The visibilization of obstetric violence, to which the feminist movement and associations have contributed, has culminated in the recognition of this often ignored and neglected form of violence, also at the legal and institutional level. In fact, numerous laws were enacted by individual states. Given the relevance of the issue, initiatives aimed at combating and eradicating the phenomenon of abusive behaviors in childbirth have also been promoted at the federal level. For the past several years, bills on combating obstetric violence have been under discussion in Parliament, including PL No. 2082/2022, signed by Senator Leila Barros and PL No. 422/2023, signed by deputy Laura Carneiro. Brazilian institutions, however, not only addressed the issue through the legal recognition of obstetric violence, but as mentioned, are also aiming to bring about profound change at a structural and cultural level, although many critical issues are still emerging on the road to full implementation. These problems are related to resources, organization of facilities, as well as the variability and adaptability of interventions depending on the regions. For example, significant disadvantages affect rural areas especially in the North and the Northeast of Brazil, with less availability of healthcare services and facilities (Leal et al. 2023). There is also resistance coming from the medical class, which is little inclined to support structural and cultural changes in a profession characterized by corporatism and strong hierarchies. This is reflected, for example, in the continued non-enforcement of the Lei do Acompanhante by healthcare professionals, who perceive it as an intrusion into a codified medical model based on rigid protocols in which childbirth is conceived as a purely medical fact. Likewise, it still seems complicated to fully implement standards and guidelines that provide for the integration of other professionals (such as *doulas* and *parteiras*) into the medical team because of the difficulty of obstetricians in engaging with different professionals and perspectives. It would be desirable for healthcare personnel to be more aware of the issue of obstetric violence, in order to recognize the limits of the existing model, and adopt a proactive attitude aimed at changing it in favor of women's well-being and rights.

References

Agência Nacional de Saúde Suplementar. 2022. “Indicadores de Atenção À Saúde Materna e Neonatal.” https://app.powerbi.com/view?r=eyJrIjoiNGFiNmUyNjktZmExMC00MmNhLWJjNm-ItZjU1NDcwMGRiZTQyIiwidCI6IjlkYmE0ODBjLTRmYTctNDJmNC1iYmEzLTBmYjEzNzVmYmU1ZiJ9 (last accessed June 9, 2025).

Azevedo, Renata A. F., Fernanda S. Dominguez, Vanderléa A. S. Gonzaga, and Giseli M. Rennó. 2023. “Estratégias de prevenção e redução da violência obstétrica no Brasil: Uma revisão integrativa.” *Research, Society and Development*. 12 (11): e80121143730. https://doi.org/10.33448/rsd-v12i11.43730.

Bessa, Raylayne, Agatha Eleone, Rebeca Freitas, Sara Tavares, and Rony Coelho. 2023. “Mortalitade materna: causas e caminhos para o enfrentamento.” IEPS. https://ieps.org.br/wp-content/uploads/2023/03/olhar-IEPS-4-mortalidade-materna.pdf (last accessed September 20, 2025).

Castro Roberto, and Joaquina Erviti. 2014. “25 años de investigación sobre violencia obstétrica en México.” *Revista Conamed*. 19 (1): 37–42.

Castro, Natália R. S., Pereira, Maria S. S., Reis, Igor O., Junior Orácio C. R., and Pinto Everton O. 2023. “Violência obstétrica na percepção de puérperas em uma maternidade pública do Norte do Brasil.” *Revista de Pesquisa Cuidado è Fundamental*. 15: 1–9. https://doi.org/10.9789/2175-5361.rpcfo.v15.12625.

CLADEM. 1998. *Silencio y Cumplicidad: Violencia contra las Mujeres en los Servicios públicos de salud en el Perú*.

Costa, Lediana D., Rafaela D. Silva, , Jadieli S. Roll, et al. 2022. “Violência obstétrica. Uma prática vivenciada por mulheres no processo parturitivo.” *Revista de Enfermagem*.16 (1): 1–22. https://doi.org/10.5205/1981-8963.2022.252768.

Davis-Floyd, Robbie. 2001. “The Technocratic, Humanistic and Holistic Paradigms of Childbirth.” *International journal of gynaecology and obstetrics*. 75 (1): S5–S23. https://doi.org/10.1016/S0020-7292(01)00510-0.

Diniz, Carmen S. G. 2005. “Humanização da assistência ao parto no Brasil: os muitos sentidos de um movimento.” *Ciência & Saúde Coletiva*. 10 (3): 627–637. https://doi.org/10.1590/S1413-81232005000300019.

Diniz, Carmen S. G., Daphne Rattner, Ana F. P. L. Oliveira, Janaina M. Aguiar, and Denise Y. Niy. 2018. “Disrespect and abuse in childbirth in Brazil: social activism, public policies and providers' training.” *Reproductive Health Matters*. 26 (53): 19–35. https://doi.org/10.1080/09688080.2018.1502019.

ENSP-Fiocruz. 2014. “Nascer no Brasil. Sumário Executivo Temático da Pesquisa”. https://nascernobrasil.ensp.fiocruz.br/wp-content/uploads/2019/12/sumario_executivo_nascer_no_brasil.pdf (last accessed September 20, 2025).

ENSP-Fiocruz. 2017. “Atenção ao Parto e Nascimento em Maternidades no Âmbito da Rede Cegonha. Sumário Executivo.” https://nascernobrasil.ensp.fiocruz.br/wp-content/uploads/2021/05/Avaliacaoredecegonha_Sumario.pdf (last accessed September 20, 2025).

Ferreira, Matheus O.S., Ana C. Conartioli, , Andressa L.M. Deguchi, , Pamela E.P. Tasca, , Sara W. Beckmann, and Elizandra A.B. Stefano, 2025. “A voz das mulheres: percepções sobre a violência obstétrica no Sul do Brasil”. *Revista Portuguesa de Investigação Comportamental e Social*. 11 (1): 1–15. https://doi.org/10.31211/rpics.2025.11.1.369.

Fundação Perseu Abramo. 2013. “Violência no parto: Na hora de fazer não gritou.” https://fpabramo.org.br/2013/03/25/violencia-no-parto-na-hora-de-fazer-nao-gritou/ (last accessed September 20, 2025).

Leal, Maria do Carmo, Silvana Granado, Sonia Bittencourt, Ana Paula Esteves, and Karina Caetano. 2023. “Nascer no Brasil II – Pesquisa Nacional sobre aborto, parto e nascimento 2022 – 2023.” https://nascernobrasil.ensp.fiocruz.br/wp-content/uploads/2023/11/Dados-preliminares-da-pesquisa-Nascer-no-Brasil-2.pdf (last accessed September 20, 2025).

Leão, Miriam R.C. and Marisa A. R. Bastos. 2001. “Doulas apoiando mulheres durante o trabalho de parto: experiência do Hospital Sofia Feldman.” *Revista Latino-Americana de Enfermagem*. 9 (3): 90–94. https://doi.org/10.1590/S0104-11692001000300014.

Leboyer, Frédérick. 2009. *Birth Without Violence*. Healing Arts Press.

López, Gilda Vera. 2010. “Relacahupan – 10 años de trabajo, desafíos y logros.” *Tempus – Actas de Saúde Coletiva*. 4(4): 233–236. https://doi.org/10.18569/tempus.v4i4.852.

Marques, Fernanda C., João Vítor M. Vilela, Emanoel N. Costa, et al. 2020. “Humanized Childbirth: a Transdisciplinary Review.” *International Journal of Research - GRANTHAALAYAH.* 8 (7): 1–16. https://doi.org/10.29121/granthaalayah.v8.i7.2020.574.

Martins, Reny B., Milaine N.G. Vasconcelos, Rachel G. Correa, and Munique T.C.M. Pontes. 2022. “Análise das denúncias de violência obstétrica registradas no Ministério Público Federal do Amazonas, Brasil.” *Cadernos de Saúde Coletiva*. 30 (1): 68–76. https://doi.org/10.1590/1414-462X202230010245.

Medeiros, Rita C. S., and Ellany G.C. Nascimento. 2022.“Na hora de fazer não chorou: a violência obstétrica e suas expressões.” *Revista Estudos Feministas*. 30 (3):1–12. https://doi.org/10.1590/1806-9584-2022v30n371008.

Ministério da Saúde. 2000. “Institui o Programa de Humanização no Pré-natal e Nascimento, no âmbito do Sistema Único de Saúde.” Portaria n.569, de 1°de junho de 2000. https://bvsms.saude.gov.br/bvs/saudelegis/gm/2000/prt0569_01_06_2000_rep.html (last accessed September 20, 2025).

Ministério da Saúde. 2005. “IV Prêmio Professor Galba de Araújo.” https://bvsms.saude.gov.br/bvs/publicacoes/humanizar_atencao_parto_nascimento_direito.pdf (last accessed September 20, 2025).

Ministério da Saúde. 2011. “Institui, no âmbito do Sistema Único de Saúde - SUS - a Rede Cegonha.” Portaria n. 1.459, de 24 de junho de 2011. https://bvsms.saude.gov.br/bvs/saudelegis/gm/2011/prt1459_24_06_2011.html (last accessed September 20, 2025).

Ministério da Saúde. 2017. “Diretrizes Nacionais de Assistência ao Parto Normal.” https://bvsms.saude.gov.br/bvs/publicacoes/diretrizes_nacionais_assistencia_parto_normal.pdf (last accessed September 20, 2025).

Ministério da Saúde. 2023. “Trabalho de parteiras e reconhecido pelo SUS.” https://www.gov.br/saude/pt-br/assuntos/noticias/2023/janeiro/trabalho-de-parteiras-e-reconhecido-pelo-sus (last accessed September 20, 2025).

Ministério da Saúde. 2024. “Nota técnica conjunta n.220/2024.” https://www.gov.br/saude/pt-br/centrais-de-conteudo/publicacoes/notas-tecnicas/2024/nota-tecnica-conjunta-no-220-2024-dgci-saps-ms-e-dahu-saes-ms.pdf (last accessed September 20, 2025).

Ministério da Saúde. 2025. “Novo PAC Saúde: Mais cuidado e estrutura para as mulheres brasileiras.” https://www.gov.br/saude/pt-br/assuntos/noticias/2025/marco/novo-pac-saude-mais-cuidado-e-estrutura-para-as-mulheres-brasileiras (last accessed September 20, 2025).

Ministério da Saúde. n.d. “71% dos brasileiros têm os serviços públicos de saúde como referência.” https://bvsms.saude.gov.br/71-dos-brasileiros-tem-os-servicos-publicos-de-saude-como-referencia/ (last accessed April 15, 2025).

Pitta, Beatriz C., Ingrid C. F. Sousa, Filippo F. Bez et al. 2024. “Transformações na Assistência ao parto no Brasil: Desafios e Perspectivas para a Humanização com a Participação de Doulas e Parteiras.” *Periódicos Brasil. Pesquisa Científica*. 3 (2): 291–308. https://doi.org/10.36557/pbpc.v3i2.71.

Quattrocchi, Patrizia. 2019. “Violenza ostetrica. Le potenzialità politico-formative di un concetto innovativo.” *EtnoAntropologia*. 7 (1): 126–147.

Rattner, Daphne, Marcos L. dos Santos, Heloisa Lessa, and Carmen S. G. Diniz. 2010. “ReHuNa – The Brazilian Network for the Humanization of Childbirth.” *Tempus Actas de Saúde Coletiva*. 4 (4): 215–228. https://doi.org/10.18569/tempus.v4i4.849.

Rede Feminista de Saúde. 2002. “Humanização do parto. Dossiê.” https://redesaude.org.br/wp-content/uploads/2021/01/Dossie_Humanizacao-do-parto.pdf (last accessed September 20, 2025).

Rede Parto do Principio. 2012. “Violência Obstétrica ’Parirás com dor’.” https://www.senado.gov.br/comissoes/documentos/sscepi/doc%20vcm%20367.pdf (last accessed September 20, 2025).

Rich, Adrienne. 1995. *Of Woman Born: Motherhood as Experience and Institution*. W.W. Norton & Company.

Sampaio, Juliana, Marita A. A. Brilhante, and Thuany B. Herculano. 2018. “Doulas: Movimento Social e Luta por Políticas Públicas sobre Direitos Sexuais e Reprodutivos.” *Revista Gênero*. 18 (2): 103–122. https://doi.org/10.22409/rg.v18i2.1145.

Sandelowski, Margarete. 1984. *Pain, Pleasure and American Childbirth from the Twilight Sleep to the Read Method 1914-1960*. Greenwood Press.

Silva, Esther L., Maria E.A. de Andrade, Sara S. L. Carvalho, Valéria Leonhardt, Maria L. R. Bezerra. 2021. “Parto humanizado: benefícios e barreiras para sua implementação.” Research Society and Development. 10 (15): e528101523275. https://doi.org/10.33448/rsd-v10i15.23275.

Umenai, Takusei. 2001. “Forewards of the Internacional Conference on the Humanization of Childbirth held on 2 – 4 November 2000, in Fortaleza, Ceara, Brazil.” *International Journal of Gynaecology and Obstetrics*. 75 (1): S1–S2. https://doi.org/10.1016/S0020-7292(01)00513-6.

UN. 1995. “Beijing Declaration and Platform for Action.” Fourth World Conference on Women. https://www.un.org/womenwatch/daw/beijing/pdf/BDPfA%20E.pdf (last accessed September 20, 2025).

UNFPA. 1994. “Programme of Action - Adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994.” https://www.unfpa.org/sites/default/files/event-pdf/PoA_en.pdf (last accessed September 20, 2025).

WHO. 1985. “Appropriate Technology for Birth.” The Lancet. 326 (8452): 436–437. https://doi.org/10.1016/S0140-6736(85)92750-3.

WHO. 1997. “Care in normal birth, a practical guide.” Birth. 24 (2): 121–123. https://doi.org/10.1111/j.1523-536X.1997.00121.pp.x.

WHO. 2014. “The prevention and elimination of disrespect and abuse during facility-based childbirth.” *World Health Organization*. WHO/RHR/14.23.

WHO. 2018. *Intrapartum Care for a Positive Childbirth Experience*. World Health Organization.

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Between Objectification and Rights Narratives of Obstetric Violence and the Question of Self-determination in Finland

Abstract: This chapter explores the tension between objectification and self-determination through the lens of an obstetric violence campaign in Finland. It draws on narratives collected in 2019 by the Finnish *Me Too In Childbirth* (MTIC) campaign, which documented women's experiences of obstetric violence. These accounts are analysed as part of activist efforts to define such encounters as violations of self-determination. By reframing routine medical practices as harmful, the MTIC campaign challenges dominant medicalised discourses and ideals of heroic resilience in childbirth. The narratives illustrate how patriarchal structures materialise in objectifying practices that deny birthing individuals agency. Decisions are often made as if the person were absent, undermining both rights and personhood as guaranteed by the Patient's Rights Act. Theoretically, the study combines phenomenological perspectives on shame with Foucauldian analyses of power, offering a framework for understanding how embodied experiences intersect with the rationalities of medical care.

1 Introduction

Patient autonomy is the guiding principle of Finnish social welfare and health care, referring to a person's right to decide on matters concerning themselves (The Patients's Rights Act 785/1992). In essence, the patient has an inalienable right to receive respectful treatment and dignity. Furthermore, treatment must be based solely on medical grounds and the patient has the right to receive information about their state of health, the various treatment options available to them, and the effects of these treatments.

The following quote from a birth story that appeared on the *Me Too In Childbirth* (MTIC)[1] campaign website provides another perspective on obstetric care in Finland:

> What was done to me in the delivery room would be called rape in any other situation. Now, it was just childbirth. (S9)

1 #MinäMyösSynnyttäjänä in Finnish.

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The writer equated her childbirth to rape, thereby opposing care and violation. The MTIC campaign was initiated in Finland in spring 2019 with the launch of a website and a Facebook page under the same name (MTIC/FB). A post asked people to share their experiences of being belittled, insulted, or abused and to be 'part of the change' by speaking out if they had experienced something similar. Violence can end 'only by making it visible' (MTIC/FB). They linked this initiative to the #MeToo movement, which rendered sexual harassment a matter of public debate. Activists insist that the experiences of birthing women are worth listening to and part of gendered power structures. Thus, it was 'the mothers' turn to say #MeToo' (MTIC). The campaign's mission served as a call to end violations. Activists demanded access to obstetric care that respects the Patients' Rights Act and the right to self-determination guaranteed by human rights conventions (MTIC; see Vihreäsalo 2025). In this way, Finnish birthers joined the anti-obstetric violence movements mobilised around the world from the early 2000s onwards (see Bohren et al. 2015; Borges 2018, 828–830; Chadwick and Mavuso 2021).

Drawing from birth narratives published on the MTIC website, this study examines the double standards of self-determination. Specifically, I focus on the contradiction between formal rights and the objectifying practices described in these narratives. My approach, grounded in the feminist tradition, interrogates the contradictions within the gender system — where formally granted rights coexist with a social reality in which those rights are neither fully realised nor perceived as sufficient (e.g., Bartky 1990; Pateman 1988). Accordingly, I explore the tension between legal entitlements and the objectifying practices experienced by birthing individuals, highlighting the dissonance between the law as it is written and the lived realities conveyed in birth narratives. Whilst I have examined the role of activism and the negotiation of the concept of violence elsewhere (see Vihreäsalo 2022; 2025), these themes only play a marginal role in this chapter, by providing an important contextual backdrop to the investigation.

Theoretically, my analysis is situated at the intersection of phenomenological studies on shame and relationality, whilst also drawing on Foucauldian perspectives of power. This framework allows for a conceptual exploration of the intersections and ruptures between micro-level corporeal experiences and macro-level medical rationalities, as well as the potential for change when agency and structural forces collide in activism and resistance — once again rendering the personal political.

2 Feminist activism contesting violence

The question of reproduction has remained a central feminist concern for decades, intertwined with broader structural critiques in which issues of sexuality, reproduction, and the control of women's bodies are fundamental. Under patriarchy, society, community, and family — in addition to their continuity — took precedence over the woman herself. Woman was conceived as a mere vessel for the renewal of society and community, the soil in which a man's seed was planted. Thus, society exercised ownership over women's bodies — institutionalising the distribution of power through cultural spaces, social practices, the state and its laws and rationalities of governing (see Firestone 1970/2015; MacKinnon 1989; Helén and Yesilova 2006; Rothman 2016, 1989; Wrede 2001; Yuval-Davies 1997).

As Carole Pateman (1988) argues, despite the formal dissolution of patriarchy, a so-called sexual contract continues to be upheld: that is, although historical patriarchy has been dismantled, its structures, values, and practices endure. In this sense, whilst historical patriarchy — manifested, for instance, in women's historical exclusion from voting and property ownership — has been abolished in the West, cultural patriarchy persists, operating alongside the rights women have secured. Thus, despite significant feminist achievements, patriarchal power relations continue to shape social structures and lived experiences.

However, power relations are not static, but subject to constant negotiation. Since the turn of the millennium, nations around the world have witnessed numerous instances of violence in childbirth (see Baker et al. 2005; Bohren et al. 2015; Borges 2018; Chadwick 2017; Chadwick, Cooper and Harries 2014; Dixon 2015; Mselle et al. 2011; Elmir et al. 2010; Schroll et al. 2013; Smith-Oka 2013; WHO 2014; UN 2019; Vihreäsalo 2022; 2025). Alongside these observations, a wave of feminist critiques, activism, resistance, and widespread social media campaigns has emerged in various countries, including Brazil, Chile, Croatia, Finland, France, Hungary, the Netherlands, Russia, Spain, and the United Kingdom. In some regions, these activist efforts have contributed to the legal recognition of reproductive rights. Notably, in several Central and Latin American countries, obstetric violence has been codified as a criminal offence (Chadwick and Mavuso 2021; Bohren et al. 2015; Borges 2018; Pérez D'Gregorio 2010).

Discussions on the inadequate or unsuccessful treatment of women in childbirth are not new. However, such discussions have been framed predominantly in relation to the quality of care and failures of medical practice (Vogel et al. 2016). Criticisms of obstetric care, in turn, have focused on medical power (see Chadwick 2017; Dixon 2015, 441–442; Rothman 2016; Martin 1992; Oakley 2016; Rich 1976). In contrast to activist criticisms from previous decades, the current movement reframes problematic routine practices as *indications of violence* — in Dixon's (2015,

444) words, "not just less-than-ideal practices carried out by unknowing but well-meaning providers, but structural patterns of inequality." It is not merely a question of medicalisation: how women are treated during childbirth is violence and should be viewed as a violation (Dixon 2025, 447). Regardless of achievements related to equal rights, activists argue, the patriarchal grip on women's reproductive bodies remains tight. In this way, the movement seeks to examine what happens in the delivery room in relation to social structures, aiming to make visible the unstated assumptions, outdated conventions, and, thus, the normalised violating practices of obstetric care (Dixon 2015, 451; Morris et al. 2023).

Recent feminist research highlights obstetric violence as a form of gender violence — one that should be viewed as a feminist question and as part of patriarchal culture and history (Borges 2018; Cohen Shabot 2016; Dixon 2015; Smith-Oka 2013; Wolf 2013). According to Dixon (2015, 450), the term *obstetric violence* is used as a means to challenge problematic practices previously unacknowledged as forms of violence. By reframing obstetric practices as violent — rather than as medical care — activists seek to situate their concerns within broader discussions of birth care, violence, gender, and inequality (Dixon 2015, 437; Vacaflor 2016). The term *obstetric violence* is politically significant because, by using it, activists take part in debates on definitions of violence (Morris et al. 2023). The introduction of a new term has become a part of the negotiations that define and take a position on what constitutes violence (Vihreäsalo 2025). Within obstetric violence movements, the new term challenges us to view pain and suffering as essential, routine, and even necessary parts of childbirth. Thus, activists question the mother myth in which motherhood, femininity, sacrifice, obedience, the fate of the woman, and love for the child go hand in hand, excluding embodied agency and subjective experiences (Cohen Shabot and Korem 2018). As Cohen Shabot and Korem (2018) argue, this idea has strongly influenced how both birthing women themselves and the medical staff attending them view the situation.

Furthermore, as I have discussed elsewhere (Vihreäsalo 2025), grievances need a push — or an opening — in the political and cultural environment in order to translate into activism. Therefore, the ability to name a grievance intertwines with the political and cultural spaces of an experience. *Without naming the experience, it is difficult to translate it into activism*. In this sense, obstetric violence movements also assign a nominalistic (see Hacking 2002a; 2002b) core to activism. With the help of a precise label, naming the disturbing and inexplicable experience becomes possible. Thus, in Ahmed's (2014, 176) words, experiences are "brought into a feminist world." Furthermore, along with naming the experience, the narrators are connected to others with similar experiences. In the case of obstetric violence movements, labelling the grievance as obstetric violence created a distinction from other problematisations and linked the activism specifically to discussions

of violence, power, patriarchy, and discrimination. This allowed individuals with similar experiences to join "into a common striving for change" (Ahmed 2014, 108, 172–178). Thus, through a corresponding label, disturbing experiences weighing on birthers' minds were verbalised, the events were given a narrative, and it was possible to join others. This is not to say there was no pain nor humiliation before the right labels were applied. With the right labels, however, the experience was made clear, visible, and explicit, such that establishing new realities and demands for justice became possible. The privately inexplicable become explicitly political (see Vihreäsalo 2025).

Following Pateman's (1988) argument, activism can be understood as an ongoing negotiation in which the sexual contract is contested and redefined. At the heart of feminism is the collective naming, identification, and politicisation of injustices, inequities, and grievances, and the constant renewal of the "feminist object" (see Ahmed 2014, 168–190). Change is generated in the movement between past, present, and future visions and hopes. New grievances are often revealed only as old ones are corrected: recognition builds upon that which was previously recognised (Vihreäsalo 2025). As such, activists seek to dismantle oppressive structures by challenging the terms of the sexual contract and asserting their right to participate in its renegotiation. Central to their efforts is drawing attention to their experiences of violence, questioning existing definitions, and expanding the discourse on what constitutes violence — including experiences that have not yet been recognised as such (Vihreäsalo 2025).

Social media platforms play a role in enabling this new kind of activist engagement, providing visibility for silenced grievances, and creating spaces to reorganise unequally distributed resources (Leong et al. 2019; Reger 2021, 8–10, 34). The use of open and shared digital spaces (Munro 2013) has increased networked feminism and generated discussions on digital feminist activism (Vachhani 2023) and the question of fourth wave feminism (Munro 2013; Pruchniewska 2019). Furthermore, social media platforms connect politics, activism, affects, experiences, and bodies in novel ways. Activists can use social media platforms as a forum and their own experiences as a voice. Narratives, in turn, verbalise affects and experiences circulating through digital media. Personal stories, shared via social media platforms, occupy an ambivalent space between social hegemony and social change (Mishler and Squire 2020). At the intersection of hegemony and rupture, birthers aim to use stories as a force of change. Historically speaking, when society has shifted in ways that reveal gender discrimination *and* resources, avenues for women's movements have become available (Reger 2021, 34). This explains the ebb and flow of feminist activism and the restructuring of power relations.

3 Narrative analysis and resisting medical rationality

On 29 April 2019, the Me Too In Childbirth Facebook page posted the following message:

> What is obstetric violence and what does it have to do with #MeToo? Obstetric violence is a form of violence during childbirth and maternity care situated at the intersection of violence against women and institutional violence. [...] Do you recognise your own experience in this description? (MTIC/FB)

Within three weeks, 200 birthers had shared their negative experiences. Amongst the stories collected, 30 were published on the campaign website with the authors' permission. The campaign aim characterised the material: the stories intend to "show that violence during childbirth is a reality in Finland, which is considered a model country for maternity care" (MTIC). The intention was not to map *all* types of childbirth experiences, but to highlight negative ones. The authors recounted their experiences in maternity wards, either focusing on their own labour experiences or in terms of maternity care during pregnancy and/or the post-partum period.

Here I will use narrative analysis (Tamboukou 2008) to examine these stories within the context of a historical situation in which birthers, by narrating their experiences, participate in defining childbirth, violence, and obstetric care.[2] The stories aim to challenge us to view birth care differently. I consider birth narratives as sites of struggle and contestation, which are tense, unfinished, and unresolved (Foucault 2020a). By creating debate and pressure, activists participate in the elongation and disruption of structures. Where there is power, there is also resistance. Experience carries a surprising and unpredictable potential (Foucault 2020b, 92–102; Oksala 2004, 111–112). Birthing bodies are not merely passive material objects, but actively sense-making subjects. Bodies both experience and are experienced. Thus, shame and pain can result in submission or a battle (Vihreäsalo 2022; 2025).

Birthers both describe pain and resist subjection as they narrate events in an alternative way, seeking to define them neither as care nor as a (typical) painful

2 I analysed the narratives by first collecting quotes from the stories in which the storytellers expressed dissatisfaction, resentment, criticism, or shock, and then by grouping the collected quotes thematically. Data saturation was quickly reached (Guest et al. 2006). Whilst the individual stories described the personal experience of each narrator, arranging the stories by theme highlighted the painful and general structure of the experiences of obstetric violence.

birth, but as obstetric violence. In doing so, the stories challenge *the rationality of medical care* itself. They thus detach obstetric care from unique actors and contingency, binding it to its own moral, epistemic, and idiomatic form (Rose 1999, 24–31). Davis-Floyd (2001, 6–7) links the contemporary rationality of medical care to the Cartesian separation of the mind from the mechanically functioning body (see also Cohen Shabot 2016, 240–244; Martin 1992, 54–67). Viewed within a broader historical framework, this has led to a rationality of care in which the patient's emotional states and mental wellbeing become secondary. As a result, the birthing person as an experiencing subject falls outside the framework of care (Davis-Floyd 2001, 6; Rothman 2016, 1989; Martin 1992, 61–62). Rothman (1989) offers yet another perspective: the pregnant woman is positioned as the maternal barrier to the foetal patient, meaning that she is not regarded as the primary patient — the unborn foetus is. Patriarchy persists through the exploitation of female bodies as labourers producing society's most valuable products: men's children.

Disagreements about obstetric care explicitly challenge the prevailing rationality of medical practice. The demand to view the current medical rationality of care from a new perspective lies at the heart of activism: as the activists see it, this framework leaves no room to identify birthers' needs, their subjectivity, nor violations of their self-determination. The question for them then is not (only) 'Why am *I* treated like this?', but also 'How does the existing medical rationality of care normalise this treatment and remain blind to objectification, violence, and neglect (see also Morris et al., 2023)?' Therefore, I delineate how activists in the narratives problematise (Foucault 1995) the current rationality of birth care using their experiences as a force of change.

More than anything else, the narratives of childbirth are grim descriptions of pain and humiliation. I focus on the experience, emphasising a phenomenological reading of shame and objectification. This makes it possible to trace the invalidation of subjectivity (see Cohen Shabot 2016, 231–234). To understand the suffering described in these narratives, I draw upon shame research. Shame brings together the individual and structural levels of violence and of being excluded, subjugated, humiliated, shamed, and embarrassed (see Bartky 1990; Katz 1992; Maibom 2010; Metcalf 2000; Scheff 2000, 2003). Shame highlights the structural and social dimensions of individual experiences. Thus, rather than stressing shame as an individual, psychological 'emotion' that operates in the inner world (Ahmed 2004), shame here illustrates the complexities of human action, emphasising the connection between these actions and power in both micro-level interactions and macro-level structures. In this way, shame inhabits the intersection of experience and structure and opens up a perspective on the tension between shame, objectification and self-determination.

4 Narratives of obstetric violence

4.1 Objectification

Shame implies an awareness of being seen by others. The interaction between two (or more) people is a potential power play and a microcosm of shame, during which individual and structural realities meet (Katz 1992; Maibom 2010; Metcalf 2000; Scheff 2000; 2003). Therefore, it is unsurprising that the narratives locate the core of obstetric violence within small interactions where the birther feels objectified.

> Nobody tells me what is going on. I don't exist. (S28)

> I became an object that was just told to do things without explaining why and for what. (S20)

In these examples, the person giving birth feels transformed into a non-person, someone invisible. She has become an object: decisions are discussed by others as if she is not there, as if she was just an object occupying a space (Wolf 2013, 105). Thus, the birther is excluded from normal human interaction and not shown even ordinary courtesy.

Bohren and colleagues (2015), who have studied childbirth abuse globally, define rough verbal exchanges between staff and patients as *verbal abuse*. This includes insinuations, mockery of one's appearance, judgement, pressure to obey, threats, blackmail regarding the wellbeing of the birther and/or the baby, and the availability and accessibility of resources (Bohren et al. 2015; Chadwick 2017, 491–492). Insensitive interactions and verbal aggression are the most common and central causes of distressing birth experiences globally (Bohren et al., 2015; Cohen Shabot and Korem 2018, 389–390; Davis-Floyd 2001, 13). Harsh words do not differ significantly from neglect.

> We tried to ring the bell, but no one showed up. (S3)

Delivering mothers are left to beg for help or left entirely alone (Bohren et al. 2015). At the heart of experiencing shame lies the fear of isolation and exclusion, and the recognition of that fear (Scheff 2000). Being ignored during childbirth results in precisely this experience: the birthing person is made to feel like an outsider during one of the most intimate and vulnerable moments of her life.

> During the birth itself, it was as if it was self-evident that the doctor gave orders (position, episiotomy, and everything) and I obeyed. Once, when I was pushing and crying in pain, the doctor looked at me and shouted, "Shut up!" I felt stupid and bad. This was a high-risk birth, the room was full of strangers, and I was just a nuisance. (S7)

In the above extract, the doctor makes all the choices and decisions, whilst the birther's experiences and emotions are considered a nuisance. This leaves the birther feeling as a source of inconvenience.

Cohen Shabot (2016) describes the process of objectification phenomenologically, using the *Leib/Körper* distinction. The first term — *Leib* — refers to the lived experienced of a sensing and moving body. The second term — *Körper* — refers to the material and physical body (see also Al-Saji 2010; Wehrle 2020). This distinction describes how the body is simultaneously a subjective and lived, but also a material, object. It is precisely the material embodiment that makes a human being vulnerable. Ideally, we are both subjects and objects in a dynamic relationship with our environment. Cohen Shabot (2016, 235–236) suggests that the experience of being ignored can be explained by these two concepts. The objectification of a living and experiencing body (*Leib*) generates suffering. The possibility of actively influencing the world is lost.

Through subtle practices, the birther is distanced from what is familiar to and safe for her. The birther becomes more naked, mere flesh and blood, and less an experiencing and sensing person. The erosion of self-determination happens bit by bit, with the restriction of movement being particularly recurrent.

> I was only allowed to lie on my back in one position; I was not listened to nor acknowledged. (S1)

> They have to take the graph for half an hour and during that time I have to lie on the bed. I ask if it's not possible to be upright. I'm told it's only possible next to the bed, within the limits of the leads and lines. […] I'm anxious and depressed, I lie down on the bed in resignation. […] After what seems like an eternity, the curves start to appear on the monitor. The midwife says the lines can't be disconnected because I'm on nitrous oxide. […] I get up in the meantime, but the signal disappears again: I have to go back to bed. I feel helpless, subdued, writhing in pain on the bed like a bug that has fallen on its back. (S19)

The narratives here describe how the material environment affects the birthers' ability to move. Davis-Floyd (2001, 7) notes how the birther is dependent on the hospital leads, monitors, and beds in the same way that the baby is dependent on the umbilical cord and the place of residence provided by the womb. The positions chosen by the obstetric staff and the limited range of movement from their point of view are concrete elements of decision-making power. Reading the narratives, attention is, therefore, drawn to the narrowing of the space of freedom in the vicinity of the bed.

The further the birth progresses, the less the birther is recognised as an experiencing and feeling subject, a *Leib*. Now seen as an object, the birther's voice begins to fade and the decision-making power of the nursing staff increases. In

the following examples, birthers describe not only harsh words and restrictions on movement, but also being forcibly held:

> Later, two nurses forced me onto the bed so that the skin on my hips and thighs 'burned' when it rubbed against something. I was held by the arms with my face buried in the pillow while someone pushed his hand forcefully into me. I was shouted at to "stay still!" This position and these events made me cry hysterically, because I had been raped in the same position when I was young. (S30)

> In the surgery, I was quickly transferred to a table and my limbs were taped to the table. I could not move and was terrified…In a state of panic, I tried to make eye contact with the nurse and doctor (who were sitting on either side of my head) but they looked straight ahead stony-faced as I cried and begged them to help me and let me go. (S7)

Cohen Shabot (2016) places control of women's physical movement into the broader patriarchal context, taking into account Young's (1980) well-known phenomenological analysis. She argues that it remains culturally permissible to restrict the space and the ways in which a woman can move. The rationality of obstetric care is not above this cultural framework; instead, it lies within it — a self-willed, mobile, writhing, screaming, noisy woman in labour is considered a nuisance. The passive patient is easier to treat and more manageable for obstetric care professionals. This is also consistent with the image of a woman's characteristic docility and cooperativeness. Indeed, Cohen Shabot (2016, 240–244) calls the taming of the labouring woman domestication (see also Rothman 2016, 111; Morris et al. 2023, 57; Smith-Oka 2013, 600). In this way, childbirth reveals the woman's position within the social order (Cohen Shabot 2016, 240–244).

4.2 Experiencing a Violation

By becoming a patient, the person giving birth often — knowingly or unknowingly — relinquishes the right to make decisions for herself. Within the hospital walls, the birther is less a subject, an agent, or a citizen — a person with the power to determine the course of her own life — than she is outside them. This loss of autonomy, however, does not result from a conscious choice or through negotiation but emerges through the subtle, routine practices embedded in the rationality of medical care. During this process, the birther becomes integrated into the hierarchical system of the hospital (Davis-Floyd 2001, 7).

Interactions within the birthing context reveal a conspicuous power dynamic: the birthing woman is at least partially unclothed, sometimes entirely naked with her genitals exposed, whilst the attending medical staff remain fully dressed.

Furthermore, professional clothing — the white coats worn by doctors or the uniforms of midwives and nurses — expresses a sense of authority that defines power relations within the birthing context (Davis-Floyd 2001, 8). The birther is stripped of her clothing and identity (Cohen Shabot 2016, 240), 'standardising' the shift from a person with a name to the status of patient (Davis-Floyd 2001, 7; Wolf 2013, 107). Fundamentally, nudity diminishes agency.

Culturally, genitalia symbolise sin, guilt, shame, and punishment (cf. Meyer 2009). The vagina, therefore, is associated with impurity and disgust, as well as with control. In essence, the vagina represents a gateway to female ownership, both on an individual level and in a social sense (Miller 1998, 101–108). In the stories analysed here, women wrote about the tension and shame associated with nudity and the exposure of their genitals, as well as the insensitive attitude of medical staff towards the situation.

> The doctor performed an internal examination while putting me in a really degrading position. At the same time, a stranger was gawking next to me. The conversation [about inducing labour] took place with me exposed, legs spread, while two people gawked beside me. I can't understand why they didn't let me down and have this scary conversation with both of us clothed and pants on. I was completely outnumbered, scared, and ashamed in every way. (S3)

The fear of being seen naked not only symbolises the experience of shame and vulnerability, but also embodies the material site where power structures and objectification are enacted. It is the body itself that renders one vulnerable (Katz 1992, 148–174; Metcalf 2000; Wehrle 2020). The anxiety associated with corporeal exposure resulted in a feeling of defencelessness. That is, the naked body renders a person vulnerable and humiliated.

Thus, in line with shame-prone nudity, the most agonising experiences reported in the narratives relate to episiotomies. An episiotomy is performed to make room for the baby to be born by making an incision between the vagina and the anus. Nowadays, routine episiotomy is controversial, often equated with mutilation and associated with experiences of obstetric violence (Zaami et al. 2019; see also Rothman 2016, 91).

> All of a sudden, I realised that the second midwife had a pair of scissors in her hand and I screamed for the first time during labour because I knew it was happening: an episiotomy. I said nothing. How could I? They did not ask, and they did not explain why. […] I feel now that the episiotomy was an intrusion, a violation of my body. (S29)

> I felt medically raped by the episiotomy, the staff took advantage of their position and made decisions for me. (S18)

These examples highlight the unexpectedness of the decision to perform an episiotomy, as well as the poor communication and lack of negotiation (see also Borges 2018, 854). The absence of an explanation and permission are apparent. The experience of being violated is essentially linked to whether the birther is the object of or a subject in the decision-making process related to an episiotomy.

In the example below, the birther granted permission for a 'little pinch', but described in her narrative how the permission granted turned into an experience of violence.

> I could feel the scissors biting into my perineum, piece by piece. I was being sliced through like a roast. Not a 'little pinch', but a deep, deep split, many, many times over. (S10)

This mother's story continued with a description of the suturing process, which amplified the woman's experience of being violated during the episiotomy:

> The stitches were sawn twice. The student stitched me up first, with the midwife watching from the side. When the work was almost finished, the midwife told the student to undo everything and then did them again herself because she did not think the first stitches were good. I cried in a panic on the bed as I was being stitched and the midwife wondered why I was crying, since for her it was a beautiful, natural, and organic childbirth! For the midwife, what made the birth great and organic was the fact that I did not have an epidural, but my reality was something completely different — I felt raped. (S10)

The suturing was done twice: first, by a student midwife, and then by a midwife. The birther, the 'roast', cries on the bed. But, in the narrative, the student and the midwife practise the sutures, and also undo them, as if they are samples on a piece of cloth in a craft class, when the student's work does not satisfy the teaching midwife. The birther's experience is radically different from the midwife's perception. The words 'great and organic' are juxtaposed against 'rape', revealing the different ways in which the midwife and narrator experienced the situation. The mother myth, discussed at the beginning of the chapter, influences the birther's perceived resilience (Cohen Shabot and Korem 2018; Morris et al. 2023, 57).

The process of suturing tears and the episiotomy wounds, alongside the episiotomy itself, represent one of the most painful aspects of obstetric violence narratives. By the time suturing occurs, the baby has already been born and there is no longer any immediate threat to the infant's health. For those who shared their stories, the practices surrounding suturing reflect an unexplained indifference and reinforce the idea that, in the delivery room, there is no human being — using the *Leib/Körper* distinction — but rather a body: a physical object to be handled, commanded, moved, held, cut, and stitched as if it were nothing more than a piece of flesh. Two birthers describe their experiences of being sutured as follows:

> I was stitched without any pain relief. (S1)

> The baby was placed on my chest and, at the same time, the midwife began stitching my tear without saying a word. The pain was indescribably horrible. I cried, and they told me to "just focus on enjoying the baby." (S2)

A recurring theme in the narratives, expressed both in the voices of the birthing individuals themselves and through the reported words of healthcare professionals, is the idea that a 'real mother' knows how to prioritise correctly — whereby her own pain becomes secondary and should be endured in silence.

A double standard appears to be at work: legally, the person giving birth has the right to self-determination. However, the birther does not experience the law as it is written, but instead the social context of that specific moment (Bartky 1990, 95): she is objectified, subordinated, and disempowered. In the extract below, a mother describes how a doctor acknowledged the birther's self-determination:

> I was resigned to my fate. The doctor said, "You do have the right to self-determination." Crying, I exclaimed, "What do you mean? All this time I have not been listened to at all!" The doctor left the room without saying anything. I was left alone in the room crying. (S30)

Both concretely and metaphorically, the birther was left alone in the room crying when the doctor left "without saying anything." The mandate to negotiate was only theoretical. Thus, objectification erodes the possibility of self-determination, even if the person giving birth is formally within the legal framework for it.

The effects of submission, objectification, and invisibility are drastic:

> The situation was horrible: no one listened when I asked for help and there was no way to escape. (S10)

> I was so shocked by the pain and so weak that I had no strength to say anything or to defend myself. (S3)

Birthers feel defenceless and want to escape or die. This situation is described as horrifying and humiliating, a phrase reflecting extreme distress and resignation.

Objectification strongly impacts the experience of childbirth. Ignoring the wishes, feelings, and autonomy of the birther, not providing her with supportive interactions, and excluding her from the decision-making process regarding her own body and childbirth all increase the likelihood that she will experience childbirth negatively and violently, and equate it with rape (Borges 2018, 851; Morris et al. 2023; Vihreäsalo 2022, 2025).

As Davis-Floyd (2001, 6) puts it, birthing individuals, as experiencing subjects, fall outside the framework of care (see also Rothman 2016, 1989; Martin 1992, 61–62).

Their treatment reflects a broader medical paradigm in which the pregnant woman is positioned as a maternal barrier to the foetal patient rather than as a primary patient herself, as Rothman (1989, 15–26) argues. This dynamic helps explain medical decision-making that prioritises the foetal patient at the expense of the pregnant woman's wellbeing (Rothman 1989, 15–26). In this way, bodies intersect with culture in profoundly painful ways.

5 Conclusions

Patient autonomy, which formally guides Finnish social welfare and health care, remains inadequate as the medical rationality of care continues to objectify birthing individuals. The inalienable right of patients to receive respectful treatment and dignity becomes little more than a dead letter of law when the agency of birthing individuals is unrecognised. Analysing shame reveals the intersections of bodies, experience and structures, exposing the objectifying core of medical rationalities and the inadequacies of the Patient's Rights Act. The latter rests on an assumption of gender neutrality and remains blind to objectifying patriarchal structures within medical rationalities. The law presents self-determination as a free exercise under "conditions of equality of power without exposing the underlying structure of constraint and disparity" (MacKinnon 1989, 175). Hence, women's experiences can be ignored and hidden under the law (cf. MacKinnon 1989).

Any interaction between two or more individuals inherently involves a power dynamic — a microcosm in which individual and structural realities converge (Katz 1992; Maibom 2010; Metcalf 2000; Scheff 2000, 2003). In this context, patriarchal structures manifest through objectifying practices that fundamentally contradict self-determination. As birthing individuals are reduced to non-persons, decisions about their care are made and discussed as if they were not present. Stripped of subjectivity, birthers are excluded from normal human interaction. This exclusion and isolation — central to the experience of shame (Scheff 2000) — erode the very foundation of personhood and rights, both of which are essential to self-determination as outlined in the Patient's Rights Act.

In line with Cohen Shabot's (2016) use of the *Leib/Körper* distinction, the dynamic interplay between the subject and object of the self is severed, reducing the birthing person solely to the materiality of the body and, consequently, to suffering. Objectification not only strips away agency, but also silences the possibility of active participation in the world. Thus, objectification and self-determination stand in fundamental contradiction to one another, whereby objectification is logically incompatible with the conditions required for self-determination. The process of

objectification begins with seemingly minor practices — such as the invisibility of the birthing person and the absence of basic courtesies — but these small acts culminate in a reality where the birther is neither able nor permitted to engage in the reciprocal interaction necessary for self-determination. Consequently, objectification not only undermines autonomy but also results in a state of exclusion from decisions concerning one's own body. Within a framework of violent interactions, the objectified patient is rendered an outsider to procedures that directly impact her.

Historically, women's sexuality and reproductive potential have been subjected to intense social control. Alongside the long history of women's oppression, however, it is also important to address moments of resistance. Even marginal experiences can become sites of unpredictable change (Ahmed 2014, 168–190; Dixon 2015, 442; Oksala 2004; Tamboukou 2008; Vihreäsalo 2022, 2025). What happens within hospital walls is not an insignificant element of private life, but a potential site of transformation, activism, and politics. The shock, anger, indignation, and sadness described in the narratives here can also be understood as part of an ongoing historical change, whereby pregnancy, childbirth, and obstetrics acquire new meanings. The campaign challenges practices that had previously been perceived as unquestionable medical necessities. It demonstrates that such practices are not immutable truths but also socially negotiable and structural. As private experiences leak out to inform public activism, experiences previously unnamed and undescribed may be repurposed to contest medical rationality and the patriarchal structures embedded within it (Vihreäsalo 2025). Fundamentally, the objectification described in birth narratives may become a force of change that reshapes the distribution of power.

References

Ahmed, Sara. 2004. “Affective Economies.” Social Text 22 (2): 117–139.

Ahmed, Sara. 2014. *The Cultural Politics of Emotion*. Edinburgh University Press.

Al-Saji, Alia. 2010. “Bodies and Sensings: On the Use of Husserlian Phenomenology for Feminist Theory.” *Continental Philosophy Review* 43: 13–37.

Baker, Sarah R., Precilla Y.L. Choi, Carol A. Henshaw and Joanne Tree. 2005. “‘I Felt as though I’d been in Jail’: Women’s Experiences of Maternity Care during Labour, Delivery and the Immediate Postpartum.” *Feminism & Psychology* 15 (3): 315–342.

Bartky, Sandra L. 1990. *Femininity and Domination. Studies in the Phenomenology of Oppression*. Routledge.

Bohren, Meghan A, Joshua P. Vogel, Erin C. Hunter, Olha Lutsiv, Suprita K. Makh, João Paulo Souza et al. 2015. “The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review.” *PLOS Medicine*. https://doi.org/10.1371/journal.pmed.1001847.

Borges, Maria. 2018. “A violent birth: Reframing coerced procedures during childbirth as obstetric violence.” *Duke Law Journal* 67 (4): 827–862.

Chadwick, Rachelle. 2017. “Ambiguous subjects: Obstetric violence, assemblage and South African birth narratives.” *Feminism & Psychology* 27 (4): 489–509.

Chadwick, Rachelle, Diane Cooper and Jane Harries. 2014. “Narratives of distress about birth in South African public maternity settings: A qualitative study.” *Midwifery* 30 (7): 862–868.

Chadwick, Rachelle and Mavuso Jabulile Mary-Jane Jace. 2021. “On reproductive violence: Framing notes.” *Agenda* 35 (3): 1–11.

Cohen Shabot, Sara and Keshet Korem. 2018. “Domesticating Bodies: The Role of Shame in Obstetric Violence.” *Hypatia* 33 (3): 384–401.

Cohen Shabot, Sara. 2016. “Making Loud Bodies ’Feminine’: A Feminist- Phenomenological Analysis of Obstetric Violence.” *Human Studies* 39 (2): 231–247.

Davis-Floyd, Robbie. 2001. “The technocratic, humanistic, and holistic paradigms of childbirth.” *International Journal of Gynecology & Obstetrics* 75: 5–23.

Dixon, Lydia. 2015. “Obstetrics in a Time of Violence: Mexican Midwives Critique Routine Hospital Practices.” *Medical Anthropology Quarterly* 29 (4): 437–454.

Elmir, Rahime, Virginia Schmied, Lesley Wilkes and Debra Jackson. 2010. “Women’s perceptions and experiences of a traumatic birth: a meta-ethnography.” *Journal of Advanced Nursing* 66 (10): 2142–2153.

Firestone, Shulamith. 1970/2015. *The Dialectic of Sex: The Case for Feminist Revolution*. Verso.

Foucault, Michel. 1995. “Polemics, politics, and problematisations: an interview with Michel Foucault.” In *Michel Foucault, Ethics, Subjectivity and Truth, Essential Works of Foucault 1954-1984: Volume One*, edited by Paul Rabinow. Routledge.

Foucault, Michel. 2020a. “Nietzsche, Genealogy, History.” In *Michel Foucault. Aesthetics. Essential Works* 1954-84, edited by James Faubion. Penguin Modern Classics.

Foucault, Michel. 2020b. *The History of Sexuality. Vol 1. The Will to Knowledge*. Penguin Classics.

Guest, Greg, Arwen Bunce and Laura Johnson. 2006. “How Many Interviews Are Enough? An Experiment with Data Saturation and Variability.” *Field Methods* 18 (1): 59–82.

Hacking, Ian. 2002a. “Inaugural lecture: Chair of Philosophy and History of Scientific Concepts at the Collége de France, 16th January 2001.” *Economy and Society* 31 (1): 1–14.

Hacking, Ian. 2002b. *Historical Ontology*. Harvard University Press.

Helén, Ilpo and Katja Yesilova. 2006. “Shepherding Desire. Sexual Health Promotion in Finland from the 1940s to the 1990s.” *Acta Sociologica* 49 (3): 257–272.

Katz, Jack. 1992. *How Emotions Work*. The University of Chicago Press.

Leong, Carmen, Shan L. Pan, Shamshul Bahri, and Ali Fauzi. 2019. “Social media empowerment in social movements: power activation and power accrual in digital activism.” *European Journal of Information Systems* 28 (2): 173–204.

MacKinnon, Catharine. 1989. *Toward A Feminist Theory of the State*. Harvard University Press.

Maibom, Heidi. 2010. “The Descent of Shame.” *Philosophy and Phenomenological Research* 80 (3): 566–594.

Martin, Emily. 1992. *The Woman in the Body: A Cultural Analysis of Reproduction*. Beacon Press.

Metcalf, Robert. 2000. “The Truth of Shame-Consciousness in Freud and Phenomenology.” *Journal of Phenomenological Psychology* 31 (1): 1–18.

Meyer, Mati. 2009. “Eve’s Nudity. A Sign of Shame or a Precursor of Christological Economy.” In Mati Meyer and Katrin Kogman-Appel. *Between Judaism and Christianity: Art Historical Essays in Honor of Elisheva (Elisabeth) Revel-Neher*. Brill.

Mishler, Elliot and Corinne Squire. 2020. “The Personal Is Political: The Social Justice Functions of Stories.” In *Stories Changing Lives. Narratives and Paths toward Social Change*, edited by Corinne Squire. Oxford University Press.

Miller, William Ian. 1998. *The Anatomy of Disgust*. Harvard University Press.

MTIC, Minä Myös Synnyttäjänä. https://www.minamyossynnyttajana.fi (accessed February 16, 2021).

MTIC/FB, Minä myös synnyttäjänä Facebook Page https://www.facebook.com/MinaMyosSynnyttajana (accessed February 3, 2022).

Morris, Theresa, Joan H. Robinson, Keridwyn Spiller and Amanda Gomez. 2023. “‘Screaming, ‘No! No!’ It was Literally Like Being Raped”: Connecting Sexual Assault Trauma and Coerced Obstetric Procedures.” *Social Problems* 70: 55–70.

Mselle, Lilian, Thecla W. Kohi, Abu Mvungi, Bjørg Evjen-Olsen, and Karen Moland. 2011. “Waiting for attention and care: Birthing accounts of women in rural Tanzania who developed obstetric fistula as an outcome of labour.” *BMC Pregnancy & Childbirth* 11 (75): 1–13.

Munro, Ealasaid. 2013. “Feminism: A Fourth Wave?” *Political Insight*: 22–25.

Oakley, Ann. 2016. “The sociology of childbirth: an autobiographical journey through four decades of research.” *Sociology of Health and Illness* 38 (5): 689–705.

Oksala, Johanna. 2004. “Anarchic Bodies: Foucault and the Feminist Question of Experience.” *Hypatia* 19 (4): 97–119.

Pateman, Carole. 1988. *The Sexual Contract*. Polity Press.

Pérez, Rogelio. 2010. “Obstetric Violence: A New Legal Term Introduced in Venezuela.” *International journal of gynecology and obstetrics* 111 (3): 201–202.

Pruchniewska, Urszula M. 2019. *Everyday Feminism in the Digital Era: Gender, the Fourth Wave, and Social Media Affordances*. Dissertation, Temple University. https://scholarshare.temple.edu/server/api/core/bitstreams/417c651f-7628-4796-902c-b935c45c5183/content (last accessed March 25, 2025).

Reger, Jo. 2021. *Gender and Social Movements*. Polity Press.

Rich, Adrienne. 1976. *Of Woman Born: Motherhood as Experience and Institution*. Norton.

Rose, Nikolas. 1999. *Powers of Freedom. Reframing Political Thought*. Cambridge University Press.

Rothman, Barbara Katz. 1989. *Recreating Motherhood*. Rutgers University Press.

Rothman, Barbara Katz. 2016. *The Bun in the Oven*. New York University Press.

Scheff, Thomas. 2000. “Shame and the Social Bond: A *Sociological Theory*.” Sociological Theory 18 (1): 84–99.

Scheff, Thomas. 2003. “Shame in Self and Society.” *Symbolic Interaction* 26 (2): 239–262.

Schroll, Anne-Mette, Hanne Kjærgaard and Julie Midtgaard. 2013. “Encountering abuse in health care; lifetime experiences in postnatal women – a qualitative study.” *BMC Pregnancy and Childbirth* 13 (74): 1–11.

Smith-Oka, Vania. 2013. “Managing Labor and Delivery among Impoverished Populations in Mexico: Cervical Examinations as Bureaucratic Practice.” *American Anthropologist* 115 (4): 595–607.

Tamboukou, Maria. 2008. “A Foucauldian Approach to Narratives.” In Molly Andrews, Corinne Squire and Maria Tamboukou. *Doing Narrative Research*. Sage Publications.

UN [United Nations]. 2019. “A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence.” https://digitallibrary.un.org/record/3823698?ln=en#record-files-collapse-header (last accessed March 25, 2025).

Vacaflor, Carlos. 2016. “Obstetric violence: a new framework for identifying challenges to maternal healthcare in Argentina.” *Reproductive Health Matters* 24 (47): 65–73.

Vachhani, Sheena J. 2023. “Networked Feminism in a Digital Age — mobilising vulnerability and reconfiguring feminist politics in digital activism.” *Gender, work, and organization* 31 (3): 1031–1048.

Vihreäsalo, Keiju. 2022. “Häpeä, objektivointi ja vastarinta synnytysväkivaltatarinoissa [Shame, objectification and resistance in narratives of obstetric violence].” *Sukupuolentutkimus* 35 (1): 4–20.

Vihreäsalo, Keiju. 2025. “At The Intersection of Experience, Activism and Nominalism: Disputes on Obstetric Violence”. *New Formations — A Journal of Culture / Theory / Politics* (forthcoming).

Vogel Joshua P., Meghan A. Bohren, Özge Tuncalp, A., and Metin Gülmezoglu. 2016. “Promoting respect and preventing mistreatment during childbirth.” *British Journal of Obstetrics & Gynaecology* 123 (5): 671–674.

Wehrle, Maren. 2020. “Being a Body and Having a Body. The Twofold Temporality of Embodied Intentionality.” *Phenom Cogn Sci* 19: 499–521.

Wolf, Allison B. 2013. “Metaphysical Violence and Medicalized Childbirth.” *The International Journal of Applied Philosophy* 7 (1): 101–111.

WHO [World Health Organisation]. 2014. “The prevention and elimination of disrespect and abuse during facility-based childbirth. WHO statement.” https://apps.who.int/iris/bitstream/handle/10665/134588/WHO_RHR_14.23_eng.pdf?s equence=1 (last accessed March 25, 2025).

Wrede, Sirpa. 2001. *Decentering Care for Mothers. The Politics of Midwifery and the Design of Finnish Maternity Services*. Åbo Akademi University Press.

Young, Iris Marion. 1980. “Throwing like a girl: A phenomenology of feminine body comportment motility and spatiality.” Human Studies 3: 137–156.

Yuval-Davis, Nira. 1997. *Gender and Nation*. Sage.

Zaami, Simona, Michael Stark, Renata Beck, Antonio Malvasi, and Enrico Marinelli. 2019. “Does Episiotomy always equate violence in obstetrics? Routine and selective episiotomy in obstetric practice and legal questions.” *European Review for Medical and Pharmacological Sciences*: 1847–1854.

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Neoliberal Paternal Authoritarianism and Obstetric Violence in Turkey: Vulnerability and Resilience in Routine Episiotomies

Abstract: This chapter discusses a distinct form of obstetric violence emerging in the context of neoliberal paternal authoritarianism, which not only threatens women's claims for autonomy about their reproductive rights but also targets doctors' authority through economic, legal and reputational risks in contemporary Turkey. Medical interventions, especially episiotomies, are routinized for a risk-free and efficient birth, creating high vulnerability to obstetric violence. This chapter argues that contestations in the medical field can be a historical opportunity for women to claim autonomy and respect, not as patients, clients or mothers, but as the central actors in birth in this era. A detailed analysis is offered on how they narrate their prenatal care experiences as an ongoing negotiation with their physicians and how they generate self-support mechanisms by mobilizing medical, familial and market resources. The chapter discusses the possible effects of their attempts to build resilience against the context-specific vulnerabilities to obstetric violence.

1 Introduction

The norms and practices shaping obstetric care are different in many countries and they have undergone significant transformations throughout history. Today, a model that balances evidence-based medical practices and respect for birth-givers' autonomy is being discussed worldwide, including Turkey, where state actors have recently revealed how they perceive this 'balance'. The Normal Birth Action Plan was introduced by the Ministry of Health in October 2024 to reduce the rates of C-section — which have reached 60% — as this procedure is considered the main cause of the country's declining fertility rates (SGGM 2025). For more than a decade, C-sections have been equated with abortions, since "women, fearing that repeat Caesarean deliveries might cause health damage, tend to restrict the number of deliveries to two" (Dogangün 2019, 128). Thus, decreasing routine medical interventions has been interpreted in Turkey, solely as a decrease in the ratio of C-sections, which are only one form of non-evidence-based medical intervention. Women's reproductive autonomy is framed as a 'risk' due to their rights-based claims regarding abortion and elective C-sections, while medical autonomy is similarly

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problematized because of high cesarean rates — suggesting that the ideal balance can only be achieved through the paternal control of the state over both domains.[1]

Although the main problematized issue within the framework of non-evidence based medical interventions in Turkey is the high rates of C-sections, vaginal births also involve routine medical interventions, referred to as 'vaginairean' births (Topcu 2019). Therefore, recent decades, marking the first time in Turkish history that almost all births became hospitalized, can be analyzed as a period when the pregnant woman's body became an object of routine medical intervention. Episiotomy provides a fruitful case to extend the discussion about medical interventions to 'normal' births as well. Turkey is among the countries where episiotomies are routinely performed during childbirth, with studies showing that the procedure is carried out in 64% to 74% of overall vaginal deliveries and in over 90% of cases among first time mothers (Bakır et al. 2024; Karaçam et al. 2013). Routine, non-evidence and/or non-consent-based use of episiotomy is a form of obstetric violence (European Parliament 2024), since birth givers who undergo routine episiotomy report greater difficulties in postpartum recovery, infant care, and breastfeeding, along with higher risks of sexual dysfunction and decreased body confidence (Fanshawe et al. 2023; Noroozi Dashtaki et al. 2023; Zielinski et al. 2017).

A distinct form of obstetric violence emerges in the context of neoliberal paternal authoritarianism. This form of authoritarianism not only threatens women's claims for autonomy about their reproductive rights but also targets doctors' authority through economic, legal and reputational risks. The AKP's overall governmental practices have been discussed in the literature as combining authoritarian/paternalistic with democratic/fraternal types of patriarchal statehood, commonly conceptualized as neoliberal-conservative patriarchy (Coşar and Yeğenoğlu 2011; Çınar 2019). However, the former is discussed as having become more prevalent in the last decade, especially after the June 2015 elections and the 2016 post-coup attempt, when the regime shifted from a parliamentary democracy to an unchecked executive presidential system (Yabancı and Maritato 2024). Paternal authoritarianism is used to depict the AKP's increased power consolidation as it adopts a more paternal role, promotes a conservative gender order, and casting them as outsiders (Eksi and Wood 2019). The patriarchal authority of medicine, particularly in obstetrics,

1 This view was also reflected in the public service announcement about C-sections titled "Mom, We Did It!" released at the launch of the "Normal Birth Action Plan," which was criticized by the Turkish Obstetrics and Gynecology Association as "offending both expectant mothers and our doctors, portraying women who give birth by cesarean section as unsuccessful mothers and doctors as people with scalpels waiting to harm them and the baby."
https://www.tjod.org/kamuoyu-aciklamasi-normal-dogum-eylem-plani/ (last accessed April 2, 2025).

became a key aspect of an autocratic emasculation agenda with an increasingly aggressive tone, especially after the Gezi movement, when "the medical profession played an important role in treating the injured in the field and [...] the AKP antagonizes the society against the medical profession with its actions and statements that discredit it" (Çorbacıoğlu Aksak 2023, 144).

In addition to the heavy workload of healthcare providers, studies have reported a high rate of obstetricians practicing defensive medicine, meaning excessive medical intervention to avoid malpractice lawsuits (Günenc et al. 2024; Küçük 2018). Given the prevalence of non-evidence-based interventions, the focus on C-sections, and the lack of open official data on medical interventions in 'normal' births for evidence-based accountability, it can be argued that the structural vulnerability to obstetric violence will persist in the near future. This study will introduce how birth givers enact resilience, rather than fully committing to the oppressive hyper-medicalization, contributing to the literature that highlights their struggle for non-traumatizing births, dignity and autonomy in the face of obstetric violence (Göbelez 2021).

2 Obstetric violence: undermining the agency and autonomy of birth-givers

Obstetric violence (OV) is a structural issue, as highlighted in key reports and academic studies (European Parliament 2024; van der Waal and Mayra 2023). It refers not to interpersonal relations or individual persons, but to unconsented routine interventions and mistreatments as violence that is "structural, systematic, and rooted in [...] unjust structures, repressive hierarchies, and unequal relations of power" (Chadwick 2021, 6). It refers to the "expropriation of women of their self-determinacy, autonomy, responsibility, community, the right to physically and emotionally safe care, and the choice to birth or not birth their children in the way that they think is best" (van der Waal, van Nistelrooij, and Leget 2023, 2). In other words, obstetric violence diminishes birth-givers' autonomy and control over reproductive health decisions (European Parliament 2024; United Nations 2019), alienating them from birth and attributing its responsibility to the lead of a medical professional. Birth-givers are expected to submit to an authoritative relationship, while their ways and strategies for claiming their voices over their reproduction are systematically ignored or unheard. When birth-givers seek to actively participate in decision-making during labor, challenge certain medical interventions, or express disagreement, they may be stigmatized as irresponsible mothers (Cohen Shabot and Korem 2018), labeled as blind with birth anxiety or infantilized for

having read too much or not enough. Such pathologization of pregnancy or reproduction as a distinct period requiring full submission to the birth leader's authority is shaped by and constitutive of the intersecting power relations in a given context. Therefore, the autonomy attributed to women during birth and the value placed on properly informing them are deeply intertwined with the gendered characteristics of the sociopolitical dynamics.

The healthcare system's conditions, especially in obstetrics, both reflect and shape potential vulnerabilities or resilience against obstetric violence. In addition to historical constructions of patriarchal relationships among actors, inadequate policies, weak infrastructure, inefficient monitoring and power dynamics between doctors and midwives reinforce violence in the healthcare settings. Examples include shortages of healthcare professionals, excessive workloads, lack of experience, and the absence of well-trained doctors and midwives knowledgeable about evidence-based practices and up-to-date guidelines, which can unintentionally lead to obstetric violence (European Parliament 2024). Insufficient budget allocations by governments for healthcare services, and the lack of focus on women's holistic health, including psychosocial aspects, are major constraints that shape obstetric violence practices (United Nations 2019).

Considering such complex power dynamics that construct vulnerability to obstetric violence, opening up space for women's autonomy during birth requires a relational focus. In other words, reducing autonomy to women's choice alone reproduces the mechanisms of obstetric violence, either isolating women under pressure or giving way to paternalistic policies and actions to protect them against these vulnerabilities. Rather, real autonomy in this context is reached only when a woman can decide about the relational structure of her actions — choosing with whom she wants to engage through this experience, what kinds of relationships she wants to be a part of, which responsibilities she is willing to accept, and which personal projects she aims to pursue (Restrepo-Sánchez 2024). Therefore, understanding how patriarchal powers operate in obstetrics is essential for recognizing and addressing the risks of obstetric violence, but it is not enough. A deeper focus on women's unique experiences, coping mechanisms, raising awareness of their strengths and opening a space where they are heard and respected is also crucial for designing OV-aware research, without equating vulnerability with victimhood.

3 Research design and data analysis

Vulnerability can simply be defined as "susceptibility to harmful wrongs, exploitation, or threats to one's interests or autonomy" (Cunniff Gilson 2016, 72). This study, while focusing on vulnerability to obstetric violence and how it is constitutive of and constructed by the discourses of obstetrician-gynecologists (OB/GYNs) and midwives — normalization of routine episiotomies without proper consent in our case — also focuses on the narrations of mothers and their husbands/partners, analyzing whether/how claims and practices of resilience emerge through their narrations. The data collected in a larger TUBITAK-funded research project in 2023, focusing on decision-making around episiotomies — incorporating insights from OB/GYNs, midwives, birth-givers and their partners, medical students, and representatives of midwives' and doulas' associations (Cindoğlu et al. 2024) — will be partially used for this purpose. The fieldwork was conducted in Istanbul and Ankara. A total of 23 OB/GYNs participated (17 in focus groups and 6 in interviews), with experience ranging from 1.5 to 45 years across various healthcare settings. Similarly, 24 midwives took part (22 in focus groups and 2 in interviews), with experience spanning 2.5 to 36 years, working in public and private hospitals or independently. Among mothers, 41 women participated, divided into first-time mothers (22) and multiparous ones (19), with diverse educational backgrounds and employment statuses. Lastly, focus groups with 10 fathers (6 first-time fathers) revealed educational levels ranging from high school to postgraduate degrees, with all participants employed.

The coding and analysis were conducted using grounded theory principles and MAXQDA software. Grounded theory coding, as outlined by Charmaz (2007), includes two stages: the first involves systematically examining, naming, and coding all words, sentences, and segments of the data, while the second focuses on synthesizing and organizing the data by refining initial codes into broader analytical categories based on their significance and frequency. Following this approach, each interview transcript was analyzed line by line, with codes assigned accordingly. To ensure inter-coder reliability, two researchers independently coded the data and compared their results throughout the process. Codes were continuously reviewed, refined, and integrated to establish relationships and structure the analysis. In line with grounded theory, coding was conducted inductively, allowing patterns and themes to emerge directly from the data (Charmaz 2007).

To understand the meaning systems and emotional baggage in the narrations of all actors, a brief look at the historical trajectory of obstetrics, starting from Turkish modernization, is important. Thus, a historical overview will first be provided on the political and symbolic reasons behind the increasing targeting and scapegoating of doctors in general and obstetricians in particular, as well as the

historical roots of midwives feeling sidelined and their discontent with the loss of status and job security in midwifery as an art.

4 The historical and political context of childbirth in Turkey

In the early decades of the 20th century, Republican Turkey was founded with a radical change from an empire of multi-religious communities to a nation state with a unified national identity and culture. The medicalization of childbirth in Turkey can be traced to this modernization process, where the regulation of health, marriage and reproduction became central to both population health and state power. "Control over birth and death, sexuality and reproduction, health, family, childcare …became vital to the power of the state" (Alemdaroğlu 2006, 129). Thus, the scientifically legitimized medical knowledge of doctors, combined with the new state's population policies, brought the hospitalization of births, which came to symbolize modernity and safety, ultimately replacing home births (Cindoğlu and Sayan-Cengiz 2010). Free maternity hospitals were established, and traditional birth practices were modernized, with a focus on institutionalizing midwifery. Midwifery education aimed to create "respectable, virtuous, and conscientious" professionals, with a clear distinction between midwives and physicians (Beyinli 2014). Midwives' expertise became increasingly subordinated to male-dominated, scientifically legitimized medical knowledge (Göbelez 2021). Thus, the initial phases of the formal doctor-centric birth model could be traced to this early modernization phase.

Still, hospital births' becoming the norm, with the marginalization of home births, is a recent process. The possibility for daily interaction with doctors was only reached in the late 1960s and early 1970s (Dole 2004). Compared to the pronatalist policies of the early Republican period,[2] when abortion and contraception

2 Here, it is important to refer to the literature which focuses on the ethnoracial politics behind the anti-natalist policies of this period. They are argued to target population decrease in the Kurdish regions and hence be aligned with the Republican practice of using reproductive policies primarily as a tool for demographic politics, rather than having women's empowerment in their agenda (Saluk 2023). This stress is relevant for the period covered in this period, considering the presidents' inviting Turkish women to reproduce, not to be overpowered by "the terrorist organization" of the Kurds. (https://yetkinreport.com/en/2022/10/20/erdogan-stirs-debate-with-his-children-advise/, last accessed April 2, 2025). Thus, the topic of intersectional vulnerabilities to obstetric violence is a very important field of study for a comprehensive country level analysis, which was not included in the research design of this study due to funding limits.

were prohibited, this corresponds to an epoch when this ban was removed and clinics for promoting the use of contraceptive methods for family planning were formed (MacFarlane et al. 2016). This was a time of significant social and political changes in terms of rapid industrialization, urbanization and increased social rights, including increased health services in general (Eryurt 2018) and services for women's health in birth in particular. In this era, the women's health movements in the world, which were critical of the patriarchal medical authority at that time, did not resonate too much in the Turkish context. This period was followed by legalization of abortion in 1983, and the anti-natalist provision of health services continued until the AKP period.

It is critical to locate the current agenda of demedicalizing birth within the authoritarian pronatalist agenda with a distinct authority claim of the state over women's reproduction. In the neoliberal era, hospitalized births started to increase gradually. However, the most dramatic increase began in the early 2000s, and since 2020, nearly all births have taken place in hospitals, with almost half now occurring at private facilities (Ministry of Health of Türkiye 2019; Hacettepe University 2018). According to the latest formal data, now 97% of deliveries occur in hospitals, with 60% taking place in public hospitals and 40% in private institutions. Among these, 83.2% are attended by doctors, 8.2% by nurses, and only 7.8% by midwives (Ministry of Health of Türkiye 2019; Hacettepe University 2018). Therefore, in this overwhelming prevalence of hospital births, OB/GYNs have the primary responsibility, and the active collaboration of midwives is very limited.

The Health Transformation Program (HTP) introduced policies such as the semi-privatization of healthcare services, performance-based measures, the bureaucratization and quantification of care, and the transformation of health professionals' working conditions, all under the primary aim of "cost reduction and efficiency" (Dayı 2019). The increased availability and scale of hospitalized care across the country began to be framed as a symbol of public 'victory' over the former state elite, who were accused of inflating the public budget while failing to provide effective and efficient services. Access to doctors also became an important factor in user satisfaction, and doctors' practices turned into a specific area of regulation, monitoring and intervention through policies, laws and projects focusing on continuous education, skill development, performance, and patient-centered evaluation. Performance, competition and contracting began to characterize doctors' working conditions, significantly impacting both medical practice and its public reputation. Compared to the social and political authority they held since the early Republican era, doctors' status shifted, shaped by debates over income disparities across hospitals, increased per capita physician visits, and the tendency to provide excessive or unnecessary care to generate more revenue for themselves and their hospitals (Ökem and Çakar 2015). The hyper-medicalization of birth in Turkey was institutionalized

in this period. One of the most significant impacts of the HTP on women's reproductive and sexual rights has been the closure of the AÇSAP (Mother-Child and Family Planning) Directory, which was the institution providing access to reproductive and family planning services, including contraception and abortion (Dayı 2019). Therefore, it is possible to observe a simultaneous loss of autonomy for medicine, midwives and women in the pronatalist neoliberal era. In this context, according to 2022 data, Turkey has the highest cesarean section rate among OECD countries, reaching 60% (Statista 2025). Research has also highlighted the prevalence of obstetric violence, with expectant mothers frequently subjected to non-consensual vaginal examinations, deprivation of food and drink, application of fundal pressure, and violations of privacy (Aşci and Bal 2023; Aksu and Serçekuş 2023).

5 Paternal authoritarianism, medical autonomy and professional authority of OB/GYNs and midwives

5.1 Routine episiotomy as a defensive medical practice

The interviewed doctors' narratives reveal that concerns over malpractice liability have led many OB/GYNs to adopt routine interventions as a protective measure. Malpractice litigations in private hospitals are personalized, directly targeting the relevant health professionals, as opposed to public institutions, and are criticized for damaging doctor-patient relationships. As the private sector's share in obstetrics increases, and with the association of these hospitals with non-evidence-based C-sections, malpractice litigations against obstetricians have risen in recent years, making obstetrics no longer among the most popular specialties for medical students as it once was. Many participants perceived a lack of institutional protection, noting the absence of legal or organizational support, which led them to rely on defensive medical practices as a means of legal and professional self-protection.[3]

3 Very recently, a law about the establishment of a Professional Responsibility Board within the Ministry of Health was enacted with the purpose of 'protecting' doctors against financial losses caused by malpractice litigations, which will detect "whether the person abused his/her duty by acting contrary to the requirements of his/her duty and the fault situation" before the judicial investigation starts. This Board, which is considered as a bureaucratic-governmental rather than scientific auditing mechanism, has been criticized by the Turkish Medical Association as reductionist. What they suggest instead is "a mechanism that will help prevent or at least

The perceived risk of uncontrolled perineal lacerations and potential litigation reinforced the routine use of episiotomies, not solely as a clinical intervention, but as a precautionary measure. OB/GYNs frequently emphasized the need to prioritize their own security, thereby normalizing defensive obstetric practices:

> I can't afford to pay the equivalent of my lifetime earnings because of a patient I met for the first time during childbirth. I mean, I won't risk losing a million just because she doesn't like a tear. I'd rather perform the episiotomy because my career and life are more valuable than avoiding it. Most doctors, like me, would do the same. (OB/GYN resident, 26, research and training hospital)

Obstetrics is associated with a high risk of litigation not only in Turkey. Studies from various countries highlight the importance of effective communication among health professionals and the birth-givers, fostering understanding and respect from the antenatal period to decrease medicolegal activity (Chandraharan and Arulkumaran 2006). As will be discussed in the following sections, while establishing communication with mothers was not prioritized by the health professionals, who focused on the unquestionability of the scientific aspects of their profession, it was often the mothers themselves who demanded and initiated such communication. This proactive stance can be seen as an expression of women's resilience — their ability to navigate a medically dominated environment, assert their needs, and foster supportive interpersonal relationships, even in the face of systemic limitations.

Another issue highlighted by OB/GYNs to emphasize their hierarchical position in relation to 'patients' and resist mothers' attempts to request an episio-free birth was their medical education. The training of doctors, particularly that of assistants, further institutionalizes routine interventions. Many obstetricians indicate that their training explicitly reinforced the necessity of episiotomies, particularly for first-time births. However, rather than considering routine practices as an immutable aspect of medical training and approach, it is more useful to understand how these narratives serve as a tool for doctors to legitimize their professional authority and sustain routine interventions. Medical education is frequently positioned as an external, neutral force shaping clinical practice; however, it also functions to sustain entrenched obstetric norms, even as global approaches to childbirth evolve. This reliance on medical training not only provides a defensive rationale for routine episiotomies but also reflects a deeper resistance to change. The assertion that

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minimize the problem through studies aimed at revealing how the damage is caused holistically, with a critical perspective on current health policies, the transformation of the value attributed to physicians' labor, and how the patient-physician relationships have deteriorated."
https://www.ttb.org.tr/haber_goster.php?Guid=9ceac7d6-daf5-11ee-8464-d8f6498bdeb7.

expertise grants them exclusive decision-making power reinforces a hierarchical model of care in which care receivers' perspectives are systematically devalued:

> I believe this should not be the patient's choice. The patient does not know childbirth — I do, as the expert. Only I can decide if an episiotomy is necessary. In pain, the patient cannot make such a decision and lacks the required knowledge. Trust is essential in the physician-patient relationship, and if it breaks down, the physician has the right to withdraw from treatment. (OB/GYN resident, 28, research and training hospital)

5.2 Sidelined midwives

Interviewed midwives emphasized that physician-centered policies in obstetric care have marginalized them, reducing their role to auxiliary personnel rather than primary birth attendants:

> I haven't been able to practice midwifery properly for years. It's been so long since I last delivered a baby. While working at a training and research hospital, I assisted in a birth but was reported to the head nurse for using a speculum. Now, I can't even do that. Can we truly support a patient and act as a sister to her? We just can't. (Midwife, 53, semi-public hospital[4])

Policies aimed at increasing the number of OB/GYNs and ensuring the presence of at least one OB/GYN in every hospital across Turkey shifted preference towards doctors, while sidelining midwives. While most OB/GYN acknowledge that childbirth is primarily the work of midwives, they contend that the combined pressures of malpractice liability, the high number of deliveries in hospitals, and midwives lack of 'hands-on' experience and training prevent them from delegating births to midwives. Restrictions placed on the active involvement of midwives in childbirth within hospital settings have led some to establish private practices by opening health cabins, thereby working as independent midwives.[5] The private midwives we interviewed indicated that they chose this path as a means of navigating systemic limitations and sustaining the midwifery profession in a more

4 This refers to the city hospitals which have been built in the second phase of the Health Transformation Program through public-private partnership, and the collaboration between the government and the private sector for infrastructure investments.

5 In Turkey, private midwives are permitted to open health cabins, provide prenatal care and postnatal follow-up, and attend home births. Although these rights are regulated by laws and official regulations, private midwives can still face investigations for reasons such as keeping a fetal doppler in their health cabins or assisting with home births.

autonomous and effective manner. They also expressed that this decision has granted them a perspective from outside the system.

This external positioning often informs their clinical views. For instance, while some midwives critically question the routine use of episiotomy — asserting that childbirth can occur without such intervention or significant perineal trauma — others argue that episiotomies are frequently unavoidable. The latter group cites physical limitations in birthing individuals, such as insufficient pelvic muscle strength or a general lack of physical preparedness attributed to modern sedentary lifestyles. This divergence in opinion underscores a fundamental difference in both philosophy and practice between midwives employed in hospital settings and those practicing privately:

> I usually attend home births and have never performed an episiotomy. Even when I was working in a state hospital, I faced the pressure from senior midwives to perform one. I chose not to follow the path the system taught us — had I done so, I would have become just another system-trained midwife. Instead, I pursued additional education and learned that birth can happen safely without episiotomy. (Private midwife, 30)

Although midwives argue that their training and expertise equip them to lead childbirth, without a strong commitment to upholding women's autonomy and critically addressing obstetric violence, their expanded role in maternity care may simply reproduce the same interventions under different hands. Some midwives, rather than critically assessing the necessity of routine episiotomy, argue that the procedure itself is not inherently problematic:

> There are midwives who successfully suture episiotomies that even doctors struggle with. But the real issues arise mostly in cases handled by inexperienced assistants — when tissue alignment is poor, improper materials are used, procedures are rushed, excessive bleeding occurs, or infections develop. Episiotomy itself is not inherently problematic. In fact, it can be quite beneficial, even elegant when done correctly. If managed well, it could prevent many later perineal repair surgeries. (Midwife, 53, semi-public hospital)

Midwives feel that despite being qualified to lead the entire delivery process, they are burdened with tasks such as obtaining informed consent, rather than being recognized for their full role. As long as the doctors are the leaders on the 'birth scene', the 'back-stage' processes are devalued:

> Informed consent is essential, but signing forms without understanding them is meaningless, as even judges agree. Patients often say, "I was in labor, my mental state was terrible, and I didn't understand anything." If a woman chooses to give birth at my hospital, she should make an informed decision when clear-headed, but that takes time. Doctors don't have the time and shift the responsibility of informed consent onto us. (Midwife, 46, semi-public hospital)

Although obtaining informed consent does not automatically guarantee women's decision-making power, its reduction to a bureaucratic formality is deeply problematic. When consent is treated as a procedural burden rather than a relational and ethical engagement, it loses its potential to affirm women's decision-making power and instead contributes to the perpetuation of obstetric violence. The valorization of attending the birth, while relegating processes like informed consent to the background, reinforces and reproduces existing hierarchies within maternity care.

5.3 The ideal vs 'disobedient' birth-giver: women trained for harmonizing with medical authority

Both doctors and midwives frequently emphasized that women should take primary responsibility for improving their childbirth experience. They suggested that birth-givers' self-confidence and better training about childbirth were the reasons why mothers in Western countries often choose not to have the same healthcare professionals throughout their antenatal care and birth, leading to fewer routine interventions. Many healthcare professionals argue that better education, regular exercise, and attendance at prenatal programs would improve maternal outcomes:

> Today, all responsibility for childbirth seems to fall on the doctor, as expectant mothers are less informed and take less responsibility. They focus more on superficial trends, wanting their birth to follow what's popular, whether it's a water birth or dimly lit natural birth. (OB/GYN, 37, private hospital)

This perspective reveals a critical tension: while women are encouraged to be informed and proactive, their preferences and decisions are often dismissed as superficial or trend-driven. The notion of an "ideal" birth-giver thus becomes paradoxical — responsible and knowledgeable, yet deferential to medical authority. On the other hand, some healthcare professionals argue that women's ability to give birth is entirely dependent on their will:

> If a woman says she will give birth, she does. She takes on the task, commits to it, and succeeds. That's it. (Midwife, 57, private hospital)

However, such narratives often ignore the systemic and institutional factors that shape childbirth experiences. The idea that a woman's willpower determines her ability to give birth overlooks the realities of obstetric violence practices, unnecessary and non-consented medical interventions, and the unequal power dynamics between caregivers and care receivers:

> When a woman becomes pregnant, she accepts all the risks. Pregnancy means that childbirth is inevitable. (OB/GYN, 33, research and training hospital)
>
> Moderator: Okay, she knows she will give birth, but maybe she could say, "Doctor, let's wait a little before performing an episiotomy."
>
> We make the decisions during childbirth. (OB/GYN, 32, research and training hospital)
>
> The patient can't understand that at the moment. (OB/GYN, 32, semi-public hospital)
>
> While she's in labor and in pain, I can't explain it to her. If I were removing her uterus, for example, I could take the time to explain everything in detail. But for someone who has come to give birth, I can't go into that explanation at that moment. (OB/GYN, 37, private hospital)

This narrative delineates the distribution of authority, where OB/GYNs retain decision-making power while mothers as "patients," despite being encouraged to take responsibility for their births, are ultimately excluded from critical decisions during labor. This dynamic reveals a paradox: although women are expected to prepare extensively for childbirth and take control of their births, their autonomy in decision-making remains constrained:

> Pregnant women should receive education. In my opinion, those who haven't taken a childbirth preparation course shouldn't be allowed to come to the hospital. They arrive completely unprepared, following only what their mother-in-law says, and this is the result. (OB/GYN, 32, semi-public hospital)

While prenatal training is undoubtedly valuable, such statements risk framing women's lack of preparation as an individual failing rather than a systemic issue. It also reinforces the gatekeeping of medical knowledge, implying that birth-givers who do not conform to institutional expectations are unfit for proper care. The quotation below about how a respondent, who is herself a midwife and hence very well 'trained' about birth giving, found herself being treated as a 'disobedient' patient by her colleagues, could be given as an example of the violence embedded in a birth-giving model where women's embodied experience of birth is not heard of, respected and assisted but rather the medical professionals seek commitment and attunement to their directives:

> Both hospital midwives were newly graduated and inexperienced, causing me a traumatic experience. I was in labor, but they said I was only halfway there. When I checked myself, I felt my baby's head, so I called my doctor. However, my doctor dismissed it, saying, "Two midwives have already examined you, you might be misinterpreting things." I waited about an hour, holding back. When my doctor finally arrived, she was shocked, saying, "You're really giving birth!" (Mother, 41, single birth)

6 Women building resilience against obstetric violence

The concept of resilience refers to the ability to withstand or overcome adversity within a social context that both creates the adversity and allows for the unfolding of strengths and resources in response. Therefore, resilience is not an inherent individual trait but rather a process of actively unfolding strengths and resources, which in turn creates new pathways for survival and erodes the conditions that reproduce adversity. Rather than equating structural violence with a totalized experience of victimhood, the unique experiences and reactions to adversity are valued as opening pathways for rewiring of "the emotional, cognitive and sociocultural capacities of individuals and groups that allow them to recognize, confront and transform constructively situations causing suffering or harm" (Suarez 2021, 708). Based on the findings of the fieldwork, distinct resilience pathways can be observed that serve as protective mechanisms for women to maintain their self-esteem and bodily integrity amidst the context-specific vulnerabilities to obstetric violence described above. Identifying and making visible women's proactive subjectivity is important not to suggest individualized resistance, but to trace potential roots that could serve as building collective resilience for women's claims of respect and autonomy in the birth field.

6.1 Finding the right doctor as a strategy for self-protection and consistent collaboration

The narratives of mothers reveal their strong emphasis on establishing a collaborative relationship with OB/GYNs, prioritizing the search for a reliable doctor to guide them and to hear them through both pregnancy and delivery. For mothers, doctors are considered central figures in the childbirth process, and the communication they establish — or fail to establish — with their doctor plays a pivotal role in shaping both the experience and the lasting memory of childbirth. A pronounced preference for continuity of care, particularly with the same OB/GYN, significantly influenced hospital selection for delivery. Many mothers articulated a dilemma between the distressing accounts of public hospitals and the extensive medical interventions linked to private healthcare institutions. Public hospitals were often described as environments where, personal preferences and privacy are neglected, and the opportunity to be attended by the same OB/GYN throughout pregnancy and delivery is rare. Private hospitals, on the other hand, presented as a setting where women could establish a connection with their obstetrician, making the birth feel more personalized and

negotiable. Negotiating a "normal" birth with private hospital doctors emerged as a way for women to avoid potentially distressing experiences in public hospitals:

> I looked into the doctor first because I wanted to have a natural birth. I checked the private hospitals nearby since I was determined not to give birth at a public hospital…I always had this in mind: if I were to have a C-section, I didn't want it to be a planned one. My doctor was already supportive in that regard. You know how some doctors are called "natural birth advocates?" I found one like that. (Mother, 38, multiple births)

The search for a doctor whose approach aligns with their preferences is not merely a matter of personal comfort but often emerges as a strategy of self-protection against medical interventions perceived as unnecessary or even harmful. Women's active role in doctor selection illustrates how they navigate institutionalized power structures in childbirth, seeking spaces where their bodily autonomy is respected. The disparity in medical approaches across different doctors further complicates women's ability to navigate the system, reinforcing the idea that finding the 'right' doctor is an essential protective measure:

> My previous doctor told me that an episiotomy was absolutely necessary. He said, "If we don't do it, you'll have uncontrolled tearing, so we have to." But I knew that wasn't always the case. Then we moved, and I found a new doctor. I told him that I didn't want an episiotomy. He waited until the very last moment and resisted performing it. We had already discussed this beforehand. I also had a doula, and she was a huge help to me. (Mother, 24, single birth)

Although women's sharing their preferences about birth was mostly observed to trigger a sense of threat to doctors' medical authority, some doctors indicated how such interactions and being addressed as the 'chosen' doctor by women was important for them as their own resource for building resilience and to bear the dissatisfaction and alienations from their profession.

> My friends are mentally exhausted and want to quit their profession. The psychological state of the doctor performing the birth is also crucial; they need to feel truly at ease. What keeps me going is being with pregnant women. We can make progress if we understand each other. Women come to me to talk, sharing their worries and ideas, and I stay strong through these connections. From the beginning, I try to instill trust in them, taking on the roles of their mother, life coach, big sister, and doctor. I prepare them for birth as if it's a beautiful ritual, saying, "We will give birth together, beautifully. (güzel güzel)[6]" (OB/GYN, 61, private hospital)

6 "Güzel güzel" here was used by the participant as the opposite of 'çatır çatır', which is mostly used to degrade cesarean births. What she means is a birth experience where evidence-based medical interventions are also part of 'normal' births.

Since defensive medicine itself is based on the feeling of insecurity, women being the initiators of collaboration and consistent dialogue was narrated as a source of relief and joy rather than threat by some doctors. In that sense, rather than as strategies for individual resilience and adaptation, women's attempts could also be read as building paths for shared resilience that refers to "shared resources and a shared language of coping" (Aldrich et al. 2024) amongst the actors involved in birth-giving. Still, while some women build trust-based relationships with doctors in private hospitals, others might experience disillusionment, realizing that their trust in medical professionals is not reciprocated with patient-centered care.

Effective collaboration with the doctor is a critical component of resilience during childbirth as it was identified as the strongest resource for women to feel self-efficacy and control over their birth. On the other hand, the limits of this collaboration and how this resource is prone to loss and causing deep disappointment could be foreseen based on all the structural conditionings discussed above. When such collaboration is perceived as limited, women often seek to broaden their support networks:

> I had hired a private midwife for my birth, and the hospital's doctor and midwife were often unable to attend. While waiting for them, I learned they were in surgery. As my labor progressed, my midwife calmed me, examined me, and called the doctor to come. I don't know what I would have done without her. (Mother, 38, multiple births)

However, being monitored regularly both manually and through using technical instruments is commonly described as causing a barrier against dialogue and collaboration with the health professionals. This is especially a cause of distress for women giving birth in public hospitals, where the chances for completing the overall antenatal care and laboring process with the familiar health professionals, which is a source of resilience in the private hospital setting, is not existent. Still, while they chose the public hospital setting deliberately for avoiding the non-evidence-based cesarean in private hospitals, such protection of their body is also reflected in their intolerance and opposition against such disrespect. In that sense, this period of mistrust for medical authority in a way serves for building a distinct awareness and not seeing "shame and pain as inherent to the birth giving experience [...] which is mostly what prevents women from receiving recognition of the harsh experiences and emotional consequences of OV" (Cohen Shabot and Korem 2018). The quotation below exemplifies many narrations of birth-giving in public hospitals, which are mostly chosen for avoiding the possibility of non-evidence-based cesareans in private hospitals, as actively expressing anger against disrespect:

> They kept coming in to check on me repeatedly while I was lying in bed, which was distressing and humiliating. I didn't understand why just one person couldn't check. I didn't want anyone else to see me, but they kept asking, "How many centimeters dilated?" Over and over. Eventually, I got frustrated and said, "Am I your test subject?" They replied, "We are assistants. We need to learn." I told them, "Go learn somewhere else, not on me." At that moment, I was in pain and fear, and what they were doing was completely inappropriate. (Mother, 37, multiple births)

Some participants' narratives can be analyzed in terms of how they destabilize the image of the birth scene in Turkey as divided between natural birth seekers, ready to bear its natural pain, and those who seek comfort and painless birth and ready to bear the medical 'cuts'. Such dichotomous thinking risks obstructing the ways in which women actively prioritize negotiation with doctors and, in some cases, deliberately defer certain decisions as part of a way to navigate hyper-medicalized birth environments. There are cases where the medical cut is not only a source of safety for doctors but also for women themselves — making it a deliberate choice rather than a complete surrender of control to medical authorities. As previously discussed, women's distress, fear and anxiety about birth were addressed as the reason behind their various 'inappropriate choices' by political and medical authorities. Rather than signaling passivity, these women — acknowledging their fear and anxiety, and actively choosing medical cuts as a protective mechanism for their bodily integrity, considering the lack of support mechanisms in the hyper-medicalized hospital setting — can be analyzed as taking another resilience pathway to avoid obstetric violence and to retain a sense of safety within institutional constraints. In other words, doctors' open communication about their routine practice of episiotomy may provide some birth-givers with a sense of reassurance and safety during childbirth. Far from uniformly opposing the routine use of episiotomy, as exemplified by the quotation below, some participants viewed it as a normalized and even reassuring aspect of childbirth:

> We already knew before birth that an episiotomy would be performed because my doctor preferred it to prevent any tearing or complications. Honestly, this reassured me because my biggest fear was having a tear during a natural birth. I went into labor with the reassurance of knowing that my doctor would perform an episiotomy. (Mother, 38, single birth)

In Turkey's hyper-medicalized birth settings, where institutional routines and medical hierarchies are often rigid and non-negotiable, women's collaboration with doctors takes on an even more complex meaning. The high degree of trust placed in doctors may appear, at first glance, as a form of submission or relinquishment of agency. However, this trust must also be understood as part of a broader strategy of resilience — an effort by women to avoid obstetric violence. In that sense, deferring

certain decisions to doctors is not necessarily a reflection of passivity, but rather a tactical engagement with structural realities, through which women seek to protect their bodily integrity and emotional well-being.

6.2 Fathers as (invisible) partners of childbirth

The fatherhood narratives in our data involve references to a desired break away from their peripheral role in birth. Hospital policies on birth companionship in Turkey vary considerably.[7] While some institutions actively support the presence of a companion during labor, others lack clear regulations or impose restrictions. Research indicates that certain hospitals still prohibit companions altogether during childbirth (Karaçam et al. 2017; Turan et al. 2006). Factors such as limited physical space, concerns about maintaining patient privacy, and the absence of institutional guidelines continue to hinder the widespread implementation of companion-friendly practices (Turan et al. 2006). Despite these institutional constraints, both mothers and fathers expressed a desire to be more actively involved in the birth process. Many women emphasized the emotional strain of giving birth alone and highlighted the importance of their partner's presence, particularly that of fathers, as a meaningful source of support. The limited number of narratives that focus on paternal involvement suggest that, when permitted, a father's presence during labor can offer women both emotional reassurance and a sense of empowerment:

> It was just my husband and me — no one else. That was a huge comfort, and I believe that's how it should be. No mother, no sister, no friend, no one else…Even before birth, they emphasized the importance of being alone during labor. I truly felt the benefits of that. (Mother, 32, single birth)

The omission of fathers from discussions on labor and delivery highlights the persistence of gendered assumptions within medicalized birth practices, where the mother is framed as the primary caregiver and the father's role is often limited to logistical or financial support. However, when the fathers' narration of their experiences of prenatal care as well as labor and delivery is analyzed, they mostly define

7 A recent regulation in Turkey has sparked significant debate by limiting the provision of childbirth-related support services exclusively to licensed healthcare professionals. According to the regulation, only authorized medical personnel are permitted to provide education and counseling to pregnant individuals within the scope of their professional duties. The law explicitly prohibits any form of guidance, counseling, accompaniment, or coaching — such as services offered by birth doulas — if delivered by individuals who are not recognized as healthcare professionals.

themselves as active agents in the whole process rather than as outsiders. Their depiction of the public/private hospital distinction is based on their total exclusion from this experience in the former. They value this experience as a source of authentic fatherhood that is not learned or inherited from fathers or father figures. As one father describes below, the exclusion of fathers from public hospital settings is deeply regretted as leaving them on the periphery of the birth experience as both fathers and partners:

> In a public hospital, you can't experience that moment. Your partner enters the hospital and stays in a room with three or four other people. Meanwhile, you're sitting in your car, waiting outside the hospital. As a father, you're not there to experience that moment. (Father, 39)

Many of the fathers interviewed for this study came from higher socio-economic backgrounds and played an active role in securing private healthcare for their partners, often framing their financial contribution as an essential paternal duty. However, this contribution is not mostly described as just purchasing services for the comfort of the mother and the baby, but also as a resource that allows them to assist women both in the negotiation process about medical interventions and sometimes during labor. Many fathers viewed private hospitals as the only viable option, despite perceiving them as profit-driven institutions with excessive medical interventions. Their distrust of private healthcare coexisted with a deep-seated fear of public hospitals, where they felt unable to fulfill their protective role due to institutional restrictions on their presence. Despite their skepticism toward private healthcare, fathers often emphasized the doctor's role as the single most important factor in their decision-making process. Their trust in the doctor paralleled that of their partners, reinforcing the idea that birth outcomes were contingent on finding the 'right' physician.

Although fathers remain largely invisible actors within the institutional birthing space, the efforts of women to secure their partner's presence emerge as a subtle yet significant form of resilience against obstetric violence. These negotiations reflect not only the emotional significance of companionship but also the ways in which birthing individuals navigate restrictive medical environments in pursuit of safer and more supportive birth experiences.

7 Discussion and conclusion

This chapter argues that the mechanisms of paternal authoritarianism in Turkey, particularly in the restructuring of obstetric care and reproductive governance, contribute to a distinct form of vulnerability to obstetric violence. The chapter

explores a unique manifestation of obstetric violence within the framework of neoliberal paternal authoritarianism, which not only undermines women's autonomy over their reproductive rights but also challenges doctors' professional authority. One of the main findings is that the predominance of the doctor-centric births in hospitals in today's Turkey, shaped and regulated by the paternal authority of the state and the market actors, is framed by doctors as a shift or break in how they perceive and practice their profession. This shift reveals a decline in professional authority of OB/GYNs and midwives, as well as the institutional power of medicine, leading to a reduction in healthcare professionals' autonomy. However, this does not necessarily correspond to an increase in birth-givers' autonomy in healthcare. On the contrary, birth-givers are often portrayed as "irresponsible mothers" or "disobedient patients," who not only fail to take responsibility for their births but also place blame on doctors for any complications or perceived failures. Birth-givers' involvement in decision-making regarding birth could be undermined, while the reluctance or resistance of healthcare professionals to question their routine practices heighten women's vulnerability to obstetric violence.

However, it is essential to recognize that women navigating this environment are not passive victims of these systemic forces. On the contrary, they actively seize this moment as an opportunity to assert their autonomy and demand respect — not merely as patients, clients, or mothers, but as the central agents in their own birthing experiences. This shift reflects a broader reclamation of agency within a socio-political and medical context that has long sought to control their reproductive autonomy.

The authoritarian and anti-democratic socio-political culture that characterizes the contemporary medical landscape in Turkey often restricts women's ability to participate fully in decision-making regarding their care. Despite these constraints, women's unique experiences and coping strategies in navigating obstetric care demonstrate a resilience that transcends passive victimization. While understanding how patriarchal structures — such as state control, market interests, and medical authority — operate within obstetrics is essential to addressing obstetric violence, this approach is insufficient on its own. It is equally crucial to acknowledge the strength of women under the conditions that create a systemic vulnerability to violence: they are not merely passive recipients of care but active agents who negotiate, adapt, and challenge the existing systems.

Research on obstetric violence must therefore adopt a perspective that views birth-givers as resilient actors navigating structural constraints, rather than as victims. While this study sheds light on the ways paternal authoritarianism shapes obstetric care in Turkey, it is important to acknowledge certain limitations regarding the intersectional scope of the data. The sample lacked sufficient representation of migrant women and ethnically diverse groups, which constrained our ability

to fully explore how obstetric violence intersects with racialized and migratory inequalities. Although efforts were made to include women from varied socioeconomic backgrounds, the fathers interviewed were predominantly from similar, middle-class positions, which limited the class diversity of the paternal perspective. These limitations point to the need for future research that more deliberately centers intersectional experiences in the field of reproductive care.

To effectively combat obstetric violence, the focus must be expanded to include not only the structural vulnerabilities faced by birth-givers but also their potential for self-empowerment. Spaces must be created where birth-givers are not only heard but also respected as decision-makers in their own care. This includes the challenging of deeply entrenched dynamics of medical authority that often marginalize women's voices. Women's decisions about their reproductive health and childbirth must be trusted, valued, and integrated into care practices. To eliminate obstetric violence practices such as routine and non-consented episiotomies, it is essential for decision-making mechanisms to include all stakeholders in the childbirth setting — OB/GYns, midwives, mothers, and fathers — and foster dialogue to ensure the process is managed effectively.

References

Aksu, Damla Feriştah, and Pınar Serçekuş. 2023. "Traumatic childbirth experiences, effects, and coping: A qualitative study." *Sexual and Reproductive Healthcare* 37. https://doi.org/10.1016/j.srhc.2023.100898.

Aldrich, Daniel P., Craig Katz, and Talia Levanon. 2024. "The Interplay between Individual and Community Resilience." *Crisis Lab*. July 5. https://www.crisislab.io/blog/the-interplay-between-individual-and-community-resilience (last accessed April 7, 2025).

Alemdaroğlu, Ayça. 2006. "Eugenics, Modernity and Nationalism". In *Social Histories of Disability and Deformity*, edited by David M. Turner and Kevin Stagg, 126–141. London: Routledge.

Aşci, Özlem, and Meltem Demirgoz Bal. 2023. "The prevalence of obstetric violence experienced by women during childbirth care and its associated factors in Türkiye: A cross-sectional study." *Midwifery* 124. https://doi.org/10.1016/j.midw.2023.103766.

Bakır, Sümeyye, Emine Gök, Semra Gün, Oya Kavlak. 2024. "Vajinal Doğum Yapan Kadınların Epizyotomi ile İlgili Görüşleri ve Doğum Memnuniyeti." *TOGU Sağlık Bilimleri Dergisi* 4 (1): 50–65.

Beyinli, Gökçen. 2014. *Elleri Tılsımlı: Modern Türkiye'de Ebelik*. Ankara: Ayizi Yayınları.

Chadwick, Rachelle. 2021. "The Dangers of Minimizing Obstetric Violence." Violence Against Women 29 (9): 1–10. https://doi.org/10.1177/10778012211037379.

Chandraharan, Edwin, and Sabaratnam Arulkumaran. 2006. "Medico-Legal Problems in Obstetrics." *Current Obstetrics & Gynaecology* 16 (4): 206–210.

Charmaz, Kathy. 2007. *Constructing Grounded Theory*. London: Sage.

Cindoğlu, Dilek, Sezen Yaraş Şeker, Eylem Mercimek Göğüş, Ebrar Begüm Üstün. 2024. *Normalizing Episiotomies in Turkey: An Analysis through an Intersectional Grounded Theory Approach*. Unpublished research report.

Cindoğlu, Dilek, and Feyda Sayan-Cengiz. 2010. "Medicalization Discourse and Modernity: Contested Meanings over Childbirth in Contemporary Turkey." *Health Care for Women International* 31 (3): 221–243.

Cohen Shabot, Sara, and Keshet Korem. 2018. "Domesticating Bodies: The Role of Shame in Obstetric Violence." *Hypatia* 33 (3): 384–401.

Coşar, Simten, and Metin Yeğenoğlu. 2011. "New Grounds for Patriarchy in Turkey? Gender Policy in the Age of AKP." *South European Society and Politics* 16 (4): 555–73. doi:10.1080/13608746.2011.571919.

Çınar, Alev. 2019. "Negotiating the Foundations of the Modern State: The Emasculated Citizen and the Call for a Post-Patriarchal State at Gezi Protests." *Theory and Society* 48: 453-482.

Çorbacıoğlu Aksak, Gül. 2023. *Transformation of Professional Autonomy of the Medical Profession under the Health Transformation Program in Turkey*. PhD diss., Middle East Technical University. https://open.metu.edu.tr/handle/11511/103056 (last accessed April 2, 2025).

Cunniff Gilson, Erinn. 2016. "Vulnerability and Victimization: Rethinking Key Concepts in Feminist Discourses on Sexual Violence." *Signs: Journal of Women in Culture and Society* 42 (1): 71–98.

Dayı, Ayşe. 2019. "Neoliberal Health Restructuring, Neoconservatism and the Limits of Law: Erosion of Reproductive Rights in Turkey", Health and Human Rights Journal, 21(2): 57-68.

Dogangün, Gökten Huriye. 2019. *Gender Politics in Turkey and Russia: From State Feminism to Authoritarian Rule*. London: Bloomsbury Publishing.

Dole, Charles. 2004. "In the Shadows of Medicine and Modernity: Medical Integration and Secular Histories of Religious Healing in Turkey." *Culture, Medicine, and Psychiatry* 28: 255–280. https://doi.org/10.1023/B:MEDI.0000046423.59991.de.

Eksi, Betul, and Elizabeth A. Wood. 2019. "Right-Wing Populism as Gendered Performance: Janus-Faced Masculinity in the Leadership of Vladimir Putin and Recep T. Erdogan." *Theory and Society* 48 (5): 733–751. https://doi.org/10.1007/s11186-019-09363-3.

Eryurt, Mehmet Ali. 2018. "Fertility Transition and Fertility Preferences in Turkey." In *Family Demography in Asia: A Comparative Analysis of Fertility Preferences*, edited by Stuart Gietel-Basten, John Casterline, and Minja Kim Choe, 371–388. Cheltenham, UK: Edward Elgar Publishing.

European Parliament. 2024. *Obstetric and Gynaecological Violence in the EU: Prevalence, Legal Frameworks, and Educational Guidelines for Prevention and Elimination.* European Parliament. https://www.europarl.europa.eu/RegData/etudes/STUD/2024/761478/IPOL_STU(2024)761478_EN.pdf (last accessed April 2, 2025).

Fanshawe, Anne-Marie, Ank De Jonge, Nicole Ginter, Lea Takács, Hannah G. Dahlen, Morris A. Swertz, and Lilian L. Peters. 2023. "The Impact of Mode of Birth, and Episiotomy, on Postpartum Sexual Function in the Medium- and Longer-Term: An Integrative Systematic Review." *International Journal of Environmental Research and Public Health* 20: 5252. https://doi.org/10.3390/ijerph20075252.

Göbelez, Selen. 2021. "Tactics of Women Up Against Obstetrical Violence and the Medicalization of Childbirth in Turkey." In *The Politics of Female Body in Turkey: Reproduction, Maternity, Sexuality*, edited by H. Alkan, A. Dayı, S. Topcu, and B. Yarar, London: I. B. Tauris.

Günenc, Oğuzhan, Nur Gözde Kulhan, Melike Geyik Bayman, Canberk Celik, A. Bilgi, Çağdaş Colluoglu, and Mehmet Kulhan. 2024. "Medical Malpractice Stress Syndrome and Defensive Medicine in Obstetricians and Gynecologists in Turkey." *International Journal of Clinical Practice* 2024. https://doi.org/10.1155/2024/8226403.

Hacettepe University. 2018. “Doğuma Yardım Eden Kişi [Person Assisting Childbirth].” https://hips.hacettepe.edu.tr/tr/2018_tnsa_analiz_ve_rapor-56 (last accessed September 22, 2025).

Karaçam, Zekiye, Hatice Ekmen, Hüsniye Çalışır, and Sibel Şeker. 2013. “Prevalence of Episiotomy in Primiparas, Related Conditions, and Effects of Episiotomy on Suture Materials Used, Perineal Pain, Wound Healing 3 Weeks Postpartum, in Turkey: A Prospective Follow-up Study.” *Iranian Journal of Nursing and Midwifery Research* 18 (3): 237–245.

Karaçam, Zekiye, Döndü Arslan Kurnaz, and Gizem Güneş. 2017. “Evaluating the Content and Quality of Intrapartum Care in Vaginal Births: An Example of a State Hospital.” *Turkish Journal of Obstetrics and Gynecology* 14 (1): 10–17. https://doi.org/10.4274/tjod.88123.

Küçük, Mert. 2018. “Defensive Medicine among Obstetricians and Gynaecologists in Turkey.” *Journal of Obstetrics and Gynaecology* 38 (2): 200–205. https://doi.org/10.1080/01443615.2017.1340933.

MacFarlane, Katrina A., Mary Lou O’Neil, Deniz Tekdemir, Elvin Çetin, Barış Bilgen, and Angel M. Foster. 2016. “Politics, Policies, Pronatalism, and Practice: Availability and Accessibility of Abortion and Reproductive Health Services in Turkey.” *Reproductive Health Matters* 24 (48): 62–70. https://doi.org/10.1016/j.rhm.2016.11.002.

Ministry of Health of Türkiye. 2019. “İBBS-1’e Göre Doğum Göstergeleri, (%), 2019 [Birth Indicators According to IBBS-1, (%) 2019].”

Noroozi Dashtaki, Mahin, Mona Baghbani Nader, Ali Hosseinzadeh Oskouei, Mohammad Sadegh Zamani Zarchi, and Amir Sam Kianimoghadam. 2023. “Comparison of Sexual Function, Body Image Concern, and Sexual Self-Esteem in Women After Natural Childbirth with Episiotomy and Cesarean Delivery.” *Iranian Journal of Psychiatry and Clinical Psychology* 28 (4): 442–459. https://dx.doi.org/10.32598/ijpcp.28.4.4420.1.

Ökem, Zeynep Güldem, and Mehmet Çakar. 2015. “What Have Health Care Reforms Achieved in Turkey? An Appraisal of the ‘Health Transformation Programme.’” *Health Policy* 119 (9): 1153–1163.

Restrepo-Sánchez, Andrés. 2024. “Autonomy, Violence, and Consent in the Obstetric Field.” *Hypatia* 2024: 1–27. https://doi.org/10.1017/hyp.2024.84.

Saluk, Seda. 2023. “Fraternal Natalism: Demographic Anxieties and the Righteous State in Turkey.” *Women's Studies International Forum* (98): 102751.

SGGM (General Directorate of Health Sciences and Technologies). 2025. “Normal Birth as the Natural One.” General Directorate of Health Sciences and Technologies. https://sggm.saglik.gov.tr/TR-106002/dogal-olan-normal-dogum.html (last accessed April 2, 2025).

Statista. 2025. “Cesarean section rates in OECD countries in 2022.” https://www.statista.com/statistics/283123/cesarean-sections-in-oecd-countries/ (last accessed September 22, 2025).

Suarez, Eliana Barrios, Carmen Logie, Jose F. Arocha, Hugo Sanchez and Takhmina Shokirova. 2021. “Contesting Everyday Violence: Resilience Pathways of Gay and Transgender Youth in Peru.” *Global Public Health* 16 (5): 706–728.

Turan, Janet Molzan, Ayşen Bulut, Hacer Nalbant, Nuriye Ortayli, and Tuğrul Erbaydar. 2006. “Challenges for the Adoption of Evidence-Based Maternity Care in Turkey.” *Social Science & Medicine* 62 (9): 2196–2204. https://doi.org/10.1016/j.socscimed.2005.10.005.

Topcu, Sezin. 2019. “Caesarean or Vaginairean Epidemics? Techno-Birth, Risk and Obstetric Practice in Turkey.” Health, Risk & Society 21 (3-4): 141–163. https://doi.org/10.1080/13698575.2019.1641588.

United Nations. 2019. “A Human Rights-Based Approach to Mistreatment and Violence Against Women in Reproductive Health Services with a Focus on Childbirth and Obstetric Violence.” https://digitallibrary.un.org/record/3823698 (last accessed September 22, 2025).

van der Waal, Rodante, and Kaveri Mayra. 2023. “Obstetric Violence.” In *Gender-Based Violence: A Comprehensive Guide*, edited by P. Ali and M. M. Rogers. London: Springer.

van der Waal, Rodante, Inge van Nistelrooij, and Carlo Leget. 2023. "The Undercommons of Childbirth and Their Abolitionist Ethic of Care: A Study into Obstetric Violence Among Mothers, Midwives (in Training), and Doulas." *Violence Against Women* 31 (1): 155–181. https://doi.org/10.1177/10778012231205591.

Yabancı, Bilge, and Chiara Maritato. 2024. "Gender Politics under Autocratization and Two Decades of Women's Movement in Turkey." In *Religion, Gender, and Populism in the Mediterranean*, 150–170. London: Routledge.

Zielinski, Ruth, Lisa Kane Low, Abigail R. Smith, and Janis M. Miller. 2017. "Body After Baby: A Pilot Survey of Genital Body Image and Sexual Esteem Following Vaginal Birth." *International Journal of Women's Health* 9: 189–198.

Sara Fariello, Giuditta Mitidieri

Incomplete Professionalization of Midwives as a Risk Factor for Obstetric Violence. Insights from Southern Italy

Abstract: This chapter examines the midwifery profession in Italy, highlighting key challenges such as limited autonomy, precarious employment, insufficient training, and lack of social recognition. Based on in-depth interviews with midwives in Campania (Southern Italy), the study reveals that the process of professionalization for midwifery in Italy remains incomplete. This persistent fragility undermines the implementation of the midwifery model of care, widely recognized as the gold standard for uncomplicated births. We argue that poor working conditions indirectly contribute to obstetric violence, as systemic pressures and professional constraints can negatively impact care quality. By foregrounding the role of care providers and professional ethics, this analysis shifts the lens of obstetric violence studies—traditionally focused on maternal experiences—toward the structural and professional dimensions of maternity care, addressing a critical gap in current literature.

1 The evolving role of midwives: professional and social transformations

Midwives today are qualified healthcare professionals responsible for assisting women during pregnancy, childbirth, and the postpartum period. According to current Italian regulations, in cases of eutocic births, midwives are those who can provide care independently, assuming full responsibility (Ministerial Decree No. 740/94). However, the social role, expertise and independence of this professional figure have undergone profound changes in Italy, as well as across the Western world, throughout the last few centuries, and particularly during the 20th century. Historically, the role of birth attendants was fulfilled by traditional, non-professionalized figures who inherited the folk female knowledge associated with

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the art of healing. In Italy, these figures were known by various dialectal terms, such as *levatrici, matrone, mammane*, or *comari*. Starting in the 16th century, as medical science became more formalized in universities and professional guilds, the role of the *levatrice* underwent systematic delegitimization. Through a typical process of professional demarcation (Abbott 2014), traditional midwives were increasingly portrayed as a relic of a superstitious and outdated world. Margaret Stacey (1988, 50) aptly summarized this process in the sentence "creating the quacks to create the profession." Gradually, across Europe, the medical establishment succeeded in institutionalizing and professionalizing the once-folk figure of the *levatrice,* placing her under the authority and supervision of physicians (Clesse et al. 2018). As Nadia Maria Filippini highlights, institutionalized education for midwives was not solely aimed at transmitting medical knowledge but mostly at "instilling behavioral models and reinforcing respect for professional hierarchies, effectively redesigning the role of the midwife" (Filippini 2017, 186). Nevertheless, in Italy as in most of Europe, the presence of unlicensed *levatrici* operating outside the formal training system remained widespread.

In Italy, a profound change occurred at the beginning of the 20th century, with the institution of the *ostetrica condotta* (R.D. 466/1906), salaried by the municipality in order to guarantee free and widespread birth care. The *condotta* midwife moved freely across the territory—midwives were among the first women to obtain a driving license—enjoying full professional autonomy. This independence granted them strong social legitimacy and a respected public role in the community, comparable to that of the priest or the doctor. In the second half of the 20th century, with the gradual hospitalization of births, the role and job of midwives changed radically. This shift led to a profound socio-professional devaluation, which culminated in 1978 with the creation of the National Health Service and the consequent suppression of the *condotta*. Within the rigidly structured and highly hierarchical hospital environment, the midwife's role was reduced to that of the doctor's 'handmaid', an auxiliary healthcare figure assimilated to a specialist nurse with whom she shared basic training (Spina 2009). In hospitals, professional hierarchy was linked to gender, since doctors were almost exclusively male and nurses predominantly female.

Since the mid-1990s, the midwifery profession in Italy has undergone significant further changes, driven by the reform of healthcare teaching regulations (L. 341/90), the definition of its professional profile (Ministerial Decree No. 740/94), and the recognition of its professional autonomy (L. 251/2000). In particular, law No. 42/1999 marked the end of the distinction between principal and auxiliary healthcare professions, enabling a process of socio-occupational repositioning. Midwives regained a certain amount of professional autonomy in the area of physiological pregnancy and childbirth care. Furthermore, beyond their traditional responsibilities,

midwives obtained an expanded role that includes socio-health counseling on pregnancy, maternity, breastfeeding and sexual education. The regulatory framework was completed with Ministerial Decree No. 509 of 1999—which established a three-year degree program in midwifery, separated from nursing education—and with the Ministerial Decree of April 2, 2001, which defined the admission criteria and program structure. With the university reform, midwifery—like nursing—was officially recognized as an intellectual profession. The Code of Ethics (approved by the National Council on June 19, 2010) also states that midwives are qualified healthcare professionals in obstetric, gynecological, and neonatal care, and that their practice is based on the freedom and independence of the profession (Art. 1).

Over the past few decades, midwives have thus begun to develop their own care model, which focuses on the physiology of female reproductive health and emphasizes the importance of social relationships and emotional experiences (Fariello and Pratschke 2024). However, as already highlighted in the literature (Spina 2014), the 'late' path of professionalization of midwifery still appears incomplete, in terms of both actual practices and social recognition.

Although the new generations seem more aware of their role, even today midwifery still appears to be a *semi-profession*, maintaining a hybrid character between professional autonomy and auxiliarity. A profound difference can be observed between freelance midwives and hospital midwives (Spina 2009): the latter, set in a strongly hierarchical context, continue to be subjected to an organization centered on medical dominance (Freidson 1970) and struggle to find the autonomy that should characterize an established profession. At a social level, the role of the midwife and her skills are not adequately recognized. Care during pregnancy and childbirth is still primarily associated with the profession of the gynecologist, the one who *delivers* babies. The professional niche of autonomy in the field of reproductive physiology, as outlined by legislation, is not reflected in midwives' training, which remains focused on pathology and is still taught and supervised by doctors. In fact, despite being recognized as an intellectual profession, there is today no de facto possibility for a midwife in Italy to pursue an academic career. The fragility of the midwife's professional profile is mirrored in precarious working conditions, characterized by staff shortages, inadequate pay and job insecurity. Although widespread throughout the public health sector, these conditions are prevalent among the least protected and recognized professional figures. Meanwhile, Italian midwives seem to neglect the need to build relational networks capable of conferring strength and legitimacy to their professional group. The profession is today poorly unionized, also because of the lack of a dedicated midwives' union, which is grouped into the nursing unions, whose professional interests, as we shall show, are sometimes in conflict with those of the midwives. What has happened in other national contexts, such as the English one, shows that

a strong professional order contributes to the consolidation of the profession and the enhancement of its occupational role, with positive repercussions in terms of both economic benefits and social prestige. Our argument is that a higher degree of professionalization and a genuine recognition of autonomy for midwives would lead to improved quality of care for women.

2 Midwifery care as a reference model for the prevention of obstetric violence

The midwifery-led approach to childbirth is a model of care in which midwives serve as the primary healthcare professionals, providing continuous support and oversight from antenatal care through the postpartum period. This model is predominant in certain countries, such as the Netherlands and the UK, where the midwifery profession has historically received strong social recognition. In contrast, in other regions, such as North America, a medically-led model prevails, meaning that obstetricians serve as the primary care providers, supported by labor and delivery nurses. In many countries, including Italy, care models are typically mixed, meaning that responsibility for the organization and delivery of maternity care is distributed among different healthcare professionals. Throughout pregnancy, childbirth, and the postnatal period, the responsibility for care may shift between different providers. In mixed-care systems, midwives might provide the actual care in most cases, but the obstetricians assume responsibility, supervision and leadership.

The midwifery model differs from the obstetrician-led one not just in the primary caregiver but mostly in its underlying philosophy of care. In general terms, midwifery care can be defined as "skilled, knowledgeable and compassionate care for childbearing women, newborn infants and families across the continuum from pre-pregnancy, pregnancy, birth, postpartum and the early weeks of life of the baby" (Renfrew et al. 2014). This model views childbirth as a bio-psycho-social event (Jordan 1993) that needs to be addressed in its biological, psychological, and social dimensions through a holistic approach. In order to achieve this goal, the model is based on a relationship of trust between the midwife and the family, offering personalized and continuous one-to-one support. This means that the same provider, or team of providers, cares for the family from antenatal care through to the postpartum period. The model emphasizes the importance of informed choice and respect for the bodily autonomy of the birthing person, who is recognized as the protagonist of the event. Moreover, this model aims to demedicalize childbirth, reframing it as a normal life event rather than a pathological condition (Van Teijlingen 2005).

Considerable efforts are made to reduce unnecessary interventions that can lead to iatrogenic consequences and negatively interfere with the birthing process. The practices enacted—which include a wide repertoire of techniques ranging from the use of water to specific postures, visualizations, free and guided movement—are designed to support and enhance the natural physiology of childbirth, following the approach of salutogenesis (Antonovsky 1996; Schmid 2018, 2007).

This model is specifically designed for low-risk births, where care can be safely provided with minimal or no medical intervention and without the presence of healthcare professionals other than midwives. However, in order to improve outcomes and humanize care, this approach can and should be also partially applied in medium or high-risk births, monitoring and medical intervention notwithstanding. An example of this mixed approach is the so-called humanized C-section, where efforts are made to protect the dyad meeting after the operation through skin-to-skin contact and immediate breastfeeding (Capogna and de Boer 2017).

The midwifery model of care can be fully implemented in home births, birthing houses and birth centers, both freestanding and alongside. Recently, the Midwifery Units Network (MUNet) drew up the care standards for a Midwifery Unit, providing a systematization of the unique aspects of midwifery care (Rocca-Ihenacho et al. 2018). According to the Standards, in order to ensure safety, effectiveness, and respectful care, a midwifery unit requires full professional autonomy for midwives, as well as strong collaboration with other healthcare professionals and a clear protocol for referral to the medical team in case of complications. Furthermore, midwives must undergo high-quality training, continuous education, and develop specific skills in the physiology of pregnancy, childbirth, and the postpartum period. Midwives should have full professional responsibility and leadership of the unit, with appropriate recognition of their workload; the care provided must be evidence-based, with clear protocols that are shared and agreed upon by the team. This model could ideally be implemented in obstetric wards as well, although this appears challenging since in this context the implicit professional hierarchy often leads to decision-making and leadership being dominated by the medical profession (Freidson 1970). Additionally, the absence of a clear distinction between low and high-risk labor, typical of obstetric wards, fosters the overuse of medical interventions, undermining the distinctive role of midwifery in supporting physiological birth.

An expanding body of evidence indicates that midwifery-led care is particularly suitable for healthy women with uncomplicated pregnancies. Within a well-functioning referral system and with well-trained midwives, this model is associated with improved quality of care as well as a decrease in maternal and fetal mortality and morbidity (Sandall et al. 2016; Scarf et al. 2018). Additionally, whether provided in freestanding or alongside centers, midwifery care has proven to be highly

cost-effective, offering significant savings compared to obstetric units (Cicero et al. 2022; Isaline et al. 2019). In fact, the World Health Organization has recognized midwifery as a key strategy for improving women's health worldwide and advancing the Sustainable Development Goals (Nove et al. 2021). National and international guidelines have acknowledged the evidence and endorsed the implementation of this care model for low-risk births. In the Italian context, the Ministry of Health issued the *Guidelines for the Definition and Organization of Autonomous Midwifery Care for Low-Risk Pregnancies* in 2017, encouraging healthcare facilities to establish BRO wards (low-risk areas). These wards are ideally designed to implement the midwifery model, ensuring that low-risk pregnancies are managed primarily by midwives, reducing unnecessary medical interventions during childbirth. However, both in Italy and globally, the midwifery model struggles to gain ground while the obstetrician-led model holds cultural dominance. The availability of well-supported and well-resourced midwife-led units remains limited, restricting access to optimal, consistent, high-quality, safe, and cost-effective care for women and their babies.

Although the benefits of this model in improving the birthing experience are known, literature has not sufficiently highlighted its role in preventing obstetric violence. By fostering a respectful, trusting relationship between healthcare providers and the family, and by tailoring care to the needs and desires of the birthing person, this model serves as the strongest protection against a directive, controlling, and invasive approach to childbirth. In fact, although the responsibility for abusive behavior is individual, we claim that the reasons why some health workers practice dehumanizing conduct during birth care are to be found at the structural level (Sadler et al. 2016). Indeed, obstetric violence is often unintentional and systemic, rooted in the implicit hierarchies and in the organization of obstetric wards, where midwives face challenging working conditions and internalize the socially hegemonic technocratic model of care (Davis-Floyd 2001), which neglects the emotional and social dimensions of childbirth. This systemic dimension of obstetric violence was also highlighted in the 2019 report by Dubravka Šimonović, UN Special Rapporteur on violence against women, who analyzed the issue of mistreatment and violence in reproductive health services with a focus on obstetric violence, addressing the root causes and structural issues. The report revealed the widespread and systematic nature of the abuse women experience during childbirth in hospital settings, which should be considered “as part of a continuum of the violations that occur in the broader context of structural inequality, discrimination, and patriarchy, and are also the result of a lack of proper education and training, as well as a lack of respect for women’s equal status and human rights” (UN. Res. 71170 2019, 5). Alongside culturally embedded assumptions on women and their bodies, resource constraints and working conditions within healthcare systems can

also contribute to mistreatment and violence against women during childbirth (UN Res. 7170 2019, 13–14).

A global survey of midwives conducted by WHO in 2016, *Midwives' Voices, Midwives'* Reality, provided an overview of the working conditions of midwives, revealing that, across various regions, these health workers face social, economic, and professional barriers. Midwives worldwide have reported that health system deficiencies, such as understaffing, high patient volumes, low salaries, long hours, and lack of infrastructures, create stressful environments that facilitate unprofessional behaviors. Many also feel constrained by unequal power dynamics and claim to be excluded from policy-making and service development due to gender inequality. According to the report, midwives' ability to provide quality care is further compromised by their lack of influence and senior positions within the health system and broader political agendas. Like many health workers, midwives reported difficulties in achieving a work-life balance due to night shifts and understaffing, while feeling their pay did not reflect the intensity of their workload or the significance of their responsibilities. The report also highlights how the increasing medicalization of childbirth contributes to the devaluation of the midwifery profession. In some countries, midwives reported low professional status, subordination to the medical profession and lack of respect by the community, which largely misunderstands their role. This is compounded by scarce recognition of midwives' qualifications, as well as lack of professional autonomy. A common sentiment reported was disillusionment with professional associations and regulatory bodies within national health systems, which were seen as unable to adequately and effectively support midwifery as a profession and midwifery personnel as workers. Considering their working conditions, it is not surprising that, despite the existing evidence and guidelines, the midwifery care model remains largely underrepresented. We believe that improvements in the professionalism of midwifery, in terms of better working conditions, training, salary, social recognition, and decision-making autonomy, would facilitate the adoption of midwifery care. This, in turn, would enhance the quality of childbirth assistance and serve as a preventive measure against obstetric violence.

3 Laboring under pressure: professional struggles and evolving practices in Campania

3.1 Methods and methodology

This research was based on an in-depth exploration of the experiences and perspectives of a group of midwives from Campania, a region in southern Italy, using qualitative methodology. A total of 27 interviews were conducted in two phases: a first set was conducted between 2022 and 2023 as part of a study on the emotional labor of midwives (Fariello and Pratschke 2024), followed by a second set in 2025. One interview was conducted with a female gynecologist. Whenever possible, participants were given the option to choose between a video call or an in-person meeting, while telephone interviews were not permitted. This decision was based on the well-established argument that telephone interviews result in the loss of valuable contextual and nonverbal cues, whereas video calls still allow for face-to-face interaction, although digital (Deakin and Wakefield 2014). The option of video interviews was particularly important to facilitate participation, as midwives often manage irregular shifts and face challenges in maintaining a work-life balance. Recent methodological literature has reassessed online interviews, highlighting not only their logistical advantages but also their potential benefits. Some studies suggest that digital interaction can enhance openness and self-disclosure by reducing self-presentation constraints and lowering face-saving mechanisms (Gibbs, Ellison and Heino 2006). Online interviews are therefore especially useful while dealing with sensitive topics, as in the case of this study. The interviews followed a semi-structured format, with a set of guiding questions designed to steer the conversation toward key research themes in order to allow for comparative analysis. However, participants were encouraged to freely share their personal experiences, introduce new issues, and express their opinions on various aspects of their profession. All interviews were recorded and subsequently transcribed verbatim. Throughout this process, we ensured strict confidentiality, handling audio recordings and participant data with the utmost care to protect the anonymity of the midwives involved in the study. To ensure anonymity, the respondents were referred to by a number and references to hospital or Family Health Centers[1] were concealed.

1 The authors have chosen the term “Family Health Centers” to translate the Italian “consultori familiari.” “Consultori” are public community-based healthcare centers established in Italy in 1975 (Law 405/75), primarily aimed at supporting women’s reproductive health. Their services include antenatal care, psychological support, counseling and care related to reproductive choices. These social and healthcare facilities are managed and funded by the Regional Health Agencies, as part

Transcribed data were coded using open coding (Strauss and Corbin 1990), identifying and labeling meaningful units related to the study's main themes, such as: training, inter- and intra-professional dynamics, North-South gap, role of private healthcare, and, most notably, perspective on obstetric violence. The dataset was then analyzed using thematic analysis techniques (Byrne 2022).

3.2 Midwifery autonomy and professional dynamics

The midwives interviewed appeared to be aware of the significant changes that have occurred in their professional field over the past two decades, particularly regarding their growing autonomy in managing labor and childbirth. However, all the interviewees were disappointed or partially unsatisfied with the training they received at universities in Campania. In particular, they complained about the failure to bring teaching up to date with the literature, claiming that they were studying obsolete textbooks that were inadequate both in the clinical practices described and in the way women were portrayed. Most of the interviewees were between 30 and 40 years old, meaning their experiences primarily reflect the situation from a decade ago. However, younger participants reported a situation largely unchanged from that of their older colleagues. Moreover, the midwives reported that their training was delivered almost entirely by doctors and, as a result, was predominantly focused on pathology. Although midwifery is officially recognized as an intellectual profession, midwives in Italy currently have no real opportunity to pursue an academic career. Teaching positions in midwifery education are monopolized by the medical profession, while midwives themselves are relegated to teaching minor courses or strictly technical internships. This lack of recognition for midwifery-specific expertise leads to a university curriculum that primarily prepares students to be gynecologists' assistants or, at best, "minor doctors."

> I have come to realize that what we practice is often not true midwifery. Our approach is heavily shaped by medicalization, hospitalization, and a mini-doctor mindset [...]. Midwives who are trained and work solely within this system come to believe that this is the midwifery model, when in reality, midwifery is rooted in a completely different approach.
> *Interviewee 12*

Consequently, midwifery training neglects the core expertise of the profession: the physiology of female reproductive life, which extends beyond childbirth to include

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of the National Health Service.

breastfeeding, menstrual health, and sexual well-being. These skills have found a place in Italy only outside institutional settings, within private schools where some midwives, dissatisfied with their university education, seek further training at their own expense, often with little recognition from the public healthcare system.

> We only had three lecturers who were midwives in all three years. Mostly we were taught pathology, very little physiology, also because physiology is neither respected nor known in clinical practice. We were studying on a text called Moracci, a text from the 1980s which still mentioned races and used words such as 'primipara attempata' [old primipara] [...those were] very old, sexist, absolutely outdated texts... and a lot of obstetrical pathology, certainly not training us to help women in puerperium or breastfeeding.
> *Interviewee 22*

The same medical dominance observed in the university environment is then experienced in the delivery room, where midwives report a lack of professional autonomy. This deficiency is primarily linked to the unclear distinction between physiological and high-risk births, as well as to the absence, both in Campania and across Italy, of in-hospital midwifery-led birth centers, dedicated to low-risk births with full midwifery management. In this context, physiology is always provisional and the low-risk status can be revoked at any time by the doctor, thus nullifying midwives' autonomy. Although Italian regulations, as previously shown, promote midwifery autonomy in low-risk care, without proper differentiation of clinical cases and spaces, midwives find themselves as the 'weaker' part of the care team, often having to accept medical decisions even for clinical cases that should be within their responsibility. All the interviewees described the interprofessional dynamic between midwives and doctors as still highly asymmetrical and hierarchical. The power hierarchy is even more evident when looking at the private healthcare sector, where the dominance of doctors is based on their privileged relationship with the patient and their market power.

> Very often, what should be the midwives' reign is instead managed by the gynecologist, even in completely physiological conditions, leading to some tension. There are always midwives who complain about this, saying they cannot fully carry out their role because the gynecologist is always present. Sometimes they are anxious, or perhaps [they] have had bad experiences in recent years, [and so are] overly cautious and inclined to be hands-on instead of allowing the midwife to handle the situation.
> *Interviewee 3*

> Our context is a private one, so most births are cesareans. Essentially, the role of the midwife is almost nonexistent, except for assisting with the cesarean procedure and checking on the post-birth recovery.
> *Interviewee 10*

> The problem is that gynecologists have complete control over treatment, labor management, and delivery...everything. As a result, we are held accountable for their decisions and have no choice but to comply. Having no freedom, I don't feel free to express my own opinion. It is very humiliating.
> *Interviewee 6*

This unclear division of labor and the ambiguity as to who should make decisions means that, according to some midwives, the doctor is perceived either as intrusive or as unavailable when the midwife seeks the support she is used to receiving.

> To tell the truth, doctors can be either intrusive or even absent. I mean, sometimes they are fugitives—you have to chase them and say "look at this, there's something I don't like; look at this tracing, there's some alteration"... then there are times when they tell you, "you have to do it like this." In short... [it's] either too much or too little.
> *Interviewee 9*

As expected, the issue of gender emerged frequently in the professional dynamics, given that the midwifery profession is almost entirely feminized. Many midwives, particularly the younger ones, reported feeling belittled both by doctors and by the women they assist, with some tending to perceive them as 'housemaids' rather than qualified healthcare professionals.

> It leans more toward a hierarchical relationship, with the doctor being perceived as superior, often overshadowing the midwife [...] You're just there as a caregiver, a maid... not feeling valued is disheartening. Given that midwives primarily deal with physiology and doctors with pathology, there could be a balanced collaboration, with both relying on each other. A doctor does not necessarily always know more, just as it is not always true that a midwife knows more.
> *Interviewee 7*

> Despite often being on duty for 12 hours, the laboring women didn't really see me… to them, I was just another person…I could have been the cleaner, I could have been anyone. They only wanted the doctor. The phrase I heard most was "The doctor has to come." So I felt downgraded in my role.
> *Interviewee 2*

It was particularly interesting to note how these gender dynamics are also at play toward the growing number of female gynecologists. Some interviewees reported relational and linguistic patterns that were highly indicative of internalized sexism, perfectly depicting the power dynamics at play during childbirth.

> Women are more mentally inclined to delegate to men! Because they think "I'm not able." As for the midwife, there's the issue that they [women] see their role as inferior... but you can see it even in [a condition of] equality. When the gynecologist is a woman, it's "Signorì! signorì!"

> ["Miss" in dialect], in a complaining tone. But when the doctor is a man, they stay silent, they call him "Doctor," with a respectful tone.
> *Interviewee 25*

The interviews showed a clear lack of social recognition for the role of midwives, whose professional expertise remains largely unknown. Although this issue is widespread across Italy, in the South, midwives are even less recognized and sought after, partly due to their more deficient training and their relegation to an assistant role under gynecologists. This is particularly evident in antenatal care: when they learn they are pregnant, most women seek private gynecologists rather than relying on Family Health Centers, which are often perceived as rundown and inadequate. Moreover, unlike in Central and Northern Italy, even when a woman with a physiological pregnancy were to visit a public health centre, antenatal care would still be provided by doctors rather than midwives. This lack of social recognition was found to be particularly challenging for midwives who had pursued further education beyond university or gained professional experience in other contexts, in Central and Northern Italy, where midwifery, though still undervalued, receives greater recognition. Having experienced a different level of respect from both medical teams and families makes it especially difficult for them to work in environments where their expertise is not adequately acknowledged.

> No one knows that the specialist for physiological pregnancy is the midwife. Absolutely no one. Even if a woman goes to a family health center, she will find a doctor, not a midwife. The midwife just weighs her, checks her blood pressure, helps her undress. Then she puts the patient's file on the bed, steps out for a cigarette, eats a pastry, chats a bit, and mocks the patients.
> *Interviewee 22*

> People don't really know what a midwife does. Sometimes I've heard, "Oh, you're the midwife! The one who washes the baby after birth." With all due respect for washing a baby — not that newborns should even to be bathed right away! — I didn't get a degree just to wash a baby.
> *Interviewee 25*

3.3 Obstetric violence: the midwives' point of view

When invited to share their perspective on obstetric violence, the interviewees expressed a range of views, though with many common threads. They all acknowledged, to varying degrees, the existence of a form of mistreatment that undermines women's health and they recognized the need to keep on improving childbirth care. Hospital midwives tended to focus on the topic of communication as the core issue of obstetric violence. Rather than questioning medical practices or the structure of

care itself, they highlighted an inadequate relational approach and communication style as key concerns.

> There are obstetric practices for which consent is not clearly asked, and this is problematic. I remember we once debated whether to ask women to sign consent for episiotomy upon admission so that we didn't have to ask during labour if we had to perform it. I felt it wasn't right. What we call violence stems from the fact that there's a lack of communication between doctors and patients, midwives and patients [...] we're not really explaining anything to them. That is the real issue: the lack of information, the failure to give proper attention to an intervention that we must perform, and that is even life-saving. That said, I would change the term because violence seems too strong to describe this.
> *Interviewee 24*

Conversely, a more radical perspective emerged among freelance midwives and those with a strong political awareness. They questioned the very foundations of the organizational structure of care and the practices themselves. Additionally, they focused on more 'subtle' aspects of obstetric violence, such as lack of privacy or the inadequate involvement of partners, who are typically allowed into the delivery room only at the active labor stage. Among these midwives, criticism also emerged of colleagues who downplay the phenomenon of obstetric violence — e.g. rejecting the use of the word 'violence' — or tend to accept the situation without reacting.

> My days in the hospital were, I repeat, hell. [...] I saw women left to fend for themselves, subjected to certain procedures, such as mandatory lithotomy... The conditioning, the management of labor itself... [...] There are gynecologists who firmly believe that a 'little help', the Kristeller maneuver, is always necessary. [...] I worked in a place where the delivery room seemed stuck in the 1980s, with two beds where women gave birth side by side, and a third bed for post-birth procedures. So at times, there were two women in labor, about to give birth, while another was undergoing a uterine curettage after a miscarriage. To me, that was inhumane.
> *Interviewee 20*

> And so, I feel ashamed. I mean, the terminology used is fitting because what we witness is indeed violence. Just the other day, a colleague called me in tears after attending a birth—not even as the assisting midwife, but just observing from outside the delivery room. She was upset with the midwife who remained silent. She said "yes, this young woman lost control, she was truly overwhelmed, but that doesn't justify calling her certain names, it doesn't justify shouting at her." If she screams, your role is to de-escalate. That is your purpose.
> *Interviewee 25*

> The midwives who perceive it [the definition of obstetric violence] as an allegation against our category are the ones who do not recognize what they see. And all in all they have adapted to this state of affairs. I don't think the term is problematic.
> *Interviewee 22*

Overall, however, all midwives appeared to recognize the importance of providing care that is as hands-off as possible, an idea often summed up in the dialectal expression “non metterci mano” (“don’t put your hands in there”). Many interviewees emphasized the iatrogenic effects of unnecessary interventions and of rushed acceleration of labor, advocating the importance of allowing the physiological process to unfold in its own time. The interviewees unanimously identified obstetricians as the primary agents responsible for disregarding the natural timing and process of spontaneous labor. This interference was attributed to constant monitoring and maneuvering aimed at steering the process of birth. Such an approach was linked to a heightened ‘alertness’ to risk, shaped by their pathology-focused training. In this sense, the issue of obstetric violence also becomes a matter of professional boundaries: on the scene of birth, a more directive approach may clash with the wait-and-see approach typical of midwifery care. Midwives’ ability to assert their clinical choices is central to their professional recognition.

> One time, a colleague opposed an episiotomy, but the gynecologist insisted and ultimately did it herself. She cut the woman so badly that it went all the way to her rectum. The woman sued but my colleague, following my advice that night, wrote right on the chart that she didn't deem the episiotomy necessary, and she came out clean. She still had to undergo a first degree trial, but it was important because in the technical expert’s report it was written that she is a professional to all intents and purposes, with her own professional and deontological profile. Since she had stated that the episiotomy was unnecessary, there was no justification for performing it, and the responsibility fell entirely on the gynecologist who made the decision. And this is important, you understand? Because you also show that you have a minimum of professionalism and that you are not the doctor's subordinate. And it’s not about going against doctors: it’s about asserting our own identity.
> *Interviewee 24*

> I wonder why professionals are not afraid to get their hands on it so much, performing the Kristeller maneuver, making a lot of fuss, but then they are scared of having someone on all fours!
> *Interviewee 22*

> What could certainly be done is to show more respect and to be less hands-on, to give things more time, in short. Give the woman time to follow her own path from the onset of labor until delivery. Be as free as possible from any procedure that is done just to speed things up.
> *Interviewee 8*

A tension has emerged between the ‘new school’ midwives and the ‘old school’ midwives, the latter being less inclined to pursue professional autonomy and to “fight the doctors” in order to keep their hands off from birth, unless strictly necessary. This tension is not just generational: some younger midwives have adopted the mainstream approach without questioning it, while some of the older midwives

have been 'revolutionaries', fighting to initiate the ongoing process of demedicalization. In general, however, the newer generations, both of midwives and doctors, seem more aware of the issues associated with an invasive approach to women's bodies and the need to ensure care that is both humane and scientifically appropriate. Younger midwives understand that this requires more professional autonomy for them.

> In the '90s, old midwives would say, "Madam, get in this position! Tie her legs!" Instead, we started working differently, bringing a new approach to midwifery, first and foremost by getting women out of bed. Because, you know, women should be free. You can't tie them down, you can't take away their right to physically express themselves.
> *Interviewee 21*

> [The head nurse] had a completely different conception of the midwife's role during labor and delivery compared to today. The midwife was simply subordinate to the doctor, and the term "humanization of childbirth" made no sense to her, nor did the idea of the father being present in the delivery room. She often mocked the chair we had set up for fathers in the delivery room, trying to involve them in the experience.
> *Interviewee 14*

> What I have noticed is that this new generation of midwives and doctors has certainly brought a fresh perspective to the hospital—I am thinking of all these new practices that they take for granted and they are passing on to staff who is no longer young.
> *Interviewee 23, Gynecologist*

> Midwives who are in their sixties today have always been accustomed to a certain type of care, with a somewhat subordinate relationship with the doctor. This is also tied to the lack of training they received, as they come from a limited educational path. We, on the other hand, completed a university degree... I have a colleague in her sixties who is not university-educated, and if you talk about guidelines or stray a little from daily practices, she panics. For thirty years, she simply did what "was always done." That being said, I've worked with excellent colleagues in their sixties in Novara, so it's not just a generational issue. But here, I do notice this.
> *Interviewee 20*

3.4 Working conditions in Campania's health system

A significant obstacle to fulfilling midwives' professional expectations concerns the structural limitations of the healthcare system and the resulting working conditions for midwives. First and foremost, staff shortages hinder the possibility to provide one-to-one care, which is essential for fostering one of the fundamental principles of midwifery care: an empathetic and trusting relationship with the

birthing woman. Staff shortage also results in an overload for midwives, who are subjected to heavy shifts and develop work-related stress.

> When they say "statistically you attend one and a half births a day, so what's the need for an extra midwife?" I feel that the hard work we do when we manage four labors simultaneously is completely overlooked. No one considers our role, our workload... cutting back on maternity units is something that drives me crazy.
> *Interviewee 14*

> Sometimes, especially in the early stages of labor, we would bring women into the delivery room to put them in water – because warm water eases the pain – so they wouldn't be left alone in their room... [we do this] when we can, of course, because handling 18 patients among 3 midwives isn't easy.
> *Interviewee 7*

Many midwives expressed discomfort about the state of the facilities, which are often described as inadequate to welcome birthing women and ensure proper working conditions.

> We often found ourselves with patients who had to stay in the hallway or in a room we set up to keep them out of the hallway, where the midwives often didn't even have a place to sit.
> *Interviewee 13*

Regarding contractual conditions, we found that, as expected, especially younger midwives experience highly precarious situations, with fixed-term contracts or self-employed statuses, particularly in private facilities. Many midwives are forced to relocate in Northern Italy for better job opportunities, with a significant impact on their private lives. As already mentioned, all the interviewees were not unionized and expressed skepticism about the ability of unions to improve their working conditions. This phenomenon is also linked to the lack of a dedicated midwives' union, as midwives are grouped into nursing unions, whose professional interests sometimes appear in conflict with their own. This is evident in the ongoing debate about the request for 'mono-professionalism,' that is, having only midwifery staff in obstetrics departments. This organizational model is well-established and consistently present in Central and Northern Italy, while in the South midwives work in hybrid obstetric wards alongside nurses, particularly in neonatal units. In addition to pointing out the lack of specific skills among nurses in obstetric care, the issue of mono-professionalism also becomes an issue of professional conflict in a context marked by staff shortages. The lack of a strong midwifery union undermines midwives' ability to voice their concerns in the public sphere and to exert pressure to demand better contractual and working conditions.

> I will join a union when there is a midwifery-specific union run by midwives who think like midwives. With all due respect for nurses, they don't have the same mindset as we do, just as I don't have theirs. I believe, and strongly hope, that obstetric departments should be run exclusively by midwives. We are trained for this. Nurses have a whole world to cover, the entire hospital, while our scope is limited to our department. And I often realize that nurses don't even have basic training... even in their interactions with women. In the North, I've always worked in mono-professional hospitals.
> *Interviewee 27*

Most of the midwives interviewed constantly compared the Campania context with the healthcare system in Northern Italy, a comparison made easier by the fact that most of them had worked in the central-northern regions. We found a widespread tendency to "idealize" the North, describing it as an environment where the role of midwives is highly recognized and valued.

> In the North, I felt [there was] a different organization and a different appreciation for midwives and midwifery. Here, they always make the same remark: "You're talking about the North, do you understand where we are? We're in Naples." But why? Why can't Naples have a different way, a different model of care? What's different about us?
> *Interviewee 14*

As a matter of fact, compared with national data, the Campania context shows some weaknesses and a more pronounced medicalization of childbirth. For instance, Campania still holds the national record for cesarean sections, with 42.7% in public facilities and 52.9% in accredited ones, compared to a national average of 30.3% (Ministero della Salute 2023). Ultimately, however, a mitigation of childbirth medicalization can be observed compared to the past. At least in some facilities, some positive transformations are emerging such as the decline of routine episiotomy, which is progressively being phased out in Campania, as well as across Italy.

A significant difference in management from the central-northern facilities that we observed concerns the absence of clear and updated hospital protocols. Most of the interviewees complained about the lack of protocols based on national and international guidelines, which would ensure evidence-based practices and limit arbitrary medicalization.

> Protocols don't exist! And this has been normalized. In our work, protocols are extremely important, they protect us and provide a standardized approach to our work. They also make you aware of how to act in certain situations. Near misses happen every day, and no audits are done. We just hear, "It happened. Well, it's over." It's really complicated to work in a situation like this. I want to work, I want to work well, but I don't want to end up facing problems because of others.
> *Interviewee 20*

Many midwives lamented significant structural deficiencies in the primary care system. Family Health Centers were described as neglected and unwelcoming, severely undermined by budget cuts over the years in a systematic dismantling of maternity welfare services.

> Women don't go to family health centers, and rightly so. Most of them are rundown, ugly, inhospitable. People who go there are either politically left-leaning women or migrants.
> *Interviewee 22*

The deficiencies in the public sector leave space to private healthcare, which is virtually the only option for antenatal care. The private gynecologist is therefore the reference figure even for low-risk pregnancies that could be handled by midwives. The midwives interviewed also reported that prenatal courses are poorly attended by families, losing another opportunity for midwives to engage with and introduce families to their role. Women often arrive at childbirth with limited awareness of the process, with the mindset of delegation typical of medicalized childbirth, which is still perceived as the norm.

> Family health centers don't provide spaces for low-risk pregnancies. The public health offering is really limited in Campania. For instance, Salerno doesn't have a high-risk pregnancy clinic, which is a serious problem. The woman is left feeling totally lost. So, who does she go to? The gynecologist her mother or her sister-in-law went to. That's the approach.
> *Interviewee 20*

4 Conclusions

In this chapter, we presented the results of a qualitative study on midwives' work in Campania, highlighting the main obstacles they encounter in their educational and professional path. Although in some facilities a partial implementation of midwifery care can be observed compared to the past, the healthcare context in Campania remains challenging for midwives. We pointed out how an incomplete process of professionalization and unfavorable working conditions hinder the full implementation of the midwifery model of care, which would serve as an effective barrier to obstetric violence. Recognizing the structural dynamics that contribute to obstetric violence should not be seen as a way to justify malpractice or an attempt to absolve the individual responsibility of the practitioners involved. The disadvantaged conditions in which the midwifery profession finds itself represent only part of the causes of obstetric violence. Other factors, such as the broader cultural dynamics surrounding childbirth—well captured by anthropology in the concept

of 'technocratic model'—also play a crucial role. However, identifying structural causes, particularly those linked to the professionalization process of midwives, is essential to understand how to shape effective public policies to combat obstetric violence and improve quality of care. In Italy, achieving this goal appears particularly difficult due to the decentralization of healthcare competences from the state to the regions. This could produce or reinforce regional imbalances that disadvantage both women and healthcare workers. In order to improve maternity care, a dynamic dialogue between the health sciences and social sciences is now necessary. This dialogue should begin with recognizing the structural dimensions of obstetric violence and acknowledging it as a distinct form of violence against women, deeply ingrained within healthcare systems.

References

Abbott, Andrew. 2014. *The System of Professions: An Essay on the Division of Expert Labor*. University of Chicago press.

Antonovsky, Aron. 1996. "The salutogenic model as a theory to guide health promotion." *Health Promotion International*, 11 (1): 11–18.

Byrne, David. 2022. "A worked example of Braun and Clarke's approach to reflexive thematic analysis." *Quality & Quantity*, 56 (3): 1391–1412. https://doi.org/10.1007/s11135-021-01182-y.

Capogna, Giorgio and Hans de Boer. 2017. "Humanization of Cesarean Section." In *Anesthesia for Cesarean Section*, edited by Giorgio Capogna, 183–189. Springer.

Cicero, Roberta V., Sofia Colaceci, Rosanna Amata, and Federico Spandonaro. 2022. "Cost analysis of planned out-of-hospital births in Italy." *Acta Bio Medica: Atenei Parmensis*, 93 (4). https://doi.org/10.23750/abm.v93i4.12923.

Clesse, Christophe, Joelle Lighezzolo-Alnot, Silvie de Lavergne, Sandrine Hamlin and Michelle Scheffler. 2018. "The evolution of birth medicalisation: A systematic review." *Midwifery*, 66: 161–167. https://doi.org/10.1016/j.midw.2018.08.003.

Davis-Floyd, Robbie. 2001. "The technocratic, humanistic, and holistic paradigms of childbirth." *International Journal of Gynecology & Obstetrics* 75: 5–23.

Deakin, Hannah and Kelly Wakefield. 2014. "Skype interviewing: Reflections of two PhD researchers." *Qualitative Research*, 14 (5): 603–616. https://doi.org/10.1177/1468794113488126.

Fariello, Sara and Jonathan Pratschke. 2024. "Corpo, emozioni e conflitti nel lavoro ostetrico". In *Quaderni del laboratorio di ricerca interdisciplinare su Corpi, Conflitti, Diritti*, Vol. IV, edited by Riccardo Caldarera and Maria Urso.PM edizioni.

Filippini, Nadia M. 2017. *Generare, partorire, nascere. Una storia dall'antichità alla provetta*. Viella.

Freidson, Eliot. 1970. *Professional Dominance: The Social Structure of Medical Care*. Transaction Publishers.

Gibbs, Jennifer L., Nicole B. Ellison and Rebecca D. Heino. 2006. "Self-presentation in online personals: The role of anticipated future interaction, self-disclosure, and perceived success in Internet dating." *Communication Research*, 33(2): 152–177. https://doi.org/10.1177/0093650205285368.

Isaline, Gonze, Marie-Christine Closon, Rudy Van Tielen, Caroline Daeleman and Englert Yvon. 2019. "An exploratory cost-effectiveness analysis: Comparison between a midwife-led birth unit and a standard obstetric unit within the same hospital in Belgium." *Midwifery* 75: 117–126. https://doi.org/10.1016/j.midw.2019.05.004.

Jordan, Brigitte. 1993. *Birth in Four Cultures: A Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden, and the United States*. Waveland press.

Ministero della Salute. 2023. "CeDAP – Certificato di Assistenza al Parto (2023)". https://www.salute.gov.it/new/it/pubblicazione/certificato-di-assistenza-al-parto-cedap-analisi-dellevento-nascita-anno-2023/ (last accessed 10.05.2025).

Nove, Andrea, Petra Ten Hoope-Bender, Martin Boyce, et al. 2021. "The State of the World's Midwifery 2021 report: Findings to drive global policy and practice." *Human Resources for Health* 19 (1): 146. https://doi.org/10.1186/s12960-021-00694-w.

Renfrew, Mary J., Alison McFadden, Maria H. Bastos, et al. 2014. "Midwifery and quality care: Findings from a new evidence-informed framework for maternal and newborn care." *The Lancet* 384 (9948): 1129–1145. https://doi.org/10.1016/S0140-6736(14)60789-3.

Rocca-Ihenacho, Lucia, Laura Batinelli, Ellen Thaels, Juliet Rayment, Mary Newburn and Christine McCourt. 2018. *Midwifery Unit Standards*. City University of London Press.

Sadler, Michelle, Mario Jds Santos, Dolores Ruiz-Berdún, Gonzalo Leiva Rojas, Elena Skoko, Patricia Gillen and Jette A. Clausen. 2016. "Moving beyond disrespect and abuse: Addressing the structural dimensions of obstetric violence." *Reproductive Health Matters* 24 (47): 47–55. https://doi.org/10.1016/j.rhm.2016.04.002.

Sandall, Jane, Hora Soltani, Simone Gates, Andrew Shennan and Declan Devane. 2016. "Midwife-led continuity models versus other models of care for childbearing women." *Cochrane database of systematic reviews* 4. https://doi.org/10.1002/14651858.CD004667.pub5.

Scarf, Vanessa L., Chris Rossiter, Saraswathi Vedam, et. al. 2018. "Maternal and perinatal outcomes by planned place of birth among women with low-risk pregnancies in high-income countries: A systematic review and meta-analysis". *Midwifery* 62: 240–255. https://doi.org/10.1016/j.midw.2018.03.024.

Schmid, Verena. 2007. *Salute e nascita. La salutogenesi in gravidanza*. Urra.

Schmid, Verena. 2018. *Il parto in casa e in casa maternità. Criteri di qualità e sicurezza. I vantaggi di un parto fisiologico e consapevole*. Terra Nuova.

Šimonović, Dubravka. 2019. *A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence*. Report of the Special Rapporteur on violence against women at the United Nations General Assembly. United Nations. https://digitallibrary.un.org/record/3823698/files/A_74_137-EN.pdf (last accessed March 10, 2025).

Spina, Elena. 2009. *Ostetriche e midwives. Spazi di autonomia e identità corporativa*. Franco Angeli.

Spina, Elena. 2014. "La professione ostetrica: Mutamenti e nuove prospettive." *Cambio. Rivista sulle Trasformazioni Sociali* 4 (7): 53–63. https://doi.org/10.1400/224641.

Stacey, Margaret. 1988. *The Sociology of Health and Healing*. Unwin Hyman.

Strauss, Anselm. and Julien Corbin. 1990. *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*. Sage Publications.

Van Teijlingen, Edwin. 2005. "A Critical Analysis of the Medical Model as used in the Study of Pregnancy and Childbirth." *Sociological Research Online* 10 (2): 63–77. https://doi.org/10.5153/sro.1034.

WHO. 1985. "Appropriate technology for birth." *Lancet* 2: 436–437. https://doi.org/10.1016/S0140-6736(85)92750-3.

WHO. 2016. "Midwives' Voices Midwives' Reality." https://www.who.int/publications/i/item/9789241516112 (last accessed March 10, 2025).

Lucia Re, Chiara Magneschi

Midwives' Voices on Obstetric Violence: Exploring Care Models and Professional Cultures in Tuscany

Abstract: This chapter presents the results of an empirical study conducted in Tuscany based on qualitative interviews with midwives working in both hospital and private practice settings. The research aimed to explore the models of motherhood, care, and professional ethics that guide the work of midwives, focusing not only on childbirth but also on the antenatal and postpartum phases. Additionally, the study sought to assess midwives' awareness of obstetric violence and its prevention. We argue that developing effective preventive measures requires a deep understanding of the professional culture, with midwives playing a central role in the development and implementation of these strategies. The interviews reveal a range of structural and communicative challenges that, if addressed, could significantly contribute to the prevention of obstetric violence.

1 The research

This chapter reports some results of the research conducted by the team from the University of Florence (Italy) as part of the Project of Significant National Interest (PRIN 2022) "Giving Birth with Care. Conceptions of maternity and professional ethics in obstetrics and gynecology for the prevention of obstetric violence," funded by the Italian Ministry of University and Research. The two-year project started in October 2023. Lucia Re designed and coordinated the research. The results we are presenting here were developed from 24 semi-structured interviews aimed at midwives working in the Tuscany Region: 17 in the public sector and 7 as private practice midwives, either exclusively or in addition to working in public hospitals.[1]

We do not claim to have constructed a representative sample. The research is qualitative in nature. However, we selected midwives working in different public maternity units in Tuscany and we chose to interview private practice midwives who work in different areas of the region and with different associations or groups. We tried to interview midwives of different ages; however, the majority of them have been working for 15–20 years. Except in one case, where Lucia Re and Chiara

1 Only one of the interviewees is retired.

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Magneschi conducted the interview jointly, the latter conducted the interviews, in-person, from February to November 2024. She recorded and transcribed them. The interviewees were pseudonymized to protect their privacy.[2] Re translated the quotes from the interviews from Italian into English, trying to remain as faithful as possible to the language, often vernacular, used by the midwives, while producing a text that is comprehensible.[3] The processing of the results was carried out jointly by the two authors, who shared the approach and content of this text. However, sections 1., 3., 4., and 8.2. were written by Re, while sections 2., 5., 6., 7., and 8.1. were written by Magneschi.

The research aimed to investigate the models of motherhood, care, and professional ethics that inspire the work of midwives, with reference not only to childbirth, but also to the preparatory and postpartum phases. We also intended to probe awareness of obstetric violence and its prevention. Indeed, the literature on obstetric violence has often focused on the victims of violence.[4] In many cases the emphasis has been on reporting and criminalizing violent behaviors by healthcare personnel. The public debate on the subject is less heated in Italy today than it was years ago, although some European research initiatives revived the interest in the topic (Quattrocchi 2024; Brunello et al. 2024).[5] The discussion at the national level appears to be rather polarized: activists, on one side; on the other, a healthcare system that is mostly unwilling to accommodate their demands. Indeed, medical and midwifery personnel in many cases feel called into question and tend to adopt a defensive posture, rejecting the accusations made against them. This phenomenon is also found in other countries, for example, in Spain and Portugal, where professionals have objected to the use of the term violence in relation to obstetric care (AGOI – Associazione degli Ostetrici Ginecologi Ospedalieri Italiani n.d.; OMC – Organización Médica Colegial de España 2021; SEGO – Sociedad Española de Ginecología y Obstetricia 2021; Quattrocchi 2024, 35-36). Moreover, the expression

2 Each of them received a research note and a personal data protection notice, in accordance with the Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data, and then signed informed consent to the collection, preservation, and use of the interviews. We took special precautions for collecting data and rendering the interviews anonymous.

3 Re translated all the quotations from interviews and texts originally written in languages other than English.

4 The few studies that focus on midwives include Barbosa et al., 2018; Oliveira and Penna, 2017; Martín-Badia et al. 2021; Fontein-Kuipers et al. 2018; Seijmonsbergen-Schermers et al. 2021.

5 Both of these papers were published when the present research was at an advanced stage of development. They bear a strong correspondence to what emerged in our empirical research.

"obstetric violence" in Italian, literally means "violence by midwives"[6] and, as is also evident from the interviews we conducted, is perceived as offensive by this professional category.

We believe that a confrontational approach is not productive, especially from the point of view of adopting appropriate prevention strategies. Indeed, these can only actively involve medical and midwifery personnel, starting with knowledge of their professional culture and ethics. We therefore decided to interview midwives in an Italian region — Tuscany — which, as will be seen in the following section, can be considered virtuous at the national level with regard to the adoption of protocols and organizational models that respect the physiology of pregnancy and childbirth and tend to avoid hyper-medicalization.

We propose that the voices of midwives offer valuable insights into the material challenges that contribute to obstetric violence, as well as the emotional and communicative difficulties that may arise. These two aspects are interconnected, suggesting the need for a multifaceted approach to the prevention of obstetric violence. Additionally, midwives' perspectives allow for the identification of strengths within professional cultures, fostering an alliance between women and midwives. As we will discuss, such an alliance is crucial not only to move away from hyper-medicalization but also to prevent the opposite extreme: a re-naturalization of pregnancy, childbirth, and the postpartum experience at all costs. It is indeed important to identify innovative models of care that are more respectful of women's autonomy. However, ideological excesses — especially when combined with "healthist" postures (Evans et al. 2020), tending to over-responsibilize women for the success of gestation, childbirth and breastfeeding — can, in turn, foster forms of physical, psychological and symbolic violence (Bourdieu 1990). This double risk had already been underlined, in light of the feminist literature dealing with the women-health-gestation-breastfeeding relationship (Pitch 2010; Guaraldo and Forti 2006), in the research design phase. The method chosen for its conduct thus consists of a mutual fertilization between the theoretical framework and the empirical research, according to an abductive approach (Tavory and Timmermans 2014).

6 The word for midwife is "ostetrica" in Italian.

2 Childbirth in Tuscany

In Tuscany, there are 23 birth units, spread across 28 hospitals under 3 health authorities (Northwest, with 8 hospitals; Central, with 7 hospitals; Southeast, with 5 hospitals) as well as the Pisa, Florence and Siena University Hospitals (Regione Toscana n.d.).

The birth pathway within the Tuscan healthcare system begins at family health centers,[7] where expectant women can receive their pregnancy booklet, which grants access to free services for monitoring a physiological pregnancy, as well as additional services in the case of a certified high-risk pregnancy. These centers are staffed by a multidisciplinary team, including midwives, gynecologists, psychologists, and social workers, who provide support throughout pregnancy, including through the offering of antenatal classes (Regione Toscana n.d.).

The Health Agency of the Tuscany Region (Ars Toscana) estimated that 21,197 births occurred in public birth units in 2023 (ARS TOSCANA – Agenzia Regionale di Sanità n.d.). According to the data provided by the National Outcomes Plan (PNE), reworked by Ars Toscana with reference to the results of this region, in Tuscany cesarean sections accounted for 15.96% of all deliveries (the national average is 22.66%). These percentages refer only to primary cesarean sections, excluding twins and complicated births. The data related to any kind of cesarean section show even more clearly the difference between the Tuscan and national data. According to the *Rapporto sull'evento nascita in Italia (CeDAP)*, in 2023, 30.3% of births in Italy were by cesarean section, with considerable variation between regions, ranging from 17% in Tuscany (the smallest percentage at national level) to 42.7% in Campania (the highest percentage at national level) (Istituto Superiore di Sanità 2025). In addition, in Tuscany, 20.96% of vaginal deliveries followed a previous cesarean (compared to a national average of 11.58%) and only 2.27% involved an episiotomy (the national average is 10.54%) (ARS TOSCANA – Agenzia Regionale di Sanità n.d.). These data thus suggest that the Tuscany Region represents a virtuous model at the national level.

Partially different modes of childbirth and postpartum management are proposed at the various birth units. For the first aspect, deliveries in the lithotomy

7 The authors have chosen the term "family health centers" to translate the Italian "consultori familiari." "Consultori" are public community-based healthcare centers established in Italy in 1975 (Law 405/75), primarily aimed at supporting women's reproductive health. Their services include antenatal care, psychological support, counseling and care related to reproductive choices. These social and healthcare facilities are managed and funded by the Regional Health Agencies as part of the National Health Service.

position prevail, but "active childbirth" is also possible. Regional sources refer to it as the modality that enhances "the decision-making role of the woman, who can move freely during labor and choose the position of childbirth in accordance with her time and needs" (Regione Toscana n.d.). Finally, water birth is also available. The use of complementary medicine is not widely offered and must be evaluated on a case-by-case basis, depending on the hospital. On the contrary, epidural analgesia is practiced in all birth units, although it depends on the availability of an anesthesiologist at the time of labor. Additionally, women must participate in an informative interview about it before receiving it.

In the postnatal period, one can have, depending on the hospital, total rooming-in (the newborn is left with the mother during the hospital stay, day and night continuously), or partial rooming-in (the woman can rest during the night, entrusting the baby to the care of the newborn nursery).

A well-established and noteworthy experience is the "Margherita Center," at the University Hospital of Florence Careggi. It's a birth unit adjacent to the hospital's obstetrics department, which is led exclusively by midwives (AOUP – Azienda Ospedaliero – Universitaria Careggi n.d.) as long as the pregnancy remains physiological. Related to this experience is the provision, now being disseminated, of intra-hospital pathways where midwifery staff independently manage "low-risk" pregnancies and births, in order to decrease the medicalization of childbirth and promote continuity of care.

As mentioned above, the research selected interviewees from the diverse settings in Tuscany. Without claiming to be exhaustive, we tried to explore as much as possible the views of midwives with diverse professional experiences.

3 The perception of "obstetric violence"

The semi-structured interview included a direct question about the awareness of obstetric violence, which was asked at the end. However, in many cases, this topic emerged spontaneously during the conversation, partly because the midwives had been briefed about the focus of the research. Our impression was that most of them had the issue in mind during the interview and had, either consciously or unconsciously, prepared for it. B. explicitly says that she agreed to the interview "to deal with this thing, that everything is now seen as obstetric violence."

Mostly midwives working in public hospitals accept that there may be mistreatment in pregnancy and childbirth, but minimize its frequency or severity. Moreover, they usually do not refer it to their own work setting, but to other settings they have heard about or worked at previously. Two main themes also emerge: 1. women

who report obstetric violence often amplify their experience; 2. attention should be paid to "violence to midwives" by patients and their families.

The forms of mistreatment most frequently acknowledged by midwives primarily relate to communication. In particular, during emergency situations, communication can become abrupt or accusatory, or may lack the clarity and completeness necessary for the woman to feel actively involved in decision-making. Instances in which healthcare professionals express conflicting opinions in front of the woman — generating confusion and a sense of insecurity — are also attributed to poor communication. The sense of abandonment that some women report, especially when left alone with the newborns during the night, is often linked to inadequate hospitalization conditions.

In addition, women may suffer the consequences of organizational shortcomings. Some midwives highlight as particularly serious the fact that, in certain facilities, women undergoing abortions and those giving birth are not adequately separated.

Lastly, in university hospitals, the presence of an excessive number of people in the delivery room, as well as unnecessary intimate examinations performed solely for educational purposes, are reported as additional sources of distress for women.

According to many of the hospital midwives, women (and their family members) often report violence because they amplify their experience for three reasons.

First, they are not used to the idea that natural childbirth is necessarily a painful event and that it involves risks. H. states: "I think there is a patient who comes for a beautiful, happy thing, and then if, when it's over, she's not as happy as she imagined, of course she's disappointed." For U. women "have expectations [...] that sometimes unfortunately are not met for 'higher' reasons, of force majeure."

It is worth noting that denial of an epidural is never considered by the interviewees as a possible form of violence. Only C. mentions a particular case in which it was not possible to guarantee an epidural to a friend because the anesthesiologist was engaged in deliveries that presented greater risks. The experience seems to have fostered understanding of the patient's point of view. Indeed, C. comments:

> For me, it was something like "you gave birth with pain like everyone else;" for her, it was an incredible violence. She still tells me: "do you remember that?" I remember it, yes, however, nothing could be done...but not being able to fulfill all her demands, to her, is violence.

N. also points out how in some cases there is a "Taliban" attitude that promotes a birth considered "natural" at all costs, opposing cesarean sections and epidurals. However, the interviewee refers these cases to the past, claiming that currently the situation has been at least partially rebalanced.

D. points out how "in any other context there can be medical violence," but if one specifically talks about "obstetric violence" it is:

> because childbirth is the only thing that is still seen through rose-tinted glasses everywhere, that is, a fairy world, so...While in all other medical situations death is envisaged as a possibility, when it comes to childbirth everything has to be beautiful, rose-tinted, with little stars and bows, everything [has to be] wonderful...joyful...instead, unfortunately...In all other medical situations, what happens [just happens], but in obstetrics everything has to be perfect.

The second reason why the perception of violence, according to many hospital midwives, is amplified lies in the fact that women are in a particularly fragile emotional state. For J.: "A woman's perception in that situation is just not the same as when she's not pregnant."

Finally, one has to consider the material conditions under which staff works in public hospitals. These can hinder communication between healthcare personnel and the patient, so that the latter does not understand the reason for the interventions she undergoes and often, postpartum, tends to misinterpret them as pleonastic and overly invasive. Sometimes — the midwife admits — "inadequate attitudes on the part of staff who are insufficiently trained in this regard can make communication difficult" (cf. sections 5–7).

The movement against obstetric violence is judged stronger in the past than today, considered as a kind of fashion, and is criticized for being radical. For D.: "About 10 years ago it was nonstop, on Facebook, on all social media...always these slogans... 'hands off my perineum!' Yes, I remember, one couldn't do anything anymore..." This protest, in her view, "has been waning, partly because there has been a generational change [...]. The generational change of midwives and also of doctors has affected it." J. also argues: "obstetric violence, now, has been turned into a federal case, but honestly maybe it was more common years ago when they were doing episiotomies..." Today there are "cautions and preventions." She adds: "So there is absolutely no obstetric violence, from, let's say, the physical point of view," yet sometimes women interpret emergency interventions that are done only as a last resort as violence.

For K., if some more invasive interventions are done, it is because they were "the lesser evil." B. points out the seemingly opposite case in which the woman complains that she didn't get a C-section. Even this complaint, however, is deemed unfair: women "don't understand that we prevented them from being cut." Similar, in her view, is the situation of those who complain that breastfeeding has been imposed on them, only because they have been informed about its benefits and invited to try it. These objections, in the experience of the interviewees, if they are formalized at all, mostly result in complaints to the public relations office. For N., the movement

against obstetric violence, criticism of episiotomy, use of forceps, cesarean sections, and WHO guidelines have produced significant change, to the point that "we have reached the other side of the river...protocols are being overrun..."

Indeed, only in a few interviews do more serious situations emerge, which are mostly referred to lack of coordination and overcrowding in delivery rooms. Note that, when admitting to cases of inadequate treatment, midwives tend to blame the medical staff.

Only a few of them frame the behaviors we analyzed under the category of obstetric violence. Reference is particularly to "Kristeller maneuvers done very violently," to "gratuitous episiotomies," to visits described as "abrupt," resulting in membrane sweeping without consent. These are behaviors that are considered rare. In many cases, as mentioned, they are blamed on non-midwifery staff and/or staff from hospitals other than those where the interviewees work, either by hearsay or, more often, based on past training or work experiences.

In some cases, the term "violence," however, is also used to frame the excessive number of examinations a woman may be subjected to, particularly in university hospitals. V. states: "If you leave a patient on their backs on a gynecological table and let half the world come in and out as if they were at a fish market, that's violence." E. observes:

> Even the fact that when you give birth there are ten of you in the delivery room...I mean, guys, are you crazy? We shouldn't be at everyone's disposal, [show] a little respect...As far as I'm concerned, residents should stay outside [the delivery room].

And she points out how in some university hospitals there can sometimes be as many as twenty people attending a delivery. She comments: "Is this normal? It's humiliating!" Also in relation to a university hospital, C. recounts that a woman can be visited for different reasons, including training, as many as four times without being asked for permission, and calls this practice "inhumane." B., while not explicitly talking about violence, refers to the excess of staff present at the time of delivery as a kind of "aggression."

Private practice midwives who touched on the topic during the interviews are more willing to talk about violence. The behaviors criticized are the same as those focused on by hospital midwives, but they are framed within a system that, due to lack of resources, organization, training, communication, and attention, can cause violence. Violence is thus represented as systemic and normalized. Private practice midwives consider it unjustifiable. In addition, some point out that victims struggle to find recognition of the violence they have experienced and even adequate consideration of perinatal death by the healthcare system. The different evaluations made by the self-employed midwives probably depend partly on a greater freedom

in talking about violence, since they do not feel implicated by this accusation, and partly on the fact that some women come to them precisely because of negative childbirth experiences they had in the hospital and therefore they can establish a deeper contact with this kind of suffering. Finally, it should be emphasized that women's emotionality during childbirth and the uniqueness of this experience are read by private practice midwives not as a factor that distorts women's perceptions, but as an aspect to be taken into consideration.

Interviews pay special attention to the material conditions under which the staff operate in public hospitals and the central role of emotions and communication. Hence, in the following sections, we will explore these aspects, which emerge as pivotal also from scientific literature (Quattrocchi 2024; Brunello et al. 2024).

4 The material factors contributing to obstetric violence

4.1 Difficult working conditions

In the interviews, midwives repeatedly declare their love for their profession, yet for those working in hospitals this comes up against difficult working conditions. Many of them believe that these characterize the entire public health sector. Thus, A. states:

> the profession is beautiful and I still enjoy it. Unfortunately, however, the healthcare environment is...far from ideal. So I'll tell you straight — sometimes I think that I wouldn't chose it again. Yeah, that's the truth.

B. also declares that she is still "completely in love" with the profession after ten years of work: "fortunately, I am still in the honeymoon phase, despite, you know, the difficulties." C. says she started "with great enthusiasm, desire to change, desire to act," but realized over time that changes in public health are slow "and have their own dinosaur-like pace."

Interviewees show passion and dedication to their work, to which they devote much energy, sacrificing their private lives. However, they deplore a lack of recognition, both material and symbolic. D. claims to have lost "stamina more than enthusiasm," because "my enthusiasm was lost years ago. You carry on because there are no viable alternatives in Italy. [It's not] even [about] more resistance... surviving is the right word in my opinion." E. also states, "[...] as much as I like my job I still can't quit it completely...but most days I say, 'my God, enough!'"

Hospital midwives express a persistent tension between their desire to be fully engaged and to play a leading role in their professional choices, and the constraints imposed by hospital organization and the lack of full recognition of their professional status. As will be further illustrated below, these two factors weigh more heavily than the physical demands of shift work or the challenges related to insufficient financial compensation. They also appear to be key motivations for midwives — many of whom have previously worked, or continue to work, within the public healthcare system — to move into private practice.

4.2 The lack of resources

In public hospitals with many deliveries, midwives complain about understaffing, mainly related to low turnover as a result of retirements. The combination of high patient numbers and high-risk pregnancies complicates the picture. In cases involving pathology, the workload is heavier and more stressful. The amount of deliveries depends primarily on the area where the hospital is located. In some cases, however, it is believed that transfers would be possible but are not authorized, "to have higher numbers at the end of the year," in accordance with an approach that is referred to as "corporate thinking," which prioritizes numbers over quality of care. Also, where it is most difficult to work, turnover increases as midwives ask to be transferred or leave the hospital for freelancing. In the hospitals where the number of deliveries is smaller, staffing problems are less felt, although, especially because of maternity leaves — which are frequent, since midwives are almost all women and many are of childbearing age — critical issues can equally occur. The leaves are usually covered with temporary staff, but not on a one-to-one basis.

The assessment of the lack of resources in the Tuscan healthcare system is very critical. For F.: "It suffers from a shortage of resources, [in terms of] a lack of staffing but also of medical devices and drugs, so on a general level." According to G.:

> What Tuscany is trying to do is save wherever it can. So now, for example, they say the lights have to be turned off — when have you ever seen the lights off in a hospital?! [...]. And now it's like: you have to turn off the lights, you can't make photocopies...and from there, it's just cutting wherever possible — including staff. And you start to wonder: how far can one push people? [...]

This condition, in some cases, affects the available devices, which are not always the most technologically up-to-date or the most suitable for adopting less invasive or more innovative techniques for women. Midwives do not judge these shortcomings severely, although in several cases they recount that they personally make

up for them. H. states: "look, where I work we make up for some deficiencies, for example the [birthing] balls, by doing self-funding, buying them as a Christmas gift...we put them under the tree." Another interviewee also highlights the ability of midwives to make up for shortages, some of which involve even essential things such as medication:

> In general, fewer drugs are coming in these days. We still manage to provide that [the epidural], but it's all a...search for...[...]. Lately, the nursery has been running out of diapers. We're at that point: [it's] not just the slightly rarer stuff...

When it comes to medication, the midwives try to solve the issue by appealing to different departments:

> Of course, we always try to borrow from other departments... "Let's ask this one or that one," meaning we try to make sure it doesn't affect the patient. We find some workaround or solution, but it's still an inconvenience, no doubt.

The negative note regarding the lack of resources mainly concerns, as mentioned above, staff management. As I. states, "they always try to cut back but the blanket is short." J. also uses the blanket metaphor:

> I'm just telling you, the staff is really stretched thin, so the blanket was always too short — when you pulled it to cover one part, it ended up uncovering something else. It was always like that. And then...you work exhausting shifts because you often have to return to duty, so you hardly get any rest.

The interviewees all refer to the lack of staff, especially at peak and crisis times, and consider the employment of temporary midwives problematic. According to I., these "are somewhat left to their fate [...as], usually contracts are confirmed month by month." Their shift schedule is described by C. as "inhumane," because "they can only dream of resting; they only do it occasionally..." Their precarious condition hinders the formation of shifts over the long term, the composition of the team, and the building of an ongoing relationship of trust between colleagues. Temporary midwives are usually young and need to be trained, but there is no time to do so unless you can call the same people you have worked with before. In many hospitals, then, temporary midwives do not enter the delivery room.

Due to the lack of stable staff, in some cases, it is difficult to schedule vacations in such a way as to not leave birth units unattended, so they are often not enjoyed. Staff shortages also weaken family health centers and hinder continuity of care. More generally, they undermine work, both because midwives have to work in

a hurry and because they generate fatigue and discontent. The need to do many things at once makes work more difficult and involves risks. As A. argues:

> Because anyway, no matter how hard one tries, how passionate, how up-to-date, how ethically upright and precise one is in his work,[8] the hospital setting is not so easy lately. So the risk of error is very high, the risk of undue stress is very high, the responsibilities are so many [and] unrecognized, very often. So honestly it's a [difficult] profession...but not only mine, all of them, because [...] if you talk to nurses they tell you the same thing, you talk to doctors they tell you...not all of them, clearly, however a good part of them tell you, "well, yes, maybe, actually, if I went back I don't know if I would choose this profession, or if I would choose it this way."

The concern about making mistakes recurs throughout the interview:

> However, when you have to juggle multiple tasks at once, it's easy to forget something. You try, but it's not always easy. If you're not someone who's used to multitasking, it's easy to lose track. It's easy to get lost...

For these reasons, on the one hand, the midwife has to "learn to anticipate," "double-check" — possibly even carrying out one more visit than necessary — keep in mind IVs that may run out, and check the forms to be printed and filled out several times, "which are important at the practical level because they document what happened."

Also according to another midwife, under conditions of overcrowding and lack of time, "the risk of human error is very high, very high." This is something the midwives themselves try to remedy with dedication: "we manage to cope quite well; however, sometimes you come home with a nagging worry: 'did I do everything right?' and there are also nights when you lie down at home...and go over it again, like a movie."

These descriptions illustrate stressful working conditions, even when the delivery is not particularly problematic. It is worth noting that these analyses don't refer directly to the significant emotional burden involved in labor. However, it can be understood how the risk of burnout is high. Hospitals offer psychological counseling to workers, but this, according to the interviewees, is little used except in the case of perinatal loss. Even "organizational well-being" initiatives provided by hospitals, in some cases, are perceived as not very useful: they are seen as a

8 We have chosen to maintain the use of the masculine form recorded in Italian. Midwives often use the masculine form in interviews, as it was a "neutral" form. This probably depends on the prevailing lexicon in the medical field. We can't go into this aspect here, but it is certainly symptomatic of an environment in which, even where the professionals are predominantly women, the masculine form is used because it is considered to dignify the profession, while the feminine form is considered to devalue it.

questionnaire that is not followed by changes. In other cases, especially when "something happens," the presence of a group focused on "organizational well-being" is seen as important. Within this group, workers can have discussions among themselves and, if needed, consult with a psychologist. However, this option is often viewed as something reserved for exceptional events.

The difficulties of night work, tiring shifts, skipping rest, and uncertainty in scheduling are reported by midwives, but appear less prominent than other critical issues. If the organization is good, the level of fatigue tolerance increases. In the interviews, organization emerges as a priority. Interviewees can understand and, within limits, accept the shortage of funds and thus staffing, but not "confusion" and "disorganization." If there is a good organization, autonomy and job satisfaction, one is more willing to make sacrifices. That is why it is important that shifts do not mix professional categories, for example by placing nurses and midwives side by side, since the former have different tasks and cannot assist with labor and delivery. Stable shifts that allow the same group to work together for extended periods are highly valued, provided the groups are well-matched, with regular checks that take the professionals' opinions into account. Also important are the coordinators and the head midwives and head nurses who forge the profile of teamwork. Interviewees feel the need to be "taken care of well," showing appreciation when there is "a leader who makes things go well, is very present, comes to us..."

According to the interviewees, "confusion," in addition to hindering work, is also perceived by patients. As K. argues:

> The frustration for me is related to the feedback we get from the patients and their families[9] because of this situation. This stresses us so much because, even if we are badly organized, [or] if we are often busy, the thing that stresses me the most, apart from feeling inadequate sometimes, honestly, is that, even if it's not your fault, you are not satisfied. You get to the end of your shift, [and] you don't always get that satisfaction of having done everything and everything well. We always stay connected all night and all afternoon on this WhatsApp [group] because something wasn't finished and you leave it to your colleague [...]. And then there's this patient base that comes to you and is always angry.

Once again, then, these words show the difficulty of disconnecting from work concerns even when the shift is over. Also for E.: "it all starts with disorganization."

It is precisely the ability to self-organize and be autonomous that underlies the choice of private practice midwives. These state that they have a very wide

9 The midwife doesn't use the words "pazienti" (patients) and "famiglie" (families) in Italian. She refers to both of them as "utenti" ("users"). This is a bureaucratic term that refers in an impersonal and neutral way to those who interact with any public service.

on-call availability, often having to travel for home births or to accompany women in the hospital, having to respond at all times to women, even for a long period after delivery, etc. However, these sacrifices are accepted as part of a profession that cannot be done otherwise. Indeed, in many cases they chose the profession because they felt the need to have "all the time it takes" and not to have "interference." As L., a retired self-employed midwife, puts it:

> Yes, there is the inconvenience of being on call [...] every time I sat at the table I didn't know if I would finish eating; every time I went to sleep I didn't know if I would wake up in the morning in my own bed. However, these are small things compared to the satisfactions of the job.

Collaboration with colleagues, either in pairs (required by the Italian law to assist home births) or in larger teams within associations supports self-employed midwives.

4.2.1 High responsibilities, low salaries

The lack of recognition for hospital midwives is also related to economic remuneration. A. points to the low salary as a source of demotivation:

> Low salaries...so in the long run, even the love for the profession [goes away]. When you're there you always feel it, but you say "G'ee, I've given up so many things, haven't I? For this job I've made a lot of sacrifices, though, wow!"

F. states:

> Our work is looked down on, it's underpaid — we don't get proper compensation for the huge responsibility we carry. That's what frustrates me the most about this job. I mean, earning just 100 or 200 euros more than someone who folds T-shirts...and I say this with all due respect, it's not about looking down on anyone — but the level of responsibility is just on a completely different scale.

However, all public health personnel are considered underpaid. For F., "at the hospital level, in general, that's the situation." For N., salary is also a source of dissatisfaction:

> It's a matter of economics and of satisfaction. I get 1,500 [euros]. I wake up every morning at 5:30. I don't work on weekends, but I come home at 8 at night and I'm so tired, from [working since] 5:30 in the morning. And for what? No, no...

4.2.2 Cramped and overcrowded spaces

The lack of resources is also reflected in the spaces in which midwives work and women give birth in the hospital. Cramped, overcrowded spaces shared among patients with different needs increase the risk of obstetric violence. In some cases, even delivery rooms are too small. As O. states, "I get that they're not going to renovate the delivery room overnight, but honestly…that could make a difference, for sure."

The presence of fathers and relatives in the wards is considered important to help mothers with newborns, especially where they stay with them all the time. In some hospitals, the father or another relative can stay for 24 hours. However, this means, as C. claims, that there are "rooms full of people, where we make a double bed for four sometimes, because the husband sleeps next to the wife and they are all together in the same room that is for two…"

The pressure from families, even large ones, who want to get to know their newborns is strong and creates problems, particularly where, next to a woman who has given birth and is doing well, there may be others who instead have had a more difficult birth or are in labor, and all this in a condition where "there is not even a divider, we are all together." The crowd of relatives — whom it is difficult to send away even when a limit of simultaneous admissions has been established — is also perceived as a risk. As P. argues, if there are twenty people in the corridor, it can also be difficult to handle an emergency.

Another issue, as we mentioned, is the mix-up of pregnant women with women undergoing abortion. C. comments:

> …I realize that when a woman comes in for an abortion, she has to sit in the same waiting room as a woman in labor. It's really a structural issue, and we know that. We do everything we can to separate the two paths as much as possible. But when they tell me I have to work this shift […], I feel bad because I know that I not only have to handle admissions, but I also have to be careful about who I'm dealing with. If I have someone who's there for an abortion, they definitely won't want to be next to someone in labor. So we all end up scrambling to separate them, doing everything we can. And these efforts? We're never really recognized for them. But we know, because we're all women — we understand the issues.

4.3 Patterns of pregnancy and delivery

4.3.1 Pathology and pathologization

Organizational conditions that may promote or, instead, prevent obstetric violence include models of gestation, delivery and postpartum management. Both hospital and private practice midwives oppose the pathologization and hyper-medicalization

of pregnancy and childbirth. In their view, when they are physiological, they should be entrusted to the midwife in partnership with the woman. For the most part, the comments give the impression of a significant improvement in this direction in hospital culture over the years: there is greater autonomy for midwives; deliveries in positions other than the lithotomy one, in some cases even water births, are encouraged; episiotomies, the Kristeller maneuver, and, to some extent, even cesarean sections have been considerably reduced. As O. states: "we've made great strides, and there's still more ground to cover." At the same time, however, some midwives point out that pregnancies and deliveries labeled as pathological have augmented due to the increased number of examinations during pregnancies. According to Q., an independent midwife:

> Women are becoming increasingly medicalized, so finding a woman – I'll be blunt — who's labeled as "physiological" is turning into a "mission: impossible"...[...] More and more screenings are being done, more and more tests. So, with every little thing out of place, you get taken off the usual path and pushed onto a different one, where the stress just keeps increasing. Unfortunately, this often leads to vicious cycles.

Also for I., who works at the hospital:

> ...here's another issue: [pregnancy] is much more medicalized than it used to be. Why? Because pregnancies are much more heavily screened now and, as a result, more problems are being detected...which, of course, is a good thing, because now the rates and percentages of negative outcomes are really low...but at the same time, if you look for problems, you'll end up finding many...

For R., a private practice midwife, it is not so much the pathologization, but the pathology that has increased. Women lead more and more sedentary lives, have a "less trained skeletal and muscular apparatus," and less resistance in childbirth. She claims:

> What I had studied as the exception today is the rule: so misplaced babies are the norm during labor and delivery, [...] and pregnant women move much less, that is, getting them to stay active during pregnancy is very difficult.

Even for P., who works in the hospital, pregnant women often face health issues: "Diabetes, high blood pressure — so many of them — plus other conditions like kidney colic or cholestasis...[...] or issues with placentation, babies that aren't growing well..."

However, the focus on women's health conditions risks veering into stereotyping and blame:

> We call them "time bombs" — overweight or even obese women, who then face issues with blood pressure, diabetes risk...and more and more of them have babies in poor positions inside the womb. Then, when you ask them what they've done, they say, "'Yes, I walked, I stayed on the couch while my husband massaged my feet..." Sure, that sounds nice, but let's put it this way: in the past, our grandmothers would work in the fields and spend all day in forward-leaning positions.

This passivity of women is also found in the attitude that some midwives record toward medical staff. R. offers an interesting view: "Covid 19 has scared the hell out of us, so people got much more inclined to just delegate: 'tell me what to do and I'll do it, as long as it turns out okay.'" Within this framework, in her view, "medicalization has become once again very, very present: women also make far fewer choices." Even for S., a freelancer who also works in the hospital, progress in the direction of "active labor, natural methods of dealing with pain, massage, aromatherapy, complementary medicine...these little things" — a process the midwife calls "humanization" — was interrupted by the pandemic. Since then "we've gone backwards a little bit."

4.3.2 Midwives' autonomy, interventions in childbirth and dealing with doctors

The autonomy of midwives in supporting physiological childbirth is highly valued by the interviewees. Doctors' interference is seen as stressful for midwives and confusing for women — whether it's the private gynecologist who saw the woman during pregnancy, fostering, according to some, her dependence and reinforcing an uninformed, overly medicalized mindset, or certain hospital gynecologists who fail to sufficiently respect midwives' autonomy.

For T., in the hospital:

> The midwife is there from the beginning of a labor, so she knows how things are going. The gynecologist comes from time to time, asks "are you okay?," checks the labor tracing and leaves. So the moment something happens, he doesn't have his finger on the pulse, in the sense that he doesn't know the whole story. And while some take advice, others don't, and you get into conflict, with the risk of more medicalization and therefore sometimes even obstetric violence.

Interviewees, while respecting the role of doctors where childbirth becomes pathological, consider that, in the case of physiological childbirth, they should not be involved. They therefore appreciate, in some cases, younger gynecologists who adopt a more equal and cooperative attitude toward midwives and "are less interventionist," while, in other cases, they prefer "older ones" with whom they feel more confident. According to C., gender can influence the relationship between

doctors and midwives: "women doctors, especially young ones, have a more pronounced sensitivity, while male gynecologists, both young and old, are all pretty rough."

The leadership skills of the head of department, his inclination to delegate work to competent staff and to organize it, are considered crucial. Whether there is a lack of authority, where "everyone is their own boss, there is no one to stand up to anyone," or whether the head of department devalues the professionalism of midwives and promotes a strong hierarchy of the team — both situations are judged negatively.

According to I., if the chief of department tends to centralize too much,

> he creates an environment of constant tension, because he always has to be the one overseeing everything...everything always has to pass through him...he's an overbearing presence, and not in a positive way.

Hence, midwives appreciate hierarchy where it is necessary and works, but not when it results in centralization of control, disdain for non-medical health personnel or unnecessary interference. For W., in some hospitals:

> Midwifery is virtually nonexistent. Midwives are treated like hostesses ["vallette"], or like they're there to cuddle babies alongside the ever present pediatricians [...] For gynecologists, you're just a hostess who takes the woman to receive the epidural as soon as she asks for it.

Hierarchy is more suffered in university hospitals where, as mentioned above, the need to train residents is seen by the interviewees as a risk factor for successful delivery and also for the occurrence of obstetric violence, as it can increase the number of unnecessary visits and the number of people present in the delivery room for teaching purposes only. According to J. the university hospital:

> It's like a seaport, both from the patient's and the doctor's perspective, because there are so many residents, anesthesiologists, gynecologists, midwives of all kinds...neonatologists...of all kinds. For every role, there's a resident, a student...so it's really like a busy port.

In these hospitals, for N.: "There is a lack of a culture of privacy [...]. They tell you, 'We're in the public sector, and we're a university hospital. That's it: students are here, end of story.'" This adds to the space issue mentioned earlier. Sometimes in "tiny rooms," so cramped that you can't even turn around, women may feel like they're in "a circus: twenty people in two meters...," or — remarkably, using a term usually associated with death in a birth context — "eleven people in a loculus."

According to some, the university hospital offers greater safety in cases of emergency or serious pathology, but J. points out that "in smaller hospitals, a midwife's

job satisfaction is higher because there's less medicalization, and the work is more effective." Q., a self-employed midwife, describes a large hospital as "a kind of baby factory," where it is difficult for women to feel seen and heard. In these hospitals, women sometimes encounter particularly attentive midwives, whose dedication is interpreted as exceptional. Instead, according to her, "these are organizational issues, as well as, in my opinion, just the basics..." For W., where the numbers are very high, there is a lot of pathology, residents, students: it's really "a mess."

Midwives, therefore, prefer a "hands off" care model, where the provider refrains from touching the perineum or the baby during expulsion, instead observing the perineum in relation to the woman's progress, allowing for personalized care. Equally important is the definition of "low-risk obstetric" pathways, which differentiate between physiological and pathological situations, ensuring that a doctor is involved only when necessary (Ministero della Salute 2017). Again, there are hospitals in which "in the pre-delivery phase the doctor is called and stands in the delivery room, and watches; he doesn't intervene." Here, even in the case of "operative deliveries," it is the head of department who decides whether the doctor conducts the delivery or whether the midwife can do it.

Episiotomies and Kristeller maneuvers are considered rare. According to E., the latter is "tried" only when "a desperate, crazy situation happens," otherwise "it should not exist," because it "does more harm than anything else." More frequent are cesarean sections. In this regard, the situation appears very different depending on the hospital. In some hospitals it is conceived as the last resort, partly because of the obligation to comply with ministerial objectives (Ministero della Salute 2010; 2012). These and WHO guidelines have led to a reduction in the rate of C-sections (WHO – World Health Organization 2018). In other hospitals, however, doctors appear more willing to perform C-sections for any woman who requests one, even when it's not medically necessary. It's important to note, however, that part of the obstetric violence movement advocates for granting such requests. For X.:

> C-sections are a bit doctor-dependent, in the sense that there are some doctors who, if the woman says "I want a C-section, I want a C-section, I want a C-section," at some point they do the C-section. [...] Instead, other times it's not on demand: sometimes women are really told: "if there's no need, you can't have it." However, it is also true that if the woman is uncooperative and wants to get the C-section, she signs the consent form...and eventually obtains it.

N. remarks that if, in order to comply with ministerial objectives and to avoid C-sections, inductions are increased and sometimes "last as long as a week," one cannot speak of success. There is thus a risk of going too far in the opposite direction: there used to be "too many cuts" [i.e. C-sections]...and so now we are on the other side."

Differences are also found in the use of the epidural. In this regard, the distrust expressed by almost all interviewees is striking. Midwives mostly see it as a form of unnecessary medicalization that can hinder the physiological course of childbirth. They tend to blame it on women who would no longer be willing to "give birth in pain." According to them, younger ones do not accept to feel pain, while "career women" often already arrive to the hospital with the information and belief that they will get the epidural. According to G.: "today's society is not aware of the pain of childbirth: babies are not born unless there is a passage through pain."

For L., the epidural was greatly pushed in the 1990s by ministerial policies. This "seemed like a big step forward, instead it was a very big step backward for us." However, as W. argues, it cannot even be said:

> in a Taliban way "no, I will never do that!"...you don't know! [...] There's nothing wrong with that, no one is judging you, it's fine...[...] when the situation 'is stuck, the woman is really tired, [her] cervix really doesn't let up, sometimes it's decisive.

Also for P., the epidural, "on the one hand is a friend and on the other hand a big foe [...] It's a bit of a problem for us, quite a big one, but we always try to do what the patient asks." For Y.:

> the right answer lies in the middle [...] It's not true that it's something to be demonized, absolutely not. In some situations, it's needed...it has to favor the success of the birth path [...] it has to be done when it's needed, otherwise you are shooting yourself in the foot.

For the most part, hospital midwives believe that, in this as in other cases, particularly breastfeeding, it would be preferable to "follow nature," but one should not be rigid. The appeal is often to contextualize, to take into account the individual woman's condition and will, and to avoid "extremism."

4.3.3 The postpartum phase: rooming-in and breastfeeding

Rooming-in has been adopted in many Tuscan hospitals. Midwives have a good opinion of it, even though it raises some critical issues, mainly because, as mentioned, it increases overcrowding in the wards and can be difficult to manage, particularly at night.

Interviewees appear attentive to the importance of encouraging breastfeeding. Some Tuscan hospitals have been recognized or are working to be recognized as "baby-friendly hospitals" where breastfeeding is promoted, including through dedicated staff (UNICEF n.d.). Where this pathway has not been followed, some report less attention from non-midwifery staff to breastfeeding. Specifically, nurses

tend to align with the advice of doctors, who sometimes favor switching to formula milk, while midwives are more autonomous and, when issues arise, explore alternative solutions suggested by WHO guidelines, such as using a breastfeeding tube, before resorting to formula.

Some hospitals have dedicated clinics that allow mothers to return with their children so that they can be supported in breastfeeding. Otherwise, mothers can turn to family health centers. According to V., a self-employed midwife who trained as a lactation consultant and works exclusively on this, public hospitals do not invest enough in breastfeeding, starting with staff training: "At the end of the day, a baby doesn't die there for lack of milk, right? There is always formula, so the resources invested [in breastfeeding] are laughably small." In her view, family health centers have a huge burden and are unable to provide the necessary care. In fact, care can become useless if it is not continuous: "a week's damage is big on breastfeeding, especially in the first few days. It can result in the ultimate switch to formula."

In hospitals, where there is no dedicated staff, attention to breastfeeding, in the opinion of more than one interviewee, is due mainly to the personal commitment of some midwives. In fact, there is little time to devote to such a delicate phase. So, as E. recounts, especially when babies are in the nursery and not in the room with their mothers, some midwives say "we don't have time to keep up...everyone is given a bottle," thus potentially compromising the breastfeeding process.

On the other hand, as mentioned above, according to many of the interviewees, it is not appropriate to overdo it. Women should not be forced to breastfeed. P.'s motto is, "I prefer a sane woman." Also for A. the balance between the woman and the family is the priority: one should not be a "Taliban."

5 The role of emotions

5.1 The feeling of frustration

Reference to the emotional state of both women and professionals emerges in almost every interview. As mentioned in the previous sections, frustration is a common feeling among many hospital midwives. In addition to work difficulties, which have already been analyzed, this also appears to be related to the lack of gratification on the part of women. According to many interviewees, these rarely value the contribution of midwives to successful childbirth because they are not aware of the risks involved. Indeed, there is now a social expectation that childbirth is a happy event and "it is not conceived that things [may] go wrong." According to N.: "People have

a negative attitude toward us: if the delivery goes well, it should have gone well, it's normal, it's expected. If it goes wrong..." Also for B.: "Sometimes you think, 'I've really sweated through this labor!' but everything is kind of taken for granted right now." Since patients pretend high standards from the hospital, "things have to go well."

In denouncing the lack of recognition by patients and their families, these midwives seem to also defend themselves against complaints of "obstetric violence" ("violenza ostetrica" in Italian). They often refer instead to "violence against the midwife" ("violenza all'ostetrica") perpetrated by disrespectful relatives. Indeed, many accounts outline a polarization between midwives and relatives. As mentioned above, this is also partly related to insufficient space. For K.: "the family around [called with contempt "parentame"] is a disaster for us. We see them, when they come, as the enemy." She adds:

> sometimes you go out to get a bottle, come back to the delivery block and find relatives saying, "there's no way my daughter has been inside for 12 hours, if something happens I'll call the police!" You go back inside with these phrases in mind, how can you work?

The relationship with doctors, as noted above, can also be problematic. This is also reflected in the different way in which they are viewed by patients and their families. According to V.: "It is an Italian mentality [to see] the gynecologist as God descended to earth. However, it's the midwife who is there for the 12 hours of labor."

When women and their families feel good about the midwives' work, this renews their motivation. As recounted by K.:

> For example, this month I've had a lot of positive feedback, and I already feel so much more recharged [...], because I've worked with so many really lovely couples — they were so thankful, we got along really well, we were on the same wavelength — and it's exactly those moments that recharge you. That's the reason you do this work.

If the judgment is negative, motivation instead suffers. Emblematic in this regard is C.'s account of breastfeeding assistance:

> If grandmothers — and I mean grandmothers, relatives, friends... — belittle our work, it can be really humiliating and demotivating at times. Sometimes you just think: "You want the formula? Fine, take it, who cares!" [...] Because you've worked so hard — especially those of us working in lactation support during the night, with nights being long and exhausting — and then in the morning, a single look, a single judgment, can undo everything the midwife has done.

Another concern that emerged during the interviews is the fear of legal repercussions. Expressions like "I have the right to get an epidural," according to some interviewees, anticipate a potential legal confrontation and often lead midwives

to comply with a woman's request — even when it goes against their own clinical judgment. As C. puts it, "There's always that fear in the background...the lawyer's bell ringing." K. also points out:

> We get sued for everything. As soon as insurers hear that we're midwives or gynecologists, it's like being orthopedists — our premiums skyrocket, because we're considered high-risk: we get sued for everything. [...] So sometimes we end up making decisions defensively, but that can lead us down a path where, because the decision wasn't the best one, the birth doesn't go well. It might result in an emergency C-section or an overly medicalized delivery, simply because it started as an operative birth and then something else happened.

This is the phenomenon of so-called "defensive medicine," which in this last testimony is indirectly brought into focus as a risk factor for the successful outcome of childbirth and, we might add, for obstetric violence. A recurring theme in many interviews is a sense of isolation — a feeling that midwives can no longer rely, as they once did, on the support of their superiors. The latter, too, often feel intimidated by the risk of lawsuits or complaints and tend to adopt a "the customer is always right" approach. This same defensive logic underpins some women's decisions to submit a birth plan — a set of written directives specifying which interventions they do or do not want to undergo in the hospital. Most public-sector midwives interviewed expressed tension and frustration in response to this practice, in some cases even describing it as a source of genuine "distress." For K.:

> It's mortifying for a practitioner — truly mortifying. I mean, I wouldn't go to a physical therapist and say: "Make sure you get the right muscles!" It's part of this whole chain reaction: we end up behaving differently, becoming more rigid and formal, because we're constantly on guard, afraid of making a misstep.

However, some midwives view the birth plan as a starting point for establishing a dialogue with the expectant mother — even if, in practice, it often serves as a tool to guide her toward understanding why certain medical interventions may be preferable for a safe and successful delivery.

Supporting the woman's desired birth experience is central to the role of private practice midwives, and they see it as part of a broader effort to foster her self-determination — a process that begins early in pregnancy. For Z.:

> The core expertise lies in listening and observing the different dimensions of health. [...] This includes paying close attention to the emotional state of the woman and the couple, because we know that emotional well-being triggers the release of substances — molecules, hormones — that support health in specific ways. Conversely, when emotional balance is disrupted, the body produces other kinds of molecules, hormones, that have a negative impact on health.

Q. also says:

> We work based on the mother's needs, helping to bring out her sensitivities and understand what is most relevant and important to her. Then, through the experience, we try to ensure that these priorities are respected by collaborating with the [hospital] midwife who is present [in the delivery room].

5.2 The importance of empathy and the anxiety of pregnant women

Frequently, interviewees recall "empathy" as a distinctive posture of their profession. The term is often evoked spontaneously, more rarely taken up by a question asked during the interview. Thus, it seems to be more or less consciously part of the professional language. Responding to a question on the subject, H. says:

> I think it is a common element of our profession, but of course there are those who have it less. Bad days happen. We're human, after all, so there will always be times when you're not the midwife you aspire to be.

J. also states: "I try to get to know them better so that the patient feels comfortable and you create this kind of empathy that is everything in the relationship between midwife and patient." According to P. the "concept of empathy" is "fundamental" for midwives. Empathy is also seen as a tool; N. states: "many times, empathy solved the situation."

However, in the accounts, empathy often overlaps with instant liking/disliking: it may happen — some interviewees say — that there is no attunement between the pregnant woman and the midwife, and that a change of practitioner may be decided in order to foster it. In these cases, a sort of natural feeling is evoked, rather than a specific ability to connect with the patient, whoever she is. R. clarifies the distinction well and finds the reason for it in the lack of time: "So: there is no time for a therapeutic relationship, there is no time to empathize. It's much easier to develop instant liking or disliking at the hospital, isn't it?" Also representative is I.'s comment:

> Empathy doesn't come with everyone, but I talk to them…with some, I'm able to be there the whole time, and we talk about all sorts of things — we really create empathy. With others, one doesn't create empathy, but the care remains the same, absolutely.

Equally significant is W.'s testimony:

> Sometimes one may even think of taking a step back, because you can't like everyone. One can also say [to a colleague], "do you want to try?" And that doesn't disqualify you. I mean, the goal is that the woman feels safe, lets go, moves forward on her journey, and gives birth in the best way. That is your goal, that's why you are there. It gives so much satisfaction to work like that.

The importance of building empathy, according to many interviewees, is underestimated in undergraduate and professional education. Yet, according to many, empathy is crucial in fostering a positive childbirth experience. Some realized this through their own experience of motherhood.

The majority of interviewees read fear as the state of mind characteristic of childbirth. The professionals experience fear, too. On some occasions, the "panic" of the practitioners may pose a risk — indirectly, even a risk of obstetric violence. This also appears to be very much related to lack of time and a defect in communication. In C.'s testimony:

> In emergency situations, we're often the first to panic. Sometimes, you panic because you feel that the doctor doesn't trust you enough, so you just try to get by, and in doing so, you completely lose focus on what needs to be done — rushing through without considering communication. There's something that needs to be done quickly, like a cesarean [and you might find yourself saying]: "Yes, move, let's go, hurry, come on!" We end up wasting little time and giving little importance to communication, because we're also caught up in the urgency to resolve things. We experience strong emotions too, and sometimes, we lose sight of the bigger picture.

C. is aware that childbirth is a destabilizing life experience: "You're dealing with an important moment of life, one that leaves a lasting mark, because regardless of the type of birth, experiencing it changes you completely." This can bring all insecurities and past traumas to the surface. As K. puts it: "Labor brings things out in you sometimes…I mean, I've gone through labor with things [...] right from deep within the soul." Similarly, for B., "Labor, beyond the pain, brings out all the experiences of the past years — both resolved and unresolved, a whole range of emotions, including fear."

Not infrequently, however, fear is taken as a distinctive cipher of the decline of a humanity that has moved away from trusting its own instinctiveness. This attitude is shared by private practice and hospital midwives. D. states: "Physical pain is no longer viewed the way it was fifty years ago, when you knew you had to give birth and endure pain, period. Now, people come with significant mental distress as well…" Similarly, I. notes, "We get primigravidas with contractions, and they tell us, 'I haven't slept for two nights!' I know that, I fully understand that fatigue is

a challenge, but these are normal things." M., a private practice midwife, attributes this attitude of pregnant women to the medicalization of pregnancy, whereby "women are increasingly depowered in their instinctive ability to...to bring children into the world." For L., also a freelancer, the midwife's task is precisely "to empower women's abilities, [their] natural abilities."

The independent midwives stress the importance of self-awareness, interpreting many of the difficulties women experience in gestation, childbirth and postpartum (especially in breastfeeding) as a loss of access to their ancestral capacities. For V., women must be helped to "trust that human beings have been going on like this for millennia." She declares: "I also try to bring back some trust in nature. I firmly believe in it, otherwise we wouldn't be here, would we?" This recovery of natural instincts is needed in the face of excessive de-naturalization: "the incredible thing is that as a mother you poorly respond to your instincts."

The women-nature link can sometimes take on a stereotypical character. "Paturnie" [bad mood associated with irritability[10]] is, for example, the Italian term used by one midwife to name the psychological discomforts of expectant women. Also emblematic are N.'s reflections: "During pregnancy, you're completely controlled by hormones; you can't really say that you're truly yourself."

According to this view, women manifest disorientation, either because they are not prepared or because they seek to make sense of the experience of childbirth only through rational frameworks. To regain a sense of control, some women turn to do-it-yourself knowledge, primarily obtained through online content and forums. Such knowledge often contributes to a growing distrust in medical professionals.

An ambivalent picture emerges: on the one hand, hospital midwives express a desire to be emotionally involved in childbirth, not merely operationally; on the other hand, they face challenges in fully engaging in the process. These difficulties stem partly from the practical issues discussed in the previous sections, but may also arise from a form of antagonism with women who criticize their work or do not share the same vision of childbirth.

On the contrary, private practice midwives believe they are consistently able to establish an empathetic connection with the women — and often the couples — who seek their care. A key factor influencing this is time: they typically can dedicate more time to building relationships. Moreover, those working in teams, when possible, select the midwife who will accompany the woman during pregnancy and childbirth based on the likelihood of mutual understanding, considering factors such as age, experience, and personal affinity.

10 It is a rather derogatory colloquial term.

We can therefore identify two main ways in which a meaningful connection between midwife and patient — one that can contribute to a positive childbirth experience for both is established. The first can be described as a form of "instant liking:" a kind of instinctive or even fateful affinity between the two women, which facilitates a more fluid and harmonious midwifery practice. As S. states: "If we find a couple with whom something clicks right away, then we succeed…" For H.:

> It's kind of like a speed date, right? You go on a blind date, not knowing who's in front of you, and you don't know what midwife you're going to get until you're face to face with her. Maybe you'll meet the one — the midwife of your life, the one you immediately connect with, and you'll feel like you're at home and can fully rely on her. Or, you might think, "Oh my God, where did this one come from? No way, she reminds me of that bitch friend who stole my boyfriend. I will never give birth with her!"

A connection between the midwife and the patient can also be established through emotional competence on the part of the midwife: i.e. empathy, which influences the course of childbirth. N. states:

> I'll be honest, it's always worked for me, because I noticed that when I stopped connecting and empathizing with the woman, things would either end in a C-section or lead to a difficult birth...but I could put that in a contract and sign it: it has always happened that way.

6 Communication and trust

Trust is essential to the relationship between the woman and the midwife. Some interviewees go as far as to call it a "covenant of alliance," emphasizing the mutual reliance that forms the foundation of their shared journey. N. states:

> It's a little game we play together: if you trust me, I have to trust you, and then we are ready to go. If there is something I see that I don't like in you, and you [see] something that you don't like in me, you have to tell me, you have to solve it on the spot.

Good communication is seen as one of the keys to successful childbirth, that is, to a care experience where the woman feels protected and respected, and the professional feels her expertise is valued. Midwives expect women to be able to speak their professional language, a skill they believe can be developed through attending antenatal classes. As H. puts it: "I believe that all information and training should be provided beforehand; giving information when the woman is having contractions is not effective."

Some emphasize the importance of communication in engaging women. The ability to openly discuss the steps to be taken, as well as any potential complications, empowers the woman to actively participate. As F. states: "I feel nervous when they don't offer her a choice, when they communicate things like: 'This is how it's done, and that's it.' No! It's never like that!"

On the other hand, it is important to highlight, particularly in the interviews with self-employed midwives, the suggestion that the use of technical language can hinder the woman's involvement in the decision-making process. For S.: "You speak to her in a language, a register, completely unfamiliar to her, making it easier to manipulate her. A woman who is unaware of what is happening to her lacks the necessary tools."

The problem arises especially for foreign women who do not speak Italian. In Tuscan hospitals there is a cultural and linguistic mediation service, which, however, according to many of the interviewees, is not always efficient. In some maternity units, there are few mediators. In others they appear more available. When emergency action must be taken, they can also be called on the telephone. However, many midwives report mediation by husbands or other relatives who are next to the woman in the delivery room and who understand Italian. They are usually the ones who translate what the midwives say. This is mostly done unsatisfactorily, as it is not clear how much they themselves are able to understand and because they tend to summarize a lot of what is communicated. According to E. they do so partly in order to reassure their wives:

> Fortunately, most of the times the husbands do it, but women often don't speak a single word, or they say they don't understand — because sometimes you get the doubt that they understand something — but the husbands always try to protect them, to keep them unaware of everything. That's it. They often condense everything we tell them into three words.

With regard to the communication between professionals, the interviewees unanimously observe that spaces for discussion, briefing and de-briefing, and psychological support should be implemented. One of the few channels of communication between midwives and medical leadership is the mediation of the organizational position. The presence of the head of department in meetings is reported only when there are serious occurrences. Significant in this respect is the testimony of Q., an independent midwife, who identifies one of her own peculiar functions precisely in filling a whole series of communication gaps found in the public sector:

> The private practice midwife helps to connect [different healthcare professionals], because otherwise they remain disconnected, and when you can network you are much more effective in your support; so this is something I really care about, and I really see the results.

For S., the woman:

> has a mediator who translates for her [what the staff say], which is crucial: even though, as a freelancer, you can't use your hands to assist the delivery...you can still say: "Look at what's happening...remember you wanted this, this, and this...they're offering you this and this, what do you want to do?" I mean...it's all about the work of translation...It's like having a kind of inner voice[11] guiding you all the time.

The interviews also identify the obstacles to good communication. Among the first causes, as mentioned above, are lack of time, working in emergency conditions, performing several tasks at once, and being assigned to several women simultaneously, which undermine the ability to communicate adequately. According to C.:

> When you do simulations you give importance to communication, because there has to be the team leader, the leader who manages the emergency...however, there [it's all] great, perfect — "look ma'am, you're losing a lot of blood, let's go to the operating room" — ...when in reality [it's more like] "come on, move, come on let's go that way!" Little time is wasted on it and little importance is given to communication.

A large proportion of private practice midwives, however, consider that difficult material working conditions can't be a valid reason for surrendering to miscommunication. For W.:

> Communication is important, even in times of obstetrical emergency: in that moment you can explain it to them and then you can come back later, you have that option. Although you should do it during [the intervention], even if you explain it to them later, they honestly understand.

According to V.:

> Even if a midwife is alone preforming multiple tasks and she has to leave the patient alone, she [could] explain it to her, or when she comes back she [could] say "forgive me for leaving you alone all this time, I left you safely with my colleague, but I had to run for an emergency"... Instead, it is taken for granted, the patient has to figure it out for herself. The patient is not a health professional, she doesn't know what it means, what happens there. Good manners dictate that you explain things, whether or not you are asked. If you have a responsibility to that individual, you must inform that individual about what is happening, regardless of the situation.

11 The expression in Italian is "grillo parlante" ("Jiminycricket"). The midwife is indirectly referring to the (Tuscan) tale of Pinocchio.

Many hospital midwives agree on this point. E. states, "It's true that we're in a hurry, there are tight schedules, not enough staff, but nothing justifies you treating a woman badly." Note that this statement evokes the degeneration of communication into mistreatment.

In the diametrically opposite position stand the interviewees for whom succinct communication is consistent with rapid and emergency action, such as obstetrical action. In these cases, the woman's reliance on healthcare staff should make verbal communication unnecessary.

Most hospital midwives, however, report the compression of communication spaces as problematic. From the point of view of midwives, especially hospital midwives, the outcome of good communication, however, is largely affected by the receptivity of patients, their willingness to listen and trust. Among the most critical moments in the profession, unsurprisingly, midwives highlight those when women complicate the delivery, which can happen in at least two ways. First, because of the woman's total mental unpreparedness for the painful event. This is a phenomenon traced in large part to an alleged disorientation of the woman, disavowing the instincts that would normally lead her. K. states:

> In my opinion, it's important to trust the midwife, to let go of all the preconceptions you have, to trust [her] totally. For me, this is fundamental: you just have to follow her and stop second-guessing what she did, why she did it, what she wanted to do [...]

Referring to her own childbirth experience, C. states:

> I felt like I did it at home; because I did it with the colleagues on my shift, whom I had known for a while. They knew who I am and what I wanted, my husband actively participated...I completely relied on them. Whereas with the first baby I was more focused on being a midwife and I was doing things midwives do while I was giving birth, that is, I didn't relax and rely on the professionals. And instead that is what we should be doing: not thinking.

In some cases, interviewees report a kind of role reversal: women would claim to dictate delivery instructions based on the information they had sourced independently, to the point that, for one interviewee, "they are in charge."

From this point of view, education — understood both in the sense of the pregnant woman's cultural level and the information inherent in pregnancy and childbirth — is seen as a cause of altering the balance of a woman's 'natural path,' as it would interfere with the woman listening to her own body.

In a second sense, the obstacle to good communication would be, on the contrary, the technical unpreparedness of pregnant women. Moreover, this leads to a difficulty in their involvement in the various stages of childbirth. For F., "very few women take good antenatal courses and arrive at the hospital knowing, for

example, what inductions are [...]" For H., "most women who arrive in labor have no idea what might happen."

She then notes that such unpreparedness is increasingly attributable to negligence on the part of pregnant women. H. insists that there are "so many women who work until the last second, who never have time, who do not take care of this pregnancy until they are in the delivery room." The same can be said of the already highlighted cases of criticism of women's lifestyles, which are inadequate to facilitate physiological gestation. Moreover, in both cases, the little information that may be acquired — the interviewees note — is almost always incorrect. For B:

> Even those who haven't taken any courses still look things up online, since nowadays everything comes from the Internet and social media anyway. The problem is, a lot of what they find is either misleading, incorrect, or based on outdated practices.

F. argues that the quality of information depends on the sources. You can "get good information on social media too — even though it's often criticized. There are some really good midwives who are influencers and share accurate, reliable content."

Still, most hospital midwives agree "it's better not to pretend you know — just trust the people who actually do." K's observation is striking:

> Paradoxically the women who are so educated and are having children late, in their 40s, have studied so much for this pregnancy, for this birth, that they are overwhelmed with information, but they are actually a mess.

However, in general, preparation doesn't depend on age. For T., "It ranges from those over 40 to the very young, and neither has adequate preparation on what pregnancy is, what childbirth is."

The loss of instinct, the over-structuring of (often misinformed) rational thinking, and a lack of trust in healthcare professionals appear to go hand in hand. Nearly all interviewees reflect on the growing mistrust displayed by women and their partners. In these and other accounts, there seems to be an underlying effort to preempt or respond to potential accusations of obstetric violence. For I., "It also depends on how the woman acts, because, honestly, more and more often they come in with a lot of prejudice, sometimes [they are] even quite aggressive — so it's hard to build a positive connection." Also, "there are some couples [...who] come with prejudice. It's really difficult to deal with them; they seem to take everything as a reason to argue." As W. puts it, "In my opinion, more and more people who come to the hospital don't trust us." J. echoes this sentiment: "These days, almost all women come in with preconceived notions — eight out of ten, I'd say, are prejudiced, about everything and everyone."

As mentioned earlier, nearly all the interviewees agree that childbirth preparation is insufficient. The antenatal classes just don't give enough information (N. even calls it "misinformation" for women). In some places, the few meetings that used to happen in hospitals, which were paused during the pandemic, still haven't been reorganized. In others, the courses just aren't up to scratch — either because the staff lack the right expertise or because they're afraid of how women might react. K. states:

> In my opinion, we also need to be a bit more honest when we run antenatal classes. We have this chance to talk to women and explain things to them [...], but we can't really do it because then they call the URP [office], complaining that we've made them anxious or...well...we should just tell the truth in these classes — like, how long labor actually lasts, that it's painful, and... there's no other way to explain it.

More frequently, the cause of unpreparedness is identified in the lack of continuity of care, which does not favor a prolonged and complete support of the pregnant woman. This is due to the fact, as already pointed out, that the link between hospitals and family health centers is becoming increasingly loose.

As mentioned above, despite critical remarks, the majority of interviewees believes that family health centers are far better than private care from gynecologists, which does not adequately prepare women for childbirth. For C.:

> You can immediately tell if a woman has been supported by the family health center — it's obvious. Women who only go the private route [...] arrive totally unprepared for everything. But sometimes, when they get support from both the private and public sectors, those women tend to do better. Women who are helped by the public services generally arrive more prepared.

7 The caring relationship

At this point in the exposition, the positions of interviewees with respect to empathy, trust and communication in the care relationship can be sorted into three macrogroups.

One group connects good communication and trust with the idea that pregnant women come into the hospital mentally prepared to handle pain, seeing it as something constructive. They're not weighed down by prejudices that put them at odds with what the medical staff is trying to do. Some hospital midwives feel that relying on healthcare staff is just expected, given their expertise, and that communication should mainly be about explaining things and reassuring patients.

But they also believe it shouldn't involve the patient in decision-making. H.'s comment is a good example of this point of view:

> I'll tell you what needs to be done, because in that moment, the relationship isn't equal. I can help you communicate and process how things went, especially if it didn't go exactly as you expected, but the key is that you have to trust who's helping you. That trust is essential for a good experience, even if it doesn't look perfect on paper. The problem is, now everyone's Dr. Google [...] Nowadays, everyone's an expert, but a doctor can't be the same as a farmer — no disrespect to the farmer! But when I need to plant something, I call a gardener because I have no idea how to do it myself.

Also for J., "I don't tell the greengrocer how to sell the fruit and he can't tell me whether I should make the cut or not. If that happens, you completely lose trust."

The most critical voices point out that sharing the medical meaning of the actions taken during childbirth, through language that is accessible, is a dangerous means of legitimizing women's interference. For S.:

> It's harder to communicate and be with a woman who knows what we're talking about, who asks questions and wants to understand what's going on. In that situation, your power is challenged, and you have to work harder to explain things to someone who has a certain background. It's a lot to handle.

Some interviewees emphasize that it's easier to interact with women who do not speak Italian and have no choice but to rely on the midwife. For C.:

> with foreigners...often a good relationship is established, often they are young girls...who cannot speak [Italian], but just making eye contact is enough. Precisely because you can't understand each other, you do things faster.

Also for U. foreign women "completely rely on you — they don't have any judgment or prejudice against you, from a human or professional standpoint, and they trust you a lot."

A second group of midwives connects the success of the therapeutic relationship to the fact that women come to the hospital ready to trust the midwife, as if they've gotten to know her during their pregnancy and share some of the same knowledge. This kind of outcome, however, is far from obvious and calls for a reform in the antenatal process and for making continuity of care more standard.

A third group believes that good communication can still happen even if women are misinformed, uninformed, prejudiced, etc. They also think that midwives are responsible for making an effort to earn the trust of expectant mothers. As D. puts it: "A minimum of trust, of building a relationship with the woman during those hours so she trusts you, that's the bare minimum. Otherwise, they won't even

believe what you say." C. adds: "If I show you that I'm a welcoming person, and I explain why I'm doing everything I do...like, if I need to insert an IV for any immediate injections, you'll trust what I'm telling you." J. also says: "I always try to tell the patients everything, never treating anything they say as insignificant. At the same time, I make sure to involve them in everything."

For these midwives, communication can establish mutual trust and favor an obstetrical course without interpersonal tension.

E. points out: "You also have to approach each woman a little differently — it's very subjective; with each one, you have to act in a different way," showing an understanding of the importance of personalizing the therapeutic relationship. A goal worth striving for would be co-leadership in childbirth, which, as F. puts it, means "evaluating the process, explaining why, and looking at the alternatives, because there isn't always only one right path." Private practice and hospital midwives share this aspiration. For T. the goal is to create a relationship that is

> As equal as possible, but making it clear that I have skills that could be helpful. So, you can do whatever you want, but when I see something that needs to be changed, I suggest it and you try to do it. I mean...sometimes what I see is a discrepancy in the professional roles, where someone imposes themselves, saying "I'm the midwife" or "I'm the doctor, so we do it my way." But actually, when it comes to childbirth, that's not true. It would be enough to give the woman more freedom to move and make choices, guiding those choices without forcing them.

8 Conclusions

8.1 Obstetric violence: between recognition and denial

We can now summarize some of the key findings from the research, focusing on midwives' views on obstetric violence. As mentioned in section 4, the interviews highlight several behaviors or situations that reflect 'obstetric violence' in hospitals. In some cases, it's explicitly recognized, but in many others, it's not directly named, even though midwives still condemn the behaviors related to it. These are mostly the cases of obstetric violence recognized by the international scientific literature (Quattrocchi 2024; Brunello et al. 2024).

Interviewees mostly criticize the overcrowding in the spaces where women go through labor and delivery, which is especially common in university hospitals. While obstetric violence isn't always explicitly mentioned, this situation is clearly condemned, and it comes across as a form of obstetric violence in itself. This overcrowding can then lead to two other behaviors that might contribute to obstetric violence: pleonastic visits and conflicting instructions.

Among the disrespectful behaviors mentioned by the interviewees are things like badmouthing colleagues while the woman is in labor or giving birth, or talking about personal matters unrelated to the woman, or discussing other pregnancies. In some cases, the behaviors they describe are even more serious. For example, some interviewees refer of comments made about the woman's abilities that can lead to feelings of guilt, like telling her "if we need to use the vacuum extractor, it's your fault because you can't push," or saying "she's not pushing properly," "she's not trying hard enough," or "she doesn't want to deliver her baby." Sometimes, they also mention more aggressive ways of interacting with the woman, like yelling at her, making her feel inadequate, or using insulting language.

Also communicative in nature is a further example of obstetric violence, which we might define as "acting without speaking," using T's words. It indicates medical acts that are practiced on the woman without informing her, without explaining to her the type of intervention and its purpose and without acquiring her consent.

Finally, as mentioned in section 4, some midwives explicitly couple some clinical acts, however rare, with obstetric violence. These are mostly the "Kristeller maneuver done very violently" (L.), "gratuitous" episiotomies (K.) and visits described as "abrupt" that result in membrane sweeping but without consent (X.).

It is appropriate to point out that insistence on breastfeeding emerges as a form of obstetric violence in only two cases and indirectly: in the account of the lactation consultant, as an experience regularly reported by her own patients, and in the interview with a hospital midwife who admits that some new mothers have explicitly complained about it as a form of obstetric violence.

It is also important to highlight two cases in which midwives point out that waiting time for an epidural (G.) and not communicating effectively what is happening (W.) do not amount to obstetric violence.

Some interviewees state that women often perceive having experienced violence during childbirth only after returning home, sometimes even long afterward. Therefore, the most effective source of feedback on obstetric violence would be the family health center (Y., P.), where women can return post-delivery. Obtaining such feedback in the hospital is challenging, given that the average postpartum stay is only three days.

As noted above, according to some midwives, personal perceptions even turn the narrative of normal circumstances of functioning hospital dynamics into violence. B. observes, for example, that "everything is now seen as obstetric violence," so much so that women are unsure about the interpretation of gestures in good faith, such as the suggestion to try certain positions. Significant is H.'s assertion that none of the medical initiatives suggested by protocol in certain circumstances and confirmed by clinical appropriateness assessment, even if practiced without asking permission, can be labeled as obstetric violence.

8.2 The prevention of obstetric violence

We can now attempt to outline the ideal setting for pregnancy and childbirth as it emerges from the interviews — both directly, through midwives' explicit reflections on what is needed to "humanize" childbirth, and indirectly, by inferring recommendations *a contrario* from the critical issues they report. These are often framed as systemic problems and pertain mainly to the organization of the work. In W.'s effective expression: obstetric violence "is a matter of numbers." Also important, however, are spaces and their organization; care time; hierarchical relationships and collaboration between healthcare professionals.

Central then is the issue of midwives' autonomy, which also appears to be linked to the need to adequately recognize their professional role, including at the salary level. In line with the literature and international guidelines on obstetric violence, the interviews highlight that assigning primary responsibility for the care of pregnant women to midwives would prevent a range of critical issues across the prenatal, delivery, and postnatal phases. In particular, it would reduce the risk of overlapping roles and conflicting interventions among healthcare professionals within the medical setting. It is therefore essential to implement and promote newly tested care models, such as the 'low-risk obstetric' pathway, which can be activated exclusively in cases of physiological pregnancy.

Antenatal education provided through family health centers has the potential to reduce the risk of pathological pregnancies by encouraging healthier lifestyles and improving women's ability to cope with childbirth and the postpartum period. In this regard, family health centers emerge as a vital resource for the protection of women's health and rights. Women should transition from the center that provided support during pregnancy to the hospital for childbirth, and then return to the center for assistance with postpartum recovery and breastfeeding. To achieve this, coordinated services are essential. In this context, a rotation of midwives between family health centers and hospital settings (both wards and delivery rooms) would be highly desirable. As noted by most interviewees, family health centers have been significantly weakened by recent health policies aimed at cost containment (CGIL – Confederazione Generale Italiana del Lavoro 2024). However, the role they play in preventing pathologies for mothers and children arising during pregnancy and the postpartum period positions them — as the lactation consultant explicitly suggests — also as an investment to reduce future costs, both in terms of health and economic resources.

As previously mentioned, the ideal model of care is the 'one-to-one' approach, which enables the development of a relationship based on mutual trust between midwife and woman. To support this model, it is necessary to reduce the often burdensome bureaucratic workload that midwives face. This also requires investment

in stable midwifery staffing through permanent contracts and a reduction in the reliance on temporary personnel.

There is an urgent need to adapt university and professional training to include the development of relational and communication skills, both in interactions with women and within the broader medical setting. This includes fostering empathy and enhancing the ability to navigate complex interpersonal dynamics. Increased opportunities for self-reflection within midwifery teams and in dialogue with supervisors — particularly aimed at identifying staff-reported critical issues and improving maternal feedback — should also be prioritized. According to some interviewees, additional desirable initiatives include the reorganization of physical spaces and the allocation of resources to support natural childbirth, in line with innovative and less invasive approaches. This latter aspect is particularly emphasized by midwives working in private practice or in maternity units where such practices are already being implemented.

The interviews don't identify a single "model of childbirth." However, they emphasize the importance of natural childbirth and they show awareness of the role of empathy. They also criticize hyper-medicalization and protocols inspired by an efficiency logic or marked by the paradigm of "defensive medicine."

Certain stereotypes remain persistent, particularly those linking childbirth to inevitable pain and attributing a heightened responsibility — if not outright blame — to women. These narratives, however, coexist with emerging attitudes that, whether consciously or not, reflect the influence of feminist thought on women's self-determination and empowerment.

While interviews with private practice midwives reveal a clear alignment with a culture and professional ethics centered on the prevention of obstetric violence, hospital midwives also express adherence to these principles, albeit in more nuanced terms. These midwives often emphasize the high standards of safety and care provided in public hospital settings, while also cautioning against an excessive idealization or re-naturalization of childbirth that may overlook clinical realities.

The emerging picture is that of an evolving public healthcare system. Above all, what seems to be lacking is the political will to invest resources in the health sector and to radically change the patterns of relationships between different professionals and with patients. On the latter aspect, however, some progress has been made. Yet, in the words of one interviewee, "there's still more ground to cover."

References

AGOI – Associazione degli Ostetrici Ginecologi Ospedalieri Italiani. n.d. https://www.aogoi.it/notiziario/archivio-news/inchiesta-doxa-violenza-ostetrica/; https://www.aogoi.it/notiziario/violenza-ostetrica-termine/ (last accessed September 22, 2025).

AOUP – Azienda Ospedaliero – Universitaria Careggi. n.d. https://www.aou-careggi.toscana.it/internet/diagnosi-e-cura/dipartimenti/dipartimento-delle-professioni-infermieristiche-e-ostetriche-dipio/gravidanza-fisiologica-centro-nascita-margherita/ (last accessed September 22, 2025).

ARS TOSCANA – Agenzia Regionale di Sanità. n.d. https://www.ars.toscana.it/banche-dati/dettaglio_indicatore-2317-parti-nei-punti-nascita?provenienza=home_consultato&par_top_geografia=090&dettaglio=ric_anno_osp_matinfcap (last accessed September 22, 2025).

Barbosa Jardim, Danúbia Mariane and Celina Maria Modena. 2018. "Obstetric violence in the daily routine of care and its characteristics." *Rev Lat Am Enfermagem* (26): e3069. https://doi.org/10.1590/1518-8345.2450.3069.

Bourdieu, Pierre. 1990. *The Logic of Practice*. Stanford University Press.

Brunello, Silvia, Magali Gay-Berthomieu, Beth Smiles, Eneida Bardho, Clémence Schantz and Virginie Rozee. 2024. *Obstetric and Gynaecological Violence in the EU-Prevalence, legal frameworks and educational guidelines for prevention and elimination*, Policy Department for Citizens' Rights and Constitutional Affairs, Directorate General for International Policies. https://www.europarl.europa.eu/thinktank/en/document/IPOL_STU(2024)761478 (last accessed September 22, 2025).

CGIL – Confederazione Generale Italiana del Lavoro. 2024. "I consultori familiari in Italia." https://files.cgil.it/version/c:YmZkNjJhN2MtZmMzZi00:NmUxN2I1OTktOTk0YS00/Consultori%20Familiari%20in%20Italia.pdf (last accessed September 22, 2025).

Evans, Adrienne, Sarah Riley and Martine Robson. 2020. "Postfeminist healthism: Pregnant with anxiety in the time of contradiction." *Jura Gentium* 17 (1): 95–118. https://www.juragentium.eu/wp-content/uploads/2023/11/JG_2020_1_EVANS_RILEY_ROBSON.pdf (last accessed September 22, 2025).

Fontein-Kuipers, Yvonne, Hanna den Hartog-van Veen, Lydia Klop and Lianne Zondag. 2018. "Conflicting Values experienced by Dutch Midwives: dilemmas of loyalty, responsibility and selfhood. Clinical Research." *Obstetrics and Gynecology* 1 (1): 1–12.

Guaraldo, Olivia, and Simona Forti. 2006. "Reinforcing the species. The female body between biopolitics and maternal religion." *Political Philosophy* 20 (1): 57–78.

Istituto Superiore di Sanità. 2025. "Rapporto sull'evento nascita in Italia (CeDAP) – anno 2023." https://www.epicentro.iss.it/materno/cedap-2023 (last accessed September 22, 2025).

Martín-Badia, Júlia, Noemí Obregón-Gutiérrez and Josefina Goberna-Tricas. 2021. "Obstetric Violence as an Infringement on Basic Bioethical Principles. Reflections inspired by focus groups with midwives." *International Journal of environmental research and public health* 18 (23): 12553. https://doi.org/10.3390/ijerph182312553.

Ministero della Salute. 2017. "Linee di indirizzo per la definizione e l'organizzazione dell'assistenza in autonomia da parte delle ostetriche alle gravidanze a basso rischio ostetrico (BRO)." https://www.salute.gov.it/imgs/C_17_pubblicazioni_2836_allegato.pdf (last accessed September 22, 2025).

Ministero della Salute. 2010. "Taglio cesareo: una scelta appropriata e consapevole (Prima parte)." https://www.salute.gov.it/new/sites/default/files/imported/C_17_pubblicazioni_1330_allegato.pdf (last accessed September 22, 2025).

Ministero della Salute. 2012. "Taglio cesareo: una scelta appropriata e consapevole (Seconda parte)." https://www.epicentro.iss.it/materno/pdf/LG_Cesareo_finaleL.pdf (last accessed September 22, 2025).

Oliveira, Virginia and Cláudia Maria de Mattos Penna. 2017. "Discussing Obstetric Violence through the Voices of Women and Health Professionals." *Texto & Contexto - Enfermagem* 26 (02) https://doi.org/10.1590/0104-07072017006500015.

OMC – Organización Médica Colegial de España. 2021. https://www.cgcom.es/noticias/el-cgcom-rechaza-el-concepto-de-violencia-obstetrica-para-describir-las-practicas (last accessed September 22, 2025).

Pitch, Tamar. 2010. *Pervasive Prevention: A Feminist Reading of the Rise of the Security Society*, Routledge.

Quattrocchi, Patrizia. 2024. *Obstetric Violence in the European Union: Situational analysis and policy recommendations*, Publication Office of the European Union. https://data.europa.eu/doi/10.2838/440301 (last accessed September 22, 2025).

Regione Toscana. n.d. https://www.regione.toscana.it/documents/10180/23325/Punti+nascita+aggiornato+al+settembre+2021.pdf/73c7bba3-7b28-b9dd-3034-ebaf270cf4cb?t=1630918776501; https://www.regione.toscana.it/-/i-consultori; https://www.regione.toscana.it/nascere-in-toscana (last accessed September 22, 2025).

SEGO – Sociedad Española de Ginecología y Obstetricia. 2021. "Comunicado: Violencia Obstétrica." https://www.fundacionvoto.org.ar/noticias-novedades/docs/comunicado-sego-julio2021.pdf (last accessed September 22, 2025).

Seijmonsbergen-Schermers, Anna, Suzanne Thompson, Esther Feijen-de Jong et al. 2021. "Understanding the Perspectives and Values of midwives." *BMJ Open* 11:e037536. https://doi.org/10.1136/bmjopen-2020-037536.

Tavory, Iddo and Stefan Timmermans. 2014. *Theorizing qualitative research*. University of Chicago Press.

UNICEF. n.d. https://www.unicef.org/documents/baby-friendly-hospital-initiative (last accessed September 22, 2025).

WHO – World Health Organization. 2018. "WHO recommendations: non-clinical interventions to reduce unnecessary caesarean sections." https://iris.who.int/bitstream/handle/10665/275377/9789241550338-eng.pdf?sequence=1 (last accessed September 22, 2025).

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Homebirth in Italy: An Alternative to Medicalisation And Vulnerability to Violence in Healthcare Facilities

Abstract: In Italy, as in many Western countries, homebirth represents a radical alternative to hospital-based childbirth, accessible mainly to healthy women with sufficient information and economic means. Based on qualitative research conducted between 2022 and 2024 with homebirthers, domiciliary midwives, doulas, and other professionals, the study reveals a widespread mistrust of hospital birth, perceived as a site of disrespect and invasive practices. Women often choose homebirth or midwife-led birth centres (*case maternità*) to avoid what they view as the rigid, medicalised protocols of mainstream healthcare. This chapter explores the forms of care that make homebirth a meaningful choice for some women and a professional commitment for birth workers. It examines how participants understand the roots and manifestations of obstetric violence, and discusses the potential — both imagined and practiced — for greater collaboration and integration between homebirth professionals and the public healthcare system.

1 Introduction

In Italy, nearly 80% of pregnant women are attended by a gynaecologist and the vast majority of deliveries (88.2%) take place in public and equivalent care facilities (Quattrocchi 2014). In health facilities, birth is treated according to the biomedical model, which sees it as a pathological process requiring technical monitoring, pharmaceutical or mechanical intervention and constant medical supervision (Ferrer et al. 2016). Longstanding critiques of this model have been advanced by women's movements and international midwifery scholars, greatly contributing to the humanisation of childbirth and the raise of alternative birth models (Davis Floyd 2001; Johanson et al. 2002; Katz Rothman 1982). In recent years, the term *obstetric violence* — coined by women's groups in Latin America — has gained increasing attention from the Italian public opinion, scholars as well as health institutions: as an emerging political and cultural object arising from the civil society, it is resemanticising the longstanding cause for a humanised and respected birth through the lexicon of gender violence while emphasising the structural dimension of the phenomenon (Antonelli 2016; Brigidi and Busquets-Gallego 2019; Davis-Floyd and Premkumar 2023; Sadler et al. 2016). Obstetric violence encompasses a wide

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range of practices, from overt forms of mistreatment, such as verbal and physical abuse, to more structural and invisible ones; these include routine interferences with physiological processes through medical practices such as episiotomy, caesarean section, vaginal examinations, the Kristeller maneuver, continuous electronic monitoring during labor and enforced lithotomy position, when performed without a medical necessity for the health of mother or child. The WHO has set thresholds beyond which medical interventions are considered unjustified, signalling excessive medicalisation. When these thresholds are exceeded, such structural excesses are viewed as forms of obstetric violence, as they often reflect procedures carried out due to organisational routines or customary practices, and frequently without the woman's full consent (Quattrocchi 2024). Obstetric violence theory posits that all these events are rooted in the status assigned to the pregnant woman in the biomedical model: that of an unhealthy body on which all interventions are authorised regardless her wishes (Dixon 2022, 266).

By measuring obstetric violence either through women's testimonies or medicalisation rates, we find that in Italy the phenomenon is widespread. According to a recent survey conducted by a civil society observatory (OVO) with 424 women aged between 18 and 54, with at least one child aged 0-14, 21% of women have suffered some forms of physical or verbal obstetric violence defined as follows: appropriation of the woman's reproductive processes by medical personnel; forcing the woman to undergo an unnecessary caesarean section, an episiotomy, or to give birth lying down with her legs in stirrups; exposing the woman naked in front of a multitude of subjects; separating the mother from the child without a medical reason; not involving the woman in decision-making processes regarding her body and her birth; verbally humiliating the woman before, during and after birth (Ravaldi et al. 2018). In terms of medicalisation of pregnancies and birth, Italy is one of the countries with the highest levels in Europe: 89.4 % of women undergo more than the four recommended antenatal visits; 74% undergo more than the three recommended ultrasound check-ups (36.1% more than seven); 31.4% of deliveries take place by caesarean section (well beyond the 10–15% range recommended by the WHO); 24.9% of them are planned; 96.5% of women who experienced a caesarean section in a previous pregnancy repeated the same type of delivery; spontaneous vaginal childbirth has high levels of interventionism and happen through artificial rupture of membranes (32% of spontaneous deliveries), episiotomy (34.7%), and the administration of oxytocin to increase the frequency and intensity of contractions (22.3%) (Spina 2023).

Only 1% of mothers[1] choose to give birth in settings where the biomedical model is mostly radically rejected, that is at home with private midwives or in birth homes and midwife-led birth centres (*case maternità*). In this chapter, it is argued that this "niche" deserves to be studied as a space where an alternative way of coming into the world is made possible, one that applies to childbirth values and modes of care radically different from those offered by mainstream medicalised birth services. These alternative or transgressive spaces are entered by a minority of women partly to escape from the experience of some sort of violence they feel they would inevitably suffer in health facilities. As will be discussed in Part 3, the "alternative" connotation stems not only from a quantitative criterion (that 1%), but above all, from the clear separation from the public health system, the low social acceptance of this birth modality, the specific values and meanings attributed to labour, birth, and body by parents and professionals within this "world," and finally from experiences that sharply contrast with those typically encountered in hospital settings.

Part 2 provides methodological information about the collection of qualitative data on which the present discussion builds. Part 3 starts with an historical overview of homebirth in Italy and develops through three sub-themes: the first addresses the widespread social prejudice against homebirth as a risky choice, along with the limited integration between public health services and private domiciliary midwives; the second explores homebirth as a subculture characterised by unique values and meanings attributed to the woman's body and to birth, which differ radically from those underpinning medicalised childbirth; the third sub-theme outlines a shared view of medicalised birth as inherently violent. Part 4 links homebirth to the concept of obstetric violence by highlighting the points of contacts and distinctions between these two fields of activism.

2 The research methodology

The chapter is based on my sociological investigation into home and alternative birth, conducted through two empirical studies. The first study aimed to shed light on the motivations of women, midwives and birth professionals to give birth or assist births at home, exploring whether their choice was linked to feminism and embodied a spirit of collective mobilisation. First-hand data were produced

1 This percentage is given by official collections of birth certificates (Ministero della Salute 2021). However, it is probably underestimated according to data collected by private midwives.

through semi-structured interviews with the following subjects: 22 women (12 of whom were interviewed together with their partners) who chose to give birth at home or in a "*casa maternità*" between 2020 and 2022 with midwives working in eight Italian regions;[2] and 16 birth professionals (with or without the title of midwife) who assist with home births or support the practice through cultural and educational activities.[3] The age of the women was between 27 and 39 at the date of the interview, their educational level varies from middle school to doctorate, with most of them being university graduates. Eight of them have only one child, and only two of the 14 multiparous women have no experience of hospital births. The second study aimed to understand how midwives, doulas, perinatal trainers, and consultants within the birth awareness movement negotiate the defence of naturalness in a society where the use of biomedical technology is a well established norm in childbirth, and is increasingly present even earlier in the procreative process, i.e. in conception. The study was carried out in 2023 through virtual focus groups with 21 participants selected from individuals involved in public actions on childbirth awareness and obstetric violence; all participants are freelancers with the following roles: 4 midwives, 8 doulas, 7 perinatal and breastfeeding trainers, 1 journalist, and 1 psychologist specializing in fertility. The issue of obstetric violence was debated in both studies, although it did not constitute a core theme in the interviews and focus groups.

3 Homebirth in Italy as an alternative niche

3.1 A historical overview

In Italy, as in other industrialised countries, homebirth arose in the 1970s from women who opposed hypermedicalisation and mass hospitalisation. They supported one another in preparing for childbirth free from hospital rituals, studying the physiology of birth also through consultation with a few physicians and revitalising traditional midwifery techniques from different cultures (Cramer 2021; Craven 2010; Katz Rothman 1982; Kitzinger 1995; Lang 1978; Perrotta 2009). In

2 Friuli-Venezia Giulia, Veneto, Lombardia, Emilia-Romagna, Campania, Basilicata, Abruzzo and Calabria.

3 From here on, this category of subjects will be called private midwives or simply midwives when there is no need to specify. This study has involved only those private midwives who practice home birth; those who engage only in pre and post birth domiciliary care are not considered in this study being part of the home birth movement.

1981, Italian midwives who wished to assist homebirths established a first informal organisation (*coordinamento*) and developed good practices and guidelines. At the same time, the International Active Birth Movement (MIPA is the Italian acronym) was established through seminars promoting the centrality of women and their right to choose where, with whom and how to give birth. In 1991, the *coordinamento* was formalised into the National Cultural Association of Midwives in Homebirth and Birth Centres, which today unites approximately 180 midwives and some twenty midwife-led birth centres (since 2003 the Association has been called *Nascere in casa*).[4] In the same years, the *Scuola Elementale di Arte Ostetrica* (SEAO) was founded and it continues to offer specialisation courses and training days, publishes a magazine and raises awareness of the importance of women's health and childbirth. MIPA is also still active today, with a training school based in Serle (Brescia). In the 1990s midwives, perinatal educators, and other birth professionals sought alliances with political representatives to promote various proposals and bills on homebirth and *case maternità* as well as local experimental projects with several local health authorities, including hospital birth centres in Florence, Genoa, Turin and Rome.

While requests for home birth and *case maternità* remained largely unheeded, in the 1990s many hospitals began to accept some of the measures to humanise birth, which were not only advocated by the movement but also recommended by the WHO (De Sanctis et al. 2020; Schmid 1992; WHO 1996). It became less frequent to prevent women from moving and eating during labour; fathers were welcomed into the delivery rooms, albeit as spectators; some facilities arranged for rooming-in and time for skin-to-skin contact with the newborn, and women began to make their wishes heard by including their own birth plan in their medical records. However, this flurry of sensitivity has not succeeded in changing the structure of the relationships between medical staff and parturients (Schmid 1992), nor in undermining the hegemony of the biomedical model, which has progressively been strengthened through continuous innovations in practices and techniques to accelerate or monitor childbirth (Pizzini 2001).

To date, in Italy, despite these efforts, there are no comprehensive public policies supporting women's ability to choose to give birth in their home or *case maternità*, with it depending mostly on the presence of private midwives in the area as well as on the families' capacity to bear the expense. Only in Reggio-Emilia and Turin a domiciliary midwifery service for birth has been put in place directly by the public health system. Other local authorities, including the Regions of Emilia-Romagna and Marche, the Autonomous Provinces of Trento and Bolzano (laws of

4 http://www.nascereacasa.it (last accessed June 10, 2025).

1998), Piemonte (law of 2002), and Lazio (laws of 2011 and 2014) provide partial reimbursement of the expenses incurred. Other regions (Lombardy with its 1987 law, Abruzzo 1990, Liguria 1995, Valle D'Aosta 1998, Marche 1998, Toscana 1999, Sicilia 2003) have passed laws that mention or address the issue of home birth, but without providing any real integration into the healthcare system.

Since the New Millennium, in Italy as well as in other Western countries, domiciliary midwives have focused more on strengthening the scientific and professional aspect of their practice, and less on activism and policy making, although their constant dedication to their clients is consistent with the intention of contributing to social change (Daviss 2006). By engaging in a form of epistemic politics through the daily practice of midwifery, they question the biomedical paradigm of pregnancy and birth, while spreading knowledge about the midwifery model. This is not to say that in recent years there have been no attempts at dialogue aimed at policy change; however, these should be understood as isolated and marginal initiatives, compared to the core activities of domiciliary midwives. Despite a general lack of interest on the part of the state, homebirth has survived and become consolidated as a social phenomenon, albeit a minority one, thanks to networks and small groups of private midwives, who sometimes experiment with opening *case maternità* in their local areas. However, it continues to be framed as an alternative to the dominant norm of hospital births.

3.2 Stigmatisation and low integration

Although in Europe, from 2015 to 2019, a slight but continuous increase in domiciliary births was observed (Galková et al. 2019), this is a largely minority choice in industrialised countries (1–3%) compared to the social norm that birth (as well as death) takes place in medicalised spaces separated from family life.[5] Parents who choose home birth generally belong to the middle class, have an above-average level of education and cross-party political preferences (Craven 2010; Galera-Barbero and Aguilera-Manrique 2022; Jackson et al. 2020; Viisainen 2000). Some of these families pursue nature-inspired lifestyles, and cultivate psychophysical well-being through holistic medicine; some choose home-schooling for their children, and generally follow intensive mothering and gentle parenting styles (Daviss 2006;

5 The Netherlands is an exception (16% of births occur at home) since it has maintained policies throughout the 20th century that discourage the use of hospitals for physiological pregnancies (De Vries 2005).

Fedele 2016).[6] In Italy, too, homebirth represents a minority birthing modality, but in the last few years and especially during the Covid pandemic, it has gained new momentum (Benaglia and Canzini 2021; Sestito 2022). Being over 35 years old, highly educated, and living in a small town in central and northern Italy are factors that increase the likelihood of a woman choosing to give birth outside the hospital (Campiotti et al. 2018).

While, in some countries,[7] the possibility of giving birth at home and in midwife-led facilities relies on the integration of domiciliary and hospital-based maternal and child health services, or on economic support to families through public funds or compulsory insurance, in Italy there is a clear separation of hospital and out-of-hospital births. In most of the national territory, giving birth at home is not supported by the public health system, which also lacks adequate pre- and postnatal domiciliary services. The possibility of homebirth with private midwives is generally neither publicised within institutional birth pathways, nor recommended by private or public gynaecologists. As a result, many women in Italy, upon discovering they are pregnant, do not even know that midwives can be a point of reference for physiological pregnancies, or that birthing with them at home is a viable option. According to research participants, this lack of information is perceived as a greater injustice than the absence of financial support, as it prevents most women from knowing their rights and from asking themselves what is best for them and their birth experience.

Those who, despite all odds, eventually choose this option, meaning they have access to private midwives and have sufficient economic resources to pay for their service, tend to be stigmatized as foolish, extremely courageous or irresponsible, and their choice is often hindered by social and family pressure (Cheyney 2011).

> Here we give birth in the hospital. You never hear of anyone giving birth at home, it's seen as something strange. People in the community think I'm crazy; I can't really talk about this approach to maternity care. Even the midwife advised me not to mention it to anyone before the birth, to avoid creating anxiety. "Aren't you scared? What if something goes wrong?" That is what people say … It really gets to me. I know of several negative hospital experiences and that just adds to the tension (homebirther, mother).

6 It is interesting to note that in Canada, after the regulation that also provided for subsidised forms of home delivery, the audience opened up to families with more ordinary and less health-conscious lifestyles, so much so that from being a niche phenomenon, home births are sometimes perceived as a choice 'à la mode' (MacDonald 2001, 2004).

7 For example, Canada (Mac Donald 2001, 2004), New Zealand (Surtees 2003), Australia (Coddington et al. 2017), Great Britain (Rocca-Ihenacho and Alonso 2020), Denmark (Jensen et al. 2017) and the Netherlands (De Vries 2005).

This prejudice is not supported by scientific evidence: on the contrary, several studies (Christiaens and Bracke 2009; Houd 2022; Olsen and Clausen 2012; Reitsma et al. 2020; Zielinski et al, 2015) show that childbirth under physiological conditions, when assisted by midwives in the woman's home or in non-medicalised out-of-hospital settings, such as midwife-led birth centres, results in fewer interventions and complications, generates a sense of empowerment, and promotes a good breast-feeding relationship. Furthermore, there is no correlation between the number of homebirths and increased neonatal mortality (Galková et al. 2019; Scarf et al. 2018). A core wish among homebirthers is a collective change to overcome the stigma of their choice and a more democratic access to this option.

> If you are not in a certain circle of people and if someone doesn't take you there, you don't even know that midwives exist outside the hospital. I hope that one day women will be free to choose. I hope it can become an informed choice on a large scale and that it no longer burdens the family budget (homebirther, mother).

Domiciliary midwives often struggle to establish and maintain collaborative relationships with public health structures: one of their routine activities, alongside training and ongoing group consultations to ensure continuity of care for their clients, is the cultivation of good relations with hospital doctors and midwives. These relationships are essential for effectively managing situations in which a woman needs to be transferred during labour or after childbirth, as well as for offering domiciliary screening services (e.g., for streptococcus and neonatal metabolic diseases) without the need to visit a hospital facility before or after birth. In the absence of Regional laws, these agreements, are often informal and must be renegotiated whenever departmental management changes. In contrast, collaborative relationships with various private sector health professionals (paediatricians, gynaecologists, osteopaths, nutritionists, psychologists, masseurs, yoga teachers, etc.) tend to be smoother. Domiciliary midwives often feel judged as incompetent by hospital staff, including hospital midwives: they are frequently downplayed and blamed especially when accompanying clients during a transfer in labour of after delivery due to complications. This attitude hinders any possible collaboration, deepens the divide between the two worlds and makes the choice of homebirth even more radical.

> They look at us as if we would try to enforce our rules at their home…in the same hospital some shifts are more open to our presence, in others any dialogue is just impossible... even private gynaecologists I send to patients tell them they are foolish (midwife).

Midwives and parents express ambivalent views about integrating public hospital care with private home-based services, and involving private midwives in designing

birth pathways. On the one hand, there is a widespread concern — captured by one interviewee's comment that "making laws is dangerous" — that institutional regulation could restrict midwives' autonomy. It may limit their ability to refrain from intervening unnecessarily, respond flexibly to women's needs, and could also narrow the criteria for births deemed eligible for home-based care. For example, in some Regional laws the reimbursement of expenses for homebirth is tied to the performance and results of certain clinical tests. In other words, reimbursement only takes place if the physiological conditions of the pregnancy are verified. The tests are carried out by applying parameters decided according to the medical model, which tends to trigger the protocol of a risk pregnancy even under conditions that in the midwifery model are considered simply elements to be kept under control. On the other hand, integration and collaboration with the public system are envisioned as a way to enable a wider group of women to access homebirth, and to overcome the stigmatization of this reproductive choice.

3.3 Subculture: a different view on the woman's body and birth

Parents who choose to give birth at home, along with their children, domiciliary midwives and doulas, form networks that share a sub-culture with a set of common values about pregnancy, birth, and parenthood that are different from those of the dominant birth culture in Italy. According to sociologist Katz Rothman, they seek to give childbirth a meaning that contrasts with the medical and mechanical view of the body (Katz Rothman 2016).

> What makes the difference is the possibility of fully experiencing this life event - which, from my point of view, is not a medical moment but a family one, something that deserves to be honoured, just like death. I don't accept that a person should have to die in a hospital, surrounded by tubes. They have the right to die at home, with their family - and the same goes for birth (midwife).

Case maternità (Quattrocchi 2014) are key physical spaces in the development of this subculture, serving as hubs for building relationships and networks among families. Within these spaces, experiences, information, and parenting advice are shared, alongside a focus on the psycho-physical well-being of women and children. Within these networks, new parents share their choice of giving birth at home as a known and accepted experience which cannot be discussed so overtly outside these networks.

> Our choice was not welcomed by those around us; even the pediatrician called us crazy and reckless. We have been labeled as extravagant and eccentric; people say, "Why can't you just do what everyone else does!?" I see surprise in others when I tell them that my son was born at home, they ask me "Was it by choice and you couldn't make to the hospital?" It feels like you have to start a whole conversation from scratch... and then you hear "but we're not living in the pre-war era!" Very few people looked at our choice with admiration (homebirther, mother).

A core belief in this sub-culture is that women have the skills and resources needed to carry out childbirth at their own pace, that mother and foetus form a collaborative dyad, and that labour is a physiological process rooted in the body, which is capable of activating endogenous solutions to temporary complications and restoring balance, provided there is the freedom to feel: in this view, a calm environment, combined with birth attendants who listen to the woman's needs and offer gentle care are essential ingredients for uterus relaxation and smooth labour (Cheyney 2011; Kitzinger 1995). The physical pain caused by contractions is accepted as part of a physiological process in which oxytocin is released and helps the woman to connect with her body and the foetus (Akbaş et al. 2022).

Birth is understood as a transformative and transcendent event for women: through a full experience of birth, the woman goes through an empowerment process that involves her self-esteem, her feminine power and her new role as a mother (Gaskin 1975; Klassen 2001). Through the active management of her labour, at her own peace, she gains the confidence to take care of the child and to question social norms and medical advice on child rearing.

> If a woman has a good birth, she comes out it feeling competent, she doesn't need to delegate to anyone, she doesn't need to go to the pediatrician and ask others how her child is: the baby is with her, she sees how they are doing. It's a powerful reclaiming of skills. Even within the couple she comes out stronger. The man who is close to her recognises her inner strength (midwife).

Birth in this niche is considered a social event with important repercussions on family life and society at large, also in terms of female emancipation and gender equality: the active and full involvement of the partner at the woman's side, during pregnancy training and labour, is propaedeutic to their participation in infant care at an equal level with the mother; also, the woman finds her strength recognised in the father's eyes.

> The father's role in childbirth is given by the woman. I assisted women who did not give birth until the husband returned from a trip, and others who waited until the husband left (midwife).

> I strongly believe that there are profound differences between men and women, and that it is beautiful that nature made us different; in the encounter of our differences we chose to walk through life together. When it comes to birth, one of us carries more weight in the decision: because it happens in her body … I trusted her choice and supported it … (homebirther, father).

> The relationship changes in the couple. Childbirth becomes a basis for the future and you are able to face future challenges together (doula).

3.4 Preventing endemic violence

Positive experiences in homebirth are described as unique and inherent to this model of care. This stands in stark contrast to routine practices and recurring accounts of medicalised hospital birth, where women feel vulnerable to arbitrary decisions made by medical staff disregarding their requests and emotional needs. It is a common belief, based both on personal experience and on others' narratives, that a woman's embodied ability to safely regulate her labour is hindered in the hospital, a setting grounded in the domain of science and technology, where the body is constrained in standardised timing and positions, as in a factory, and is often violated. In such an environment, feelings of joy and pain, as well as women's own judgment about what is happening, are subordinated to organisational needs and medical authority. These alienating conditions are considered iatrogenic (Illich 1995; Liese et al. 2021) as they can lead to blockages, complications, trauma, and negative consequences on the mother-foetus relationship.

> In the hospital, they put their hands everywhere… the woman feels violated… after a while in the delivery room, she ends up having a caesarean because, in the end, it feels more dignified. At home, by contrast, a woman's power and freedom are acknowledged (midwife).

> In hospitals, there are mechanisms that are disrespectful to women and to the emotions of the baby. The woman is subjected to the doctor, to the power of the hospital, to cultural dynamics [...]. In the hospital, I heard women whispering "this happened to me, that too," but these stories stay there unspoken because outside there is a cultural system outside that tells you "What are you complaining about? You have your child in your arms…" It is a gratuitous wound inflicted on us as women and by extension on the family. You can see how a woman's gaze changes when she is invited to reflect on her birth experience.

Women — and their partners as well — often feel disempowered in the hospital, as they are unable to protect their newborn from routine screenings, cleanings and measurements that are perceived as unnecessary, postponable, and potentiality harmful to the baby's health and personality.

> We wanted the baby to be respected too, unlike what happened with my first child, who was born in the hospital. Because his bilirubin levels were a bit high, they gave him phototherapy. He wasn't over the limit, but they said they wanted to do it anyway, just to be safe. It felt like a violation — he was so little, just born, and had to stay under the lamp with those little goggles on. I started feeling anxious because they told me he had to stay there as much as possible. (mother, homebirther).

Since birth is seen as a rite of passage in which societal values are expressed (Davis-Floyd 1992), it is believed that medicalised birth imprints society's violent values on human beings (Leboyer 1974). If the child comes into the world through practices that are insensitive to their subjectivity, bewilderment and fear, a violent and hierarchical societal model is reiterated. Hence, alternative birth advocates believe that changing the way we come into the world constitutes an act of social transformation. A common belief is that there will be no peace as long as children are born this way.

In this vein, domiciliary midwives do not clean the baby immediately after birth, but encourage a calm and deep connection with the mother and the father while waiting for the placenta to be delivered. Cord clumping is also seen as an act of violence, as it interrupts the natural transfusion of blood from the placenta to the newborn and affects the baby's spiritual balance. Homebirthers are therefore introduced to the practice of lotus birth, which involves keeping the placenta attached to the baby for a few days, wrapped in cloths (Zinsser 2018).

4 Bridging homebirth to the obstetric violence construct

From the above discussion, it is noteworthy that the preference for domiciliary birth services is partly driven by a perception of hospital birth as structurally insensitive and unresponsive to the woman's will and feelings, indeed, even humiliating and potentially dangerous for the health and wellbeing of both birthing women and their babies. This perception clearly aligns with the theoretical construct of obstetric violence: the collected testimonies point to the structural and embedded nature of perceived violence in birth facilities, tracing its roots to the very framing of childbirth as a pathology and a medical event, with little to no active engagement of the patients. As mentioned in the Introduction, a distinctive feature of obstetric violence theory is its emphasis on the systematic dimension of abuse in reproductive healthcare and the structural factors underlying negative experiences of childbirth. It identifies as a primary cause the routine interference in the physiological processes of pregnancy and childbirth through the application of medical practices

that are not always necessary and for which a real and fully informed consent has not been obtained.

Despite the similarity in the meanings attributed to birth and in their critiques of medicalised birth, it is important to note that the obstetric violence movement and the homebirth movement run often on parallel and separate paths, as they engage in different types of actions and fields of intervention. While domiciliary midwives, through their organizations, primarily focus on their daily professional practice and on raising public awareness on the birth options they offer, the concept of obstetric violence is more commonly advanced through activism, advocacy and academic research, with the aim of bringing about structural change in mainstream maternity services; in other words, while the former provides an alternative for women, the latter seeks to change the norm. Associations of domiciliary midwives tend not to take sides in controversial debates in the field of reproduction, in order to avoid interferences with their core mission of supporting women, regardless of their personal choices. That said, the separation between the two fields of action is not absolute: birth professionals do occasionally participate in advocacy initiatives promoted by other social movements, including those addressing obstetric violence.

Interestingly, this study highlighted a widespread discontent with the term obstetric violence: on the one hand, the term is now well-known and increasingly accepted, on the other, it remains unconvincing to many. One core perplexity raised by research participants is that obstetric violence is too wide a category, encompassing features so diverse as to make the phenomenon difficult to define and identify (Dixon 2022). Linked to this point is an epistemological issue embedded in the very theoretical construct of obstetric violence as a social problem which can be identified either by looking at over-medicalisation rates (Quattrocchi 2024) or at the women's subjective experiences (Annborn and Finnbogadóttir 2022). Birth professionals raise compelling questions about whether certain medical practices – such as those not perceived as violent by the parturient herself or even actively requested – can still be considered forms of obstetric violence. One case in point is elective C-section.

> There is also a lot of normalised violence. Some women actually seek out violent procedures to give birth. Younger women ask for C-sections, for separation from the newborn. Maybe ten years ago, there was more interest in natural birth; now it seems that we are moving towards violent birth on demand (doula).

Furthermore, research participants highlight how individual perceptions of birth experiences are shaped by cultural norms that legitimise asymmetrical relational dynamics between patients and medical staff. These perceptions also evolve over time, partly due to the influence of collective movements such as the one raising

awareness on obstetric violence. Naturalisation is a core point addressed in the obstetric violence literature: violence is not always visible and recognised, neither by healthcare providers nor by women themselves, as it is often naturalised within healthcare practices, professional cultures, and the contemporary imaginary of childbirth as a medical event managed by experts whom women are culturally expected to trust (Antonelli 2016). This gives rise to questions about the reliability of women's subjective perceptions of their birth experiences, given that such perceptions shift in relation to broader cultural changes regarding what behaviours are deemed acceptable or condemnable. Women who are today socialised with the new sensibilities introduced by the obstetric violence collective movement may come to reinterpret as violent those treatments and experiences that had previously gone unquestioned.

> It depends a lot on perception. I had a very medicalised birth, but I didn't perceive it as violent, because my expectations hadn't been shaped by any discussion around obstetric violence. And that has a great impact on birth outcomes. A lot depends on the subject's perception, more than on the action itself (perinatal educator).

5 Conclusions

Through the concept of obstetric violence, routine medical intervention is positioned in opposition to the physiology of the female body, understood as a spontaneous and self-regulating process, which the interventionist approach of obstetrics has traditionally viewed as imperfect and risky. The woman's will is generally seen as being at odds with medical practices, which are routinely applied precisely because women are often not adequately consulted. Only in cases where there is both an explicit request from the woman and a real medical need, would medicalisation not be considered a form of violence. In this view, medicalisation is portrayed as being in opposition to physiology and to the woman's will, on the assumption that, if adequately encouraged, the latter would allow for a more selective case-by-case application of interventions. A central theme in the discourse on obstetric violence is precisely the imbalance between the authority of medical knowledge and the low consideration of the bodily, intellectual and emotional knowledge of women, an imbalance that supports the structural indifference to the individual's preferences regarding childbirth.

In homebirth, respect for the woman's decision-making is a central value, fulfilled within the boundaries of healthy pregnancies and midwifery care that is committed to the preserving physiology through minimal intervention. Homebirth is therefore configured as an affirmative choice — possible only under certain

conditions (access to midwives, appropriate health status, economic resources) — that transgresses the social norm of medicalised birth: thus, the individual decision to give birth at home becomes both a critique of the dominant model and a personal strategy to avoid the risk of experiencing obstetric violence in healthcare facilities. However, as discussed in Part 3, the alternative character of this practice prevents homebirth from constituting a collective solution to obstetric violence. To express its collective potential, homebirth experiences and the care models offered by domiciliary professionals should be studied and recognised as evidence of the concrete possibility of removing childbirth from the widespread association with vulnerability to violence. The legitimisation of homebirth as an individual procreative choice, supported through improved access to this service and accurate information, would represent an important step in the collective critique of dominant birth practices and, consequently, in the necessary modification of medicalised childbirth.

References

Annborn Anna, and Hafrún Rafnar Finnbogadóttir. 2022. "Obstetric Violence a Qualitative Interview Study". *Midwifery* 105: 103212.

Akbaş, Pınar, Özkan Şat, Sultan, and Şengül Yaman Sözbir. 2022. "The Effect of Holistic Birth Support Strategies on Coping With Labor Pain, Birth Satisfaction, and Fear of Childbirth: A Randomized, Triple-Blind, Controlled Trial". *Clinical Nursing Research* 31 (7): 1352–1361. https://doi.org/10.1177/10547738221103329.

Antonelli, Francesco. 2016. "La violenza ostetrica: Ipotesi interpretative su una categoria in ascesa". *Autonomie Locali e Servizi Sociali* 2: 265–279.

Benaglia, Brenda, and Daniela Canzini. 2021. "They Would Have Stopped Births, If They Only Could Have: Short-and Long-term Impacts of the COVID-19 Pandemic. A Case Study from Bologna, Italy". *Frontiers in Sociology* 21:173–181.

Brigidi, Serena, and Marta Busquets-Gallego. 2019. "Interseccionalidades de género y violencias obstétricas". *MUSAS. Revista De Investigación En Mujer, Salud Y Sociedad* 4 (2): 37–52.

Campiotti, Marta, Rita Campi, Michele Zanetti, Paola Olivieri, Alice Faggianelli and Maurizio Bonati. 2018. "Nascite a basso rischio programmate fuori dall'ospedale in Italia". *Ricerca e Pratica* 34 (2): 58–66.

Cheyney, Melissa, 2011. "Reinscribing the Birthing Body: Homebirth as Ritual Performance". *Medical Anthropology Quarterly* 25 (4): 519–542.

Christiaens, Wendy, and Piet Bracke. 2009. "Place of Birth and Satisfaction in Childbirth in Belgium and the Netherlands". *Midwifery* 25 (2): 11–19.

Coddington, Rebecca, Christine Catling and Caroline S.E. Homer. 2017. "From Hospital to Home: Australian Midwives' Experiences of Transitioning into Publicly-funded Homebirth Programs". *Women and Birth* 30 (1): 70–76.

Conesa Ferrer, Ma Bélen, Jordana Manuel Canteras, Carmen Ballesteros Meseguer, César Carrillo García, and M. Emilia Martínez Roche. 2016. "Comparative Study Analysing Women's Childbirth Satisfaction and Obstetric Outcomes across Two Different Models of Maternity Care." *BMJ Open* 6 (8): e011362. https://doi.org/10.1136/bmjopen-2016-011362.

Cramer, Renée Ann. 2021. *Birthing a Movement. Midwives, Law, And the Politics of Reproductive Care*. Stanford University Press.

Craven, Christa. 2010. *Pushing for Midwives: Homebirth Mothers and the Reproductive Rights Movement*. Temple University Press.

Davis-Floyd, Robbie. 1992. *Birth as an American Rite of Passage*. University of California Press.

Davis-Floyd, Robbie. 2001. "The Technocratic, Humanistic, and Holistic Paradigms of Childbirth". *International Journal of Gynaecology and Obstetrics* 75 Suppl 1: 5–23.

Davis-Floyd, Robbie and Ashish Premkumar, eds. (2023) *Obstetric Violence and Systemic Disparities: Can Obstetrics Be Humanized and Decolonized?* Bergham.

Daviss, Betty-Anne. 2006. "From Calling to Career: Keeping the Social Movement in the Professional Project". In *Mainstreaming Midwives. The Politics of Change*, edited by Robbie Davis-Floyd and Christine Barbara Johnson. Taylor and Francis.

De Sanctis, Davide, Sara Fariello and Irene Strazzeri. 2020. *Sociologia della maternità*. Mimesis.

De Vries, Raymond 2005. *Pleasing Birth: Midwives and Maternity Care in the Netherlands*. Amsterdam University Press.

Dixon, Lydia Z. 2022. "'Everything is Obstetric Violence Now': Contextualizing the Movement in Mexico". In *Obstetric Violence: Realities, and Resistance from Around the World*, edited by Angela N. Castañeda, Julie Johnson Searcy, and Nicole Hill. Demeter Press.

Fedele, Anna. 2016. "Holistic Mothers or Bad Mothers? Challenging Biomedical Models of the Body in Portugal". *Religion & Gender* 6 (1): 95-111.

Galera-Barbero, Trinidad María, and Gabriel Aguilera-Manrique. 2022. "Women's Reasons and Motivations around Planning a Home Birth with a Qualified Midwife in Spain". *Journal of Advanced Nursing* 78 (8): 2608–2621.

Galková, Gabriela, Pavel Böhm, Zdeněk Hon, Tomáš Heřman, Radan Doubrava, and Leoš Navrátil. 2022. "Comparison of Frequency of Home Births in the Member States of the EU between 2015 and 2019". *Global Pediatric Health* 9: 1–18.

Gaskin, Ina May. 1975. *Spiritual Midwifery*. Book Publishing Company.

Houd, Susanne, Hans Christian Florian Sørensen, Jette Aaroe Clausen, and Rikke Damkjær Maimburg. 2022. "Giving Birth in Rural Arctic Greenland. Results from an Eastern Greenlandic Birth Cohort". *International Journal of Circumpolar Health* 81 (1): 1–10.

Jackson, Melanie K., Virginia Schmied, and Hannah G. Dahlen. 2020. "Birthing Outside the System: The Motivation Behind the Choice to Freebirth or Have a Homebirth with Risk Factors in Australia". *BMC Pregnancy Childbirth* 20: 254–267.

Johanson, Richard, Mary Newburn, and Alison Macfarlane. 2002. "Has the Medicalisation of Childbirth Gone Too Far?". *BMJ* (Clinical research ed.) 324 (7342): 892–895.

Katz Rothman, Barbara. 1982. *In Labor. Women and Power in the Birthplace*. W.W. Norton and Company.

Katz Rothman, Barbara. 2016. *A Bun in the Oven. How the Food and Birth Movements Resist Industrialization*. New York University Press.

Klassen, Pamela E. 2001. "Sacred Maternities and Postbiomedical Bodies: Religion and Nature in Contemporary Home Birth". *Signs: Journal of Women in Culture and Society* 26 (3): 776–809.

Kitzinger, Sheila. 1995. *Homebirth and Other Alternatives to Hospital*. Dorling Kindersley.

Illich, Ivan. 1995. *Limits to Medicine: Medical Nemesis and the Expropriation of Health.* Marion Boyars.

Jensen Sabrina, Lotte B, Colmorn, Anne-Mette Schroll, and Lone Krebs. 2017. "Quality Assessment of Home Births in Denmark". *Danish Medical Journal*, 64 (5): 53–67.

Lang, Raven. 1978. *Riprendiamoci il parto*. Savelli.

Leboyer, Frédérick. 1974. *Pour une naissance sans violence*. SEUIL.

Liese L. Kylea, Robbie Davis-Floyd, Karie Stewart, and Melissa Cheyney. 2021. “Obstetric Iatrogenesis in the United States: The Spectrum of Unintentional Harm, Disrespect, Violence, and Abuse”. *Anthropology and Medicine* 28 (2): 188–204.

Mac Donald, Margaret. 2001. “Postmodern Negotiations with Medical Technology: the Role of Midwifery Clients in the New Midwifery in Canada”. *Medical Anthropology, Cross-Cultural Studies in Health and Illness* 20 (2): 245–276

Mac Donald, Margaret. 2004. “Tradition as a Political Symbol in the New Midwifery in Canada”. In *Reconceiving Midwifery*, edited by Ivy Lynn Bourgeault, Cecilia Benoit and Robbie Davis-Floyd. McGill-Queen's University Press.

Ministero della Salute. 2021. “Certificato di Assistenza al Parto (CEDAP). Analisi dell'evento nascita–anno 2020.” https://www.salute.gov.it/imgs/C_17_pubblicazioni_3149_allegato.pdf (last accessed September 23, 2025).

Olsen, Ole, and Jette A. Clausen. 2012 “Planned Hospital Birth Versus Planned Home Birth”. *Cochrane Database Systematic Review* 9 (9).

Perrotta, D. 2009. “Il parto conteso. L’ostetrica tra discorso medico e discorso umanizzante”. *Etnografia e ricerca qualitativa* 3: 383–412.

Pizzini, Franca. 2001. “La costruzione sociale della gravidanza e del parto”. In *Sociologia della salute*, edited by Massimiano Bucchi and Federico Neresini. Carocci.

Quattrocchi, Patrizia. 2014. “Homebirth and the National Health Service in Italy. A Qualitative Study in the Emilia-Romagna Region” *Revue Canadienne de la recherche et de la pratique sage-femme* 13 (3): 32–39.

Quattrocchi, Patrizia. 2024. *Obstetric Violence in the European Union – Situational analysis and Policy Recommendations*. Publications Office of the European Union, European Commission, Directorate-General for Justice and Consumers. https://op.europa.eu/en/publication-detail/-/publication/74238fad-0b63-11ef-a251-01aa75ed71a1/language-en (last accessed September 23, 2025).

Ravaldi, Claudia, Elena Skoko, Alessandra Battisti, Michela Cericco, and Alfredo Vannacci. 2018. “Sociodemographic Characteristics of Women participating to the LOVE-THEM (Listening to Obstetric Violence Experiences Through Enunciations and Measurement) Investigation in Italy.” *Data in Brief* 19: 226–229. https://doi.org/10.1016/j.dib.2018.04.146.

Reitsma, Angela, Julia Simionia, Ginny Bruntonb, Karyn Kaufmana, and Eileen K. Hutton. 2020. “Maternal Outcomes and Birth Interventions Among Women Who Begin Labour Intending to Give Birth at Home Compared to Women of Low Obstetrical Risk Who Intend to Give Birth in Hospital: A Systematic Review and Meta-analyses”. *E-clinical Medicine (The Lancet)* 21. https://doi.org/10.1016/j.eclinm.2020.100319.

Rocca-Ihenacho, Lucia, and Cristina Alonso. 2020. “Where Do Women Birth During a Pandemic? Changing Perspectives on Safe Motherhood During the COVID-19 Pandemic”. *Journal of Global Health Science* 2 (1): 1–9.

Sadler, Michelle, Mário Jds Santos, Dolores Ruiz-Berdún, et al. 2016. “Moving Beyond Disrespect and Abuse: Addressing the Structural Dimensions of Obstetric Violence”. *Reproductive Health Matters* 24 (47): 47–55.

Scarf, L. Vanessa, Chris Rossiter, Saraswathi Vedam, et al. 2018. “Maternal and Perinatal Outcomes by Planned Place of Birth Among Women with Low-Risk Pregnancies in High-Income Countries: A Systematic Review and Meta-Analysis”. *Midwifery* 62: 240–255.

Schmid, Verena. 1992. “Figura e compiti dell'ostetrica. Problemi aperti e possibilità di evoluzione”. In *Come sapere il parto: storia, scenari, linguaggi*, edited by Marina Sbisà. Rosenberg and Sellier.

Sestito, Rosanna. 2022. “Covid-19: restare a casa o andare in ospedale per partorire? Intervista con Gabriella Pacini”. In *Coronial. Antropologia della riproduzione e delle sessualità al tempo del Covid-19*, edited by Lucia Gentile, Chiara Quagliariello and Rosanna Sestito. Franco Angeli.

Spina, Elena. 2023. “The Several Faces of the Medicalization of Birth. Italy and its Peculiarities”. *Frontiers in Sociology*, 8. https://doi.org/10.3389/fsoc.2023.1000518.

Surtees, Ruth Joy. 2003. *Midwifery as Feminist Praxis in Aotearoa/New Zealand*, PhD thesis. University of Canterbury.

Viisainen, Kirsi. 2000. “The Moral Dangers of Home Birth: Parents’ Perceptions of Risks in Home Birth in Finland”. *Sociology of Health and Illness* 6 (1): 792–814.

WHO. 1996. “Care in Normal Birth. A Practical Guide.” World Health 1: 31.

Zielinski, Ruth, Kelly Ackerson and Lisa Kane Low. 2015. “Planned home birth: benefits, risks, and opportunities”. *International Journal of Women's Health* 8 (7): 361–377.

Zinsser, Laura A. 2018. “Lotus Birth, a Holistic Approach on Physiological Cord Clamping”. *Women and Birth* 31 (2): 73–76.

Irene Strazzeri, Anna Maria Rizzo, Chiara Spagnolo

Obstetric Violence: Between Recognition of Rights and Trust in Transformation

Abstract: Obstetric violence denotes the mistreatment, abuse, or neglect that women may endure during childbirth, frequently perpetrated by healthcare professionals. The concepts of trust and transformation are pivotal in addressing this phenomenon and in restoring the historically rooted relationship between women, their bodies, and midwifery care. Traditionally, this bond was embedded within culturally rich frameworks, wherein childbirth knowledge and practices were transmitted orally across generations. However, the contemporary predominance of highly medicalised—and at times coercive — approaches to childbirth has significantly eroded this trust, disrupting the relational continuity between birthing individuals and their caregivers.

1 Introduction

This paper proposes to consider obstetric violence a distinct form of gender-based violence. The reflection will focus on the woman's body, which is often seen as the "object" of medical and social control even within the context of maternity.

The first part of this paper will address the processes of medicalisation (Meo 2014) that have profoundly influenced the way women's reproductive bodies are observed, perceived, and controlled. Over time, the female body has been redefined in biological terms, being regarded as a system to be monitored and corrected, with the menstrual cycle, pregnancy, childbirth, and menopause increasingly falling under the domain of medical sciences. Although for centuries childbirth was a private event, managed by women within the domestic sphere, the advancement of science and technology led to healthcare professionals gradually taking care of pregnant women and dealing with the physiology of childbirth. This shift significantly reduced the risks associated with complications from home births, while contributing to a rise in unnecessary medical interventions. Consequently, the scientific evolution of childbirth care has highlighted both the invasive nature of

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interventions —such as induced labour, episiotomy, and caesarean section — and the resulting indirect erosion of pregnant women's decision-making power.

In the second part of this paper, a comparison will be made between different cultural practices related to childbirth (Quattrocchi 2011). On the one hand, childbirth will be shown to be a hospital-based event in Western societies. On the other hand, the importance of home birth in non-Western cultures will be highlighted, revealing how the process is characterised by strong rituals and social norms, with specialised midwives attending to the mother's psychophysical well-being and making childbirth a natural experience. Yet, despite such cultural differences, globalisation has gradually led to non-Western childbirth practices increasingly resembling the "rituals" associated with Western childbirth (Quattrocchi 2001).

Finally, the paper addresses female genital mutilation as a specific case of obstetric violence, focusing in particular on the implications that infibulation and de-infibulation may have on childbirth. By examining the physical and institutional consequences of these practices, the analysis highlights how they can deeply affect women's reproductive experiences, positioning them within a broader framework of structural and gender-based violence in obstetric care. The discussion situates them within a broader critique of the structural and gendered dimensions of reproductive healthcare.

Conventionally described as the result of unnecessary medical interventions, lack of informed consent, and dehumanising treatment, obstetric violence leads to women being deprived of their freedom before, during, and after childbirth. Therefore, obstetric violence should be denounced and recognised as a distinct form of gender-based violence.

1.1 Women's bodies between myth and medicalisation

Throughout history, female body has often been alienated from its own physicality, which has been shaped and constructed based on the pleasures of others. Women and their bodies have been associated with both motherhood and seduction, systems of meaning that have absorbed female subjectivity. Paradoxically, both aspects are most often described and narrated by men. As a result, women have been estranged from their own bodies. They have started questioning the extent to which they actually know themselves, reflecting on the nature of their desires.

Since ancient times, various social transformations have impacted the patriarchal social order, with women embarking on a journey of (re)discovery of their own desires and, more in general, their physicality. The evolution of the female body throughout history has been widely debated by feminist movements (Melandri

1993, 7). The theories they developed in the 1970s have revolutionised the concept of the body itself, placing it at the centre of public and political discourse.

By analysing the labelling of the female body over time, Alice Manfroni has shown that, particularly in Western societies, it has been considered the emblem of fertility and reproduction. While it has been regarded as a sensitive and delicate body, whose disturbances may lead to dangerous and devastating consequences (Manfroni 2022), it has also been conceptualised as strong and resilient. Michel Foucault has often highlighted such characteristics through his reflection on medical sciences. The French philosopher maintained that, since the twentieth century, the function of the body has progressively been regulated and legitimised by medical knowledge, with the understanding of the female body being increasingly grounded in essentialist and biological aspects (Foucault 1978). Such a narrative has sparked a fierce debate on rights. On 24 June 2022, the Supreme Court of the United States overturned the federal protection of abortion rights, making it clear that the female body has been — and continues to be — at the centre of a conflict between the will to control women and their self-determination (McKenzie 2024).

Anthropological studies offer crucial contributions to the dissemination of new perspectives on physicality, beginning with the recognition of the female body as a historically situated category that acquires different meanings depending on its specific cultural and social context (Marone 2003). Understood as a historical category, the female body emerges as a site where power relations and social tensions are enacted and displayed. A true political arena for identity struggles, it is seen as the political subject in which power is exercised and negotiated. Indeed, the woman-reproduction pairing pervades the Western sociocultural context and unsurprisingly underpins the concept of "women's health," particularly when it becomes the focus of state-sponsored prevention and protection campaigns. Repeated attempts to revoke the right to abortion clearly show how "women's health" is ideologically linked to female genitalia and solely associated with sexual and reproductive health.

According to Manfroni, feminist movements have been fundamental to the cultural and political redefinition of the female body, as they fought to secure rights such as abortion and access to contraception. These rights have long been central to the political debate, as they entail the recognition of women's sovereignty. In advanced modern societies, the medicalisation of the female body, through the ongoing development of assisted reproductive technologies (Meo 2014), opens up new horizons in relation to maternity and sexuality, thereby challenging traditional models. At the same time, the experiences of non-Western, non-white, non-heterosexual women prompt reflection on the need to go beyond a universal and uniform conception of the female body. This means acknowledging the experiences of non-Western, Black, and transgender women. A new perspective is needed

that accounts for the political and social conditioning impacting the female reproductive body, which should be considered in terms of a woman's experiences, transcending essentialism and purely biological factors. The use of the plural category "women's bodies" can serve as a first step towards legitimising and recognising the multiplicity of women's experiences, practices, and identities. This is a path that advances, retreats, and shifts direction, constantly seeking new ways to affirm emerging and unpredictable subjectivities.

Women's subjectivity remained at the heart of debates throughout the twentieth century, with the female body undergoing a long process of transformation from an idealised to an objectified form. As Francesca Buccini (2023) has pointed out, the depiction of the soul, the lover, and the female body is central to Aristotle's works. His concept of woman-as-matter portrays women as confined to the domestic sphere, with their perceived inferiority being justified by the anatomy of their bodies, which passively receive the vitality of male semen, the sole source of life. In this framework, man's power is exercised both materially, through the division of gender roles and labour, and symbolically, as an expression of an androcentric culture in which the subjugation of women is regarded as a natural fact (Buccini 2023, 27). The female body was so stigmatised and subjected to manipulation that women were indoctrinated to accept the roles to which they were assigned. Taking a stand on their own bodies and sexuality enabled them to become more self-aware, reject a series of paralysing and conditioning sexual models, and gain a new familiarity with their own desires (Manfroni 2022). Since the 1970s, women have developed a new self-awareness, beginning to recognise the wisdom and experience embedded in their physicality, finally seen as a source of power rather than a limitation. At the same time, the female body became an object of male envy that could cause social tension, as generative capacity can only be experienced through maternity, thus instilling fear and creating anxiety in the male world (Marone 2003).

Contemporary Western society tends to standardise the image of young, attractive and seductive women. As a result, the imposed aesthetic ideal is that of a successful woman who does not conform to the traditional role of wife or mother. Yet, the female body continues to be objectified, as such a model is not universally accessible. In this context, Michael Foucault speaks of biopower, which is exercised through self-surveillance and control over the body, particularly the female body, which has long been the site of social struggle and the target of male domination — a dynamic that continues to threaten women's freedom (Foucault 1978). Women's bodies, constantly objectified and sexualised, are subjected to a form of oppression that is also rooted in the relationship between female identity and physical appearance. This results in women being often evaluated based more on their outward appearance than their personality. The gaze through which they view themselves is a male gaze, internalised to the extent that it influences their

subjectivity. By objectifying themselves through the male gaze, women tend to compare their bodies with those of others, assessing themselves according to male standards and focusing on an ideal that values a slender figure, large breasts, full lips, and wrinkle-free skin (Ulivieri 1995, 19). This translates into women perceiving themselves as inferior, which pushes them to pursue such an assumed ideal of femininity, even to the extent of modifying their bodies surgically (Strazzeri 2013, 44–45).

This dynamic intersects significantly with the broader process of medicalisation, which increasingly frames women's bodies as objects to be monitored, corrected, and controlled. In this context, physical well-being and optimal health become central concerns, not only from a personal perspective but also within the expanding scope of the doctor-patient relationship. Medicine, rather than supporting holistic wellness, often prioritises the treatment of illness, leading to a form of encroachment on individual autonomy. Medicalisation thus encompasses the growing reliance on technologically advanced procedures, hospitalisation, pharmaceutical interventions, and other forms of medical control — practices that can reinforce normative ideals of femininity and perpetuate gendered expectations about the female body.

Foucault's socio-clinical perspective offers a horizontal reconstruction of the human body in the hospital bed, "as if it were a corpse still alive," thereby suggesting that the key to understanding modern medicine lies in a vertical conception of the body — an unprecedented form of hierarchical knowledge (Foucault 1978, 65–66). Foucault highlighted the modern mechanisms of control over the body: the patient becomes nothing more than a sick body, which can be cut open, sutured, and potentially dissected. As such, the body loses its status as a socially interactive human corpus (Foucault 1978, 66). Yet, a patient who entrusts their health and deepest experience to a physician has the right to feel safe and be acknowledged as a whole person. In this sense, medical deontology does not require compassion, but rather involvement in a patient's psychophysical health and suffering, when pain or discomfort is evident. According to the Hippocratic Oath, a physician needs to overcome personal biases, refraining from imposing their beliefs or expressing regret before a patient (Fortuna 2021). The contemporary physician has become more of a specialist who makes choices based on data, measurements, and clinical analysis. Contemporary medical practice is incomparable to that of the past, as specialist medicine has replaced generalist medicine, with diagnoses being now fully recognised even by patients themselves.

In the context of the technical transformation of medicine, the concept of health prevention emerges: medicine is no longer a science that simply cures disease, but rather one that detects, hypotheses, and prevents it. As a result, during pregnancy, medical dependence gains the strength of a moral imperative: certain

actions are forbidden or advised against, with the failure to follow guidelines causing feelings of guilt. In the United States, it has become possible for children to bring legal claims based on omissions in the care provided to their mothers during pregnancy or childbirth. Therefore, a woman may be seen as a potential "bad mother" as early as during pregnancy: anything that happens to the child while growing up may be traced back to the way the mother experienced pregnancy. Prevention takes on the characteristics of an investment in a better future. Consequently, adequate medical and psychological training becomes necessary, in order for healthcare professionals supporting pregnant women not to contribute to the physical and psychological difficulties women may already face. The issue of training — particularly for midwives — is especially sensitive, as it is currently shaped by both the integrity of the trainer and market-driven considerations. According to Chervenak and McCullough (2001), all healthcare workers should demonstrate four professional qualities: integrity, compassion, self-effacement, and self-sacrifice.

1.2 Cultural idols and stereotypes about the maternal body

In her novel *Frantumaglia*, Elena Ferrante writes that "the task of a woman writer today is not to stop at the pleasures of the pregnant body, of childbirth, of childcare, but to go with truth to the darkest depths" (Ferrante 2016, 7). In its original Italian version, this passage opens the first chapter of Adriana Cavarero's *Donne che allattano cuccioli di lupo*, a work that explores the symbolic and cultural meanings of maternity (Cavarero 2023, 4).

According to Cavarero, maternity is not celebrated through mystical or ecstatic imagery. Life as a form of creative energy is neither idealised nor represented as a complete fusion between the mother and the life process but is rather portrayed as a concrete experience. Being a mother means undergoing a profound experience marked by what Cavarero terms "the tremendous." This concept refers to the repulsion caused by the physical and carnal reality of generating another life. At the centre of the discourse lies the maternal body, the site where a new human being is formed. However, birth is considered a moment of separation, as a new life emerges — distinct and singular — from the mother's body. Childbirth is often framed in opposition to death, which is described as a return to indistinct matter. Cavarero refers to the "dark side" of motherhood when analysing the intimate and profound experience of pregnancy, during which a woman feels at one with her child and perceives another life within herself. Comparable to certain representations in the Christian tradition, such as the Madonna with Child, this idea commonly evokes only the bright and serene side of motherhood. Conversely, Cavarero aims

at highlighting that motherhood is actually conflict, fear, and self-transformation following childbirth.

In Ireland and elsewhere in Europe, sheela na gig carvings can be admired in churches or on walls. Dating back to pre-Christian times, a sheela na gig is a carving of a squatting woman displaying an exaggerated vulva, which she enlarges with her own hands. She represents the generative power of mothers. Everyone is born from a mother's body, a body that opens to give birth to another living being — another singular living being that has grown and moved in the womb before emerging through the vagina.

In Greece, the story of Baubo is widespread. It is connected with the myth of Demeter, and thus with that of Mother Earth. Portrayed as a woman who lifts her robe to show her swollen belly and genitalia, Baubo has been described by Nietzsche (2011) as the female counterpart of Dionysus. The sculptures or statuettes of women with swollen bellies and large breasts that are disproportionate to the rest of their bodies symbolise the fertility of the female body. Such sculptures depict the Mother Goddess or Mother Earth, a deity known as Rhea, Cybele, Inanna, and Ishtar in different contexts.

Childbirth can be described as a living body breaking and opening in order to create another living body. Even the postpartum period continues to reflect this process of breaking and opening. Regarding the concept of the open body, Hannah Arendt has observed that the female body is, by nature, predisposed to tearing, while the male body may be imagined as invulnerable and intact (Arendt 1958). Arendt's observation may also be read as a reference to intercourse, as the tearing of the hymen during the first-time sexual experience may signify a profound violability of the female body. Between intercourse and childbirth, a woman may be seen as unable to claim full bodily integrity.

Several statuettes and rituals celebrate the cult of the "Great Mother." Among such statuettes, those depicting the Snake Goddess stand out, the most famous examples of which were discovered in the Palace of Knossos, in Crete. Symbols of the artistic sophistication of the Minoan civilisation, the faience figures portray the goddess in a flowing ceremonial dress, with exposed breasts, and holding two small snakes in her hands.

Large breasts symbolise not only femininity, but also the vital energy provided by breastmilk and bodily strength. This representation of nurturers alludes to the maenads, groups of women who accompanied a god and honoured him with drunkenness during ritual ceremonies. The maenads owe their name to the madness that Dionysus causes in them. The same mania is described in *The Bacchae* by Euripides (Euripides 2004). Nurturers devoted to Bacchus, the Bacchae experience a powerful sense of motherhood, breastfeeding both infants and cubs with their free flowing and intoxicating breastmilk. Just like wine, milk, and honey come from the earth

and nourish all living beings, the Bacchae breastfeed human and non-human beings alike, in a spontaneous and natural way. This may be understood as a nurturing exuberance tied to a kind of motherhood that knows no boundaries — a kind of hyper-motherhood, a feeding frenzy where the body nourishes other bodies, life nourishes life. Cavarero has also highlighted how the Bacchae experience biological pleasure, due to oxytocin flowing through their veins, this being a natural opioid whose effects combine with intoxication.

Cavarero's reference to Niobe being turned into stone is also crucial (Cavarero 2023, 73). As described in a passage from the Twelfth Canto of Dante's *Purgatorio*: "O Niobe, what tears afflicted me / when, on that path, I saw your effigy / among your slaughtered children, seven and seven!" (Alighieri, XII, 70–72). According to philologist Károly Kerény (1949), the name *Niobe* originates from Asia Minor and can be associated with the figure of the Great Mother, often identified with Mother Earth, a female body that generates living beings — human beings — with a certain disturbing ambiguity. Niobe exerts her power through procreation, having borne as many as fourteen children — seven sons and seven daughters — of whom she is proud, as is evident from Ovid's *Metamorphoses* (Ovidio 6). Niobe provides another example of maternity as a life-generating force. Her mythical figure evokes a specific concept of maternity, shaped by the numerical perfection of her offspring and the exaltation of the female body as a powerful generator of lives, as flesh that tears in procreation. In Ovid's version of the myth, men play no part in this story of hyper-maternity. Only Niobe's husband, Amphion, is mentioned as a role model, as he dies of grief at the loss of his children.

2 Childbirth between tradition and modernity: a cultural comparison

The ways in which women give birth raise questions that can be said to be political, rather than a mere matter of obstetrics. Women in labour, women who undergo voluntary termination of pregnancy, women who wait for their period, and women who take hormonal contraceptives never act in complete freedom. Every decision related to childbirth is influenced by moral and social norms.

In Judaeo-Christian theology, the pain of childbirth is seen as divine punishment, a curse placed on Eve in *Genesis*: women are condemned to suffer in giving birth. In 1591, a midwife named Agnes Simpson was burned alive for attempting to ease labour pain using opium or laudanum. In the nineteenth century, the use of chloroform was introduced to render women unconscious during childbirth, so that they would awaken with no memory of the experience.

In the eighteenth century, physician Benjamin Rush investigated childbirth practices among Native American women. He observed that childbirth occurred naturally, with women receiving little to no assistance, their labour being short and not particularly painful. After giving birth, women washed with cold water, which they did autonomously in their huts. They returned to their daily routines within a matter of days (Rush 1830). The image of the Aboriginal woman giving birth without pain, medical interventions, and complications is steeped in exoticism. Aboriginal women often became mothers at a very young age, usually in their teens. They rarely suffered from pelvic malformations and seldom contracted infections, as they gave birth on their own, avoiding physical contact with strangers. In medical writings on the subject, it is pointed out that an Aboriginal midwife's main responsibilities were to care for the mother during pregnancy, assist her during childbirth, help her with the expulsion of the placenta, cut the umbilical cord, and tend to the newborn.

On the other hand, Athenian midwives were more than just midwives, as they prescribed contraceptives, gave advice on sexual problems, and performed abortions. Often accompanied by priestesses, they chanted and cast spells to relieve labour. Physicians were forbidden to induce abortions, although they were the only ones who were allowed to perform an external cephalic version, a method used to turn a breech baby into a head-down position to facilitate delivery. In Egypt, the external cephalic version was already being performed as early as 1500 B.C. by priests, rather than midwives or physicians, who intervened only when delivery became particularly difficult. In Ancient Rome, three figures assisted the mother during childbirth: the midwife, the assistant, and the priestess who prayed for a safe delivery.

It was only after the Middle Ages, as obstetrics became increasingly influenced by male roles, that doctors began striving to save the life of the woman giving birth as well. At the same time, the role of the midwife in the childbirth process started to decline. Such a shift came to be symbolised by forceps, medical instruments that represent the art of obstetrics more than any other. Forceps were a commercial device, an invention that effectively eliminated the role of the midwife, cementing the male monopoly in childbirth.

Most women have always associated childbirth with fear, physical pain, death, and numerous superstitions. Birth pains play a key role in female perception. Patriarchy has imposed suffering on women in labour, with pain being considered necessary to give birth to an extraordinary child, especially if male. Women in labour were seen as those who gave life to heads of families, heirs, and soldiers destined to fight for the tribe or nation (Rich 2024, 200–215). The fear of birth pains in both primitive and advanced societies often stems from stories, phrases, and anecdotes, being further reinforced by literature. To emphasise this point, Adrienne Rich has

made reference to the passage in Tolstoj's *War and Peace* that describes Princess Lisa giving birth:

> The cries ceased. A few seconds passed. Suddenly a terrible scream — a scream not hers, for she could not scream like that — resounded from the room. Prince Andrei ran to the door; the scream ceased, and he heard the wailing of a newborn baby. A woman came out and, seeing Prince Andrei, stopped in confusion on the threshold. He entered. She lay in the same position as before, her head thrown back, her arms extended (Tolstoj 2007, 350).

In the patriarchal order, the child's life is valued more than the mother's. Another kind of fear is experienced: the fear of change, transformation, and the unknown. Pregnancy can be perceived as the death of a former self, as it involves profound changes in a woman's life. Even those who decide to place their child for adoption shortly after birth undergo irreversible physiological and psychic changes during pregnancy.

Anthropologist Brigitte Jordan has conducted a study on the experience of childbirth across different cultures. She described hospital-based childbirth in the United States as a sequence of interventions that are medically justified in the interest of both the mother's and baby's health. Such interventions include the induction and acceleration of labour through medication, and the routine administration of sedatives and analgesics. According to Jordan, depriving the woman in labour of psychological support, performing amniotomies and routine episiotomies, using forceps, and requiring the supine birthing position show that childbirth is a culturally conditioned event even in the United States, where the same method is adopted regardless of individual needs (Jordan, Davis-Floyd 1993). Although episiotomy is useful to prevent perineal tearing, lacerations are much more frequent when the woman is forced to give birth in the supine position than when squatting, using an obstetric chair, or lying in a hammock, as it is common in Yucatán. Similarly, the use of forceps becomes more likely in the lithotomy position, where gravity cannot aid in expelling the baby. In cultures as diverse as the Swedish and Yucatecan, women are actively involved in the decision-making process regarding childbirth (Jordan 1992, 102–106). In Yucatán, midwives emphasise that each woman needs to "buscar la forma," that is, find the position that is most comfortable for her, with the midwife assisting her while respecting her decision (Jordan 1992, 105).

3 Reproductive knowledge, health policy frameworks, and forms of resistance

The anthropological investigation undertaken in the Yucatán — focusing on the practices of *parteras* and the therapeutic function of *sobada* in promoting reproductive health — constitutes only one dimension of the broader scholarly contributions of Patrizia Quattrocchi, a leading figure in the field of obstetric violence. Her work, which is extensively cited throughout this volume, is widely recognised for advancing critical understandings of the interplay between indigenous knowledge systems, public health policies, and gendered power relations in reproductive care. The ethnographic fieldwork conducted in a Mayan village between 2000 and 2006 offers nuanced insights into how traditional midwifery practices serve not only as forms of clinical intervention but also as culturally embedded strategies of resistance to biomedical hegemony. Central to this analysis are: the role of *parteras* as socially legitimised knowledge holders, the significance of intergenerational knowledge transmission, and the critique of institutional health interventions that marginalise local epistemologies. These findings have contributed substantively to contemporary academic debates on the medicalisation of childbirth and the structural forms of violence enacted upon women's bodies within clinical settings.

Patrizia Quattrocchi's work has significantly contributed to broadening knowledge of women's bodies, even from an anthropological perspective. Her book *Corpo, riproduzione e salute tra le donne maya dello Yucatán*, which is only available in its original Italian edition, presents field research conducted in the Mayan village of Kaua, located 125 km from Mérida, the capital of Yucatán. Between 2000 and 2006, Quattrocchi devoted 15 months to observing the practices of local midwives, with her work providing a detailed overview of techniques and knowledge related to the female body. She studied *sobada*, a distinctive abdominal massage with therapeutic effects. *Sobada* is not a simple massage, as it is only given by specialists, who may be either women or men. The objective of *sobada* is to reposition organs that are believed to be misaligned as a result of pregnancy, in order to prevent any physical problems that could affect the woman's well-being. Different types of *sobada* may be identified. One type of *sobada* is given by *parteras* — midwives — both during pregnancy and in the postpartum period: during pregnancy it is useful to reposition the foetus for a safer and less painful birth; in the postpartum period, it helps to reposition the woman's abdominal organs after childbirth.

Quattrocchi has also explored the history of demographic and health policies in the twentieth century, focusing on their impact on Mayan midwives who, initially having no proper medical training, were required to take training courses starting in the 1970s. Although such state measures improved the situation, poverty,

malnutrition, and poor hygienic conditions among the Mayan population in Yucatán remained the primary causes of the high mortality rates among women and children. Quattrocchi found that maternal and infant mortality was not due to the practices of *parteras*, as the highest rates occurred in hospitals. The place of delivery was crucial, and hence the choice between hospital and home birth. Based on information provided by women in Kaua, Quattrocchi understood that their choice to give birth either at home, with the help of a midwife, or in the hospital, surrounded by doctors, was influenced by their view of home birth as a natural process that does not involve the surgical violation of the woman's body. By contrast, hospital births were exclusively associated with *cortada* (caesarean section) and *picada* (episiotomy). Strong social, economic, and gender disparities within the Yucatecan population also contributed to difficulties in accessing healthcare facilities.

Quattrocchi also investigated the reproductive trajectories of women in Kaua. After recounting the stories and describing the profiles of the nine *parteras* with whom she established relationships, she analysed the role midwives play in the different stages of procreation — pregnancy, childbirth, and the postpartum period. Midwives provide not only practical assistance, but also emotional and cognitive support, ensuring that future mothers can benefit from a reassuring atmosphere. Since midwives tend to manage childbirth differently, some practices that were once common in the postpartum period are no longer widely adopted.

Quattrocchi's research focuses on *sobada*, in order to analyse the conception of organs, their balance and mobility as essential to women's well-being. Owing to their experience, *parteras* are considered the only ones who can restore balance to the female body. As pregnant women do not routinely undergo *sobada*, they are rarely blamed when complications arise during childbirth. This suggests that a power imbalance exists between pregnant women of childbearing age and experienced midwives. Such power dynamics are also evident within the family, between husbands and wives, fathers and daughters, brothers and sisters. These relationships shape the role of pregnant women, who can assert greater self-determination, particularly during pregnancy (Quattrocchi 2012, 291, 296). *Sobada* can be considered a form of women's discourse on the female body, an embedded practice, a means of female resistance to male power, a way for women to assert control over their own bodies, a safeguard of local knowledge from external cultural paradigms, and a defence of the midwife's role in the face of government health workers.

Their knowledge and power make *parteras* respected and admired, even in the male world. *Parteras* who provide assistance during childbirth are greatly appreciated, with such appreciation being expressed through recognition and titles. As Quattrocchi (2001, 128) explained, *parteras* believe they have a true God-given calling, without which they could not have learned anything about the trade. The

calling usually comes through a dream or vision that shows them how to act. "Soy *parteras* gracias a Dios" — I am a *partera* thanks to God — is a phrase that numerous women interviewed by Quattrocchi have used at various times and on different occasions. *Parteras* begin putting their knowledge into practice much later than when they start learning. They acquire knowledge of medicinal plants and massage techniques when they are twelve or thirteen years old, although they begin assisting during childbirth only when they are around twenty-five. Mature age, experience, and, in many cases, the fact of already being a mother are considered undisputed indicators of reliability.

Regardless of a young girl's reasons for approaching this job, in most cases, training is formalised through participation in one or more courses, called *capacitaciones*. It was in the 1950s that the Honduran Ministry of Public Health officially recognised the important role of *parteras* and began to take an interest in their work. This resulted in the first courses in health education, hygiene, nutrition, and childbirth assistance, which, however, soon proved to be a failure. The reason for that lies in the fact that giving a mere technical and obstetrical significance to the relationship between a *partera* and a pregnant woman does not take into account the broader role that *parteras* play within the community and the social life of a pregnant woman. The *partera* is the first to diagnose that conception has taken place, relying on fundamental symptoms such as nausea, poor appetite, cravings for particular foods, headaches, and other typical indicators of pregnancy. Only after being visited by a *partera* does a woman go to a health centre, often accompanied by the midwife herself, to receive confirmation of her pregnancy. During pregnancy, the midwife sees the pregnant woman once a month, to check that everything is progressing well, with the greatest concern being the position of the baby, which should be upright. If, by touching the pregnant woman's belly, the *partera* understands that the baby is in an incorrect position, she gives her a special three-minute massage, *sobada*, which repositions the baby. During pregnancy, the *partera* advises her patients on what to eat and wear. In the last month of pregnancy, the *partera* sees her patients more frequently.

It was not until the late 1980s that a new methodology for delivering *capacitaciones* was developed. In addition to *capacitadas*, an untold number of non-*capacitadas parteras*, who reject any form of external interference in their work, have become active in communities. Quattrocchi pointed out that *sobada* is not given in hospitals, which illustrates the perceived epistemological superiority of local knowledge systems over Western obstetrics. Similarly, in the treatment of certain illnesses, it has been repeatedly observed that biomedical practitioners often fail to comprehend the clinical manifestations at hand, while *parteras* demonstrate an intuitive and culturally embedded understanding of the condition (Quattrocchi 2001, 131).

These divergences between traditional and biomedical knowledge systems acquire an additional layer of complexity within migratory contexts, where cultural dissonances and systemic inequalities often influence healthcare access and outcomes.

3.1 Culture, health, and immigration

National culture, familial trajectories, educational background, religious orientation, migratory experiences, personal attributes, health status, economic position, social capital, and degree of societal inclusion or marginalisation intersect in unique configurations within each individual. These multifaceted and interwoven dimensions pose significant challenges in the interface between migrant populations — or populations of migrant origin — and the host society, specifically within the Italian context. Such complexity becomes particularly salient in the organisation and delivery of healthcare services. Ensuring the health of foreign populations constitutes a critical and non-negotiable public health obligation, to be upheld through coherent and inclusive socio-health policies, grounded in the recognition of health as a fundamental and inalienable right.

Therefore, the way healthcare services are organised and provided is crucial, as it can either result in mechanisms perpetrating inequality and disease or contribute to addressing both.

Focusing on Italy, where access to care for the immigrant population is protected by one of the most inclusive legislative frameworks in both the European and global context, we can highlight that the national healthcare service is founded on the key principles — universality, comprehensiveness, and equity — which should always underpin the realisation of the right to health protection, enshrined in Article 32 of the Italian Constitution. Furthermore, healthcare planning should always be guided by the organisational principles established at the national level — centrality of the person, public responsibility for health protection through the guarantee of essential levels of care, collaboration between the various branches of the national healthcare service, integration of social and healthcare services, and valorisation of the professional skills of healthcare workers. Despite this, the interpretation and implementation of legislation concerning access to healthcare for foreigners remains highly uneven across the country, as well as within regions and autonomous provinces.

Although the right to health is universal, several obstacles continue to hinder immigrants' access to healthcare services. Such obstacles include language and cultural barriers, limited knowledge of the rules and functioning of the national healthcare service, distrust of a healthcare system that immigrants do not recognise

as their own, and difficulties and misunderstandings in interactions with healthcare professionals. Characterised by complexity and dynamism, the protection of immigrants' health requires multidisciplinary and integrated tools that draw on the theoretical frameworks of social determinants of health promotion (Cardano and Costa 1998; Sarti 2006; Terraneo 2018).

The intertwining of an immigrant's culture and religion tends to persist and be passed down from generation to generation. Even when situations change, identity, adherence to traditions, and social cohesion continue to play a significant role in an immigrant's life. If the concepts of health and disease may vary across different cultures, this is even more true when it comes to gender.

3.2 Immigrant women with female genital mutilation between tradition and change

The migration process introduces new subjects and cultural aspects that may produce a shared community project, which is often hindered by oppositional dialectical dynamics. The interaction of multiple cultures may lead to cultural uncertainty, conflict, and disorientation that result in cultural distress (UNICEF n.d.). This is caused by a clash between two realities: on the one hand, immigrants need to adjust their expectations and cultural perceptions to the host country; on the other hand, the host country holds a generic, concise, and homogeneous idea of the immigrant (Weny et al. 2020).

The increase in foreign users requires a redefinition of the national healthcare service. Immigrant women coming from countries in the Global South may have experienced violations of basic human rights, having faced poverty, hunger, disease, excessive workload, tyranny, repression, and war. Numerous foreign women who reach Italy bear wounds that cannot be healed, as they are the result of ancient excisional practices. One of these is Female Genital Mutilation (FGM), a phrase label that encompasses several traditional ritual practices. Migration has contributed to the spread of FGM to industrialised countries, such as the United States, Canada, Australia, and several European nations (UNFPA n.d.). Female genital mutilation holds significant value in African cultures, as it is an initiation rite that marks group membership, a rite of passage for the construction of identity. These values are not shared by host societies, which results in immigrant women living within communities that regard everything they valued — and that contributed to their womanhood — as violent, inhuman, and illogical.

The practice of FGM is based on socio-cultural, aesthetic, hygienic, spiritual, religious, psychological, and sexual reasons. While participating in a study conducted in Lecce, in southern Italy, in 1999, some young immigrant women coming from

countries with an excisional tradition talked about the two main types of cuts used in excisional practices. They explained that in some cases only a small cut is made, which is better than when "everything" is removed. A woman mentioned being "as smooth as a hand" and stated that if she had a daughter she would opt for a small cut (Rizzo 1999, 153). In another study, also carried in southern Italy with immigrant women, thorugh more than a decade later, a Somali mother who wanted to ensure the best for her daughter said that eliminating "that junk" was the only way for her girl to have a future, as she would otherwise never find a husband, with her fate being life on the street (Morrone and Sannella 2010). Findings from research carried out in 2022 confirm that the situation in Europe remains unchanged (Thomas et al. 2022). The latest data, collected by the UK Immigration Centre in January 2025, even report a 30% increase in FGM over the past 10 years. Paradoxically, the practice of FGM is supported and performed by women, as it is seen as being vital to the maintenance of fundamental social structures, such as the patrilineal system, family honour, and social standing. Performing FGM is believed to be in the best interests of girls, so as to ensure them a happy future as wives and mothers. Not practising FGM is therefore tantamount to exposing a young woman to enormous risk.

The construction of female identity is a process that includes complex dynamics, such as the introjection of female figures, cultural and social influences, and any relationship that may lead a child to become a woman. A key role is also played by culture, religion, values, and traditions. Self-representation is shaped not only by the reality of the body, but also by the gaze of others, particularly the way the child perceives her parents' gaze. This process becomes even more complex when migration is involved, as women who have developed a certain self-image based on their own culture and beliefs have to face a new reality where those values and beliefs are not recognised. Following migration, a woman's self-representation may conflict with her new reality, which does not often accept it and may even reject it. This can lead to a loss of identity and significant psychological distress. Adopting an unbiased view of women from different cultures becomes crucial, even when they hold values and beliefs that involve practices such as female genital mutilation.

According to the classification of the World Health Organization (WHO 2023), four types of FGM can be identified: Type 1 is the partial or complete removal of the clitoral glans; Type 2 is the partial or complete removal of the clitoral glans and labia minora; Type 3, also called infibulation, is the narrowing of the vaginal opening through the creation of a covering seal, sometimes through stitching; and Type 4 includes all the other harmful procedures to female genitalia performed for nontherapeutic purposes.

As these practices pose a high risk to a woman's health, they should receive particular attention from health professionals. Not only should the cultural background

and prevalent diseases in migrant women's countries of origin be taken into account, but it should also be considered that healthcare professionals in the host country may be unprepared to face such situations. These aspects are essential in maternal and child care, and hence should be emphasised when developing intervention strategies for obstetric and paediatric care. Failing to assess cultural and gender determinants may further jeopardise adherence to care and reduce the therapeutic efficacy of health interventions. Discrimination may occur when healthcare professionals strictly follow treatment protocols, having little to no awareness of differences in terms of cultural aspects, medical practices, experiences, and beliefs. This may result in immigrant women choosing not to benefit from the national healthcare service. A number of immigrant women have reported experiencing double victimisation during gynaecological examinations, due to harsh comments being made about their body.

It seems necessary to integrate a culturally adapted, gender-sensitive approach into the organisation of healthcare services, in order to ensure adequate responses to the health needs of the immigrant population, improve access to care, and protect immigrant women and their families. As the World Health Organization has pointed out, the assessment of gender-sensitive roles and relationships is a crucial health determinant that may help to protect beneficiaries' well-being and perceptions, promote mental and physical health, prevent the onset of illness, facilitate adherence to treatment protocols, and improve their effectiveness. As the literature has shown and healthcare professionals have reported (UNFPA n.d.; Farouki et al. 2022), foreign women undergo fewer pregnancy screenings and ultrasound examinations than Italian women. Additionally, foreign women tend to have their first medical check-up later in pregnancy than Italian women, with 11.5% of foreign women having their first visit after the twelfth week of pregnancy, compared to 2.65% of Italian women. This delay may hinder early diagnosis and the monitoring of clinical conditions that may help to identify pre-existing physical or social problems.

3.3 Main aspects of deinfibulation

Deinfibulation is a relatively simple surgical procedure performed to reopen the vaginal introitus of women with Type 3 FGM. Deinfibulation surgery can partially or fully repair the physical effects of FGM, although it may not be sufficient to reduce psychological distress, which makes it essential to provide sensitive and culturally oriented support to women undergoing it. Deinfibulation cannot be viewed as a mere "anatomical reopening," as it is characterised by deep, shifting, and sometimes conflicting symbolic and social meanings. Deciding to undergo this surgery

means confronting one's past and the painful implications tied to it, which may lead to a break with tradition and, in some cases, conflict with one's community of origin (AMSI; UMEM). On the other hand, deinfibulation surgery also represents a choice for improved physical, reproductive, psychological, and sexual health, with women securing a better future for both themselves and their daughters.

An operative protocol of therapeutic deinfibulation has been devised that involves preparation for surgery and postoperative support. Such a protocol consists of three phases during which the patient undergoing surgery meets the team that will support her throughout the entire process. In the first phase, preparatory information about deinfibulation surgery is provided, with a linguistic-cultural mediator being present, if necessary. Anaesthetic options are discussed, and the patient is given a clear and comprehensive explanation of the surgical procedure, in terms of the steps involved, the professionals present in the operating room, surgery and recovery times, and postoperative care. In the second phase, deinfibulation surgery is performed, with the patient having the opportunity to be supported by a psychologist and a cultural mediator during the procedure. The third phase involves postoperative follow-up, treatment, and support. The patient is seen by a gynaecologist, and her emotional state is monitored through psychological follow-up, with appointments scheduled based on her needs and preferences.

The procedure can be performed either *antepartum* or *intrapartum* (Purchase et al. 2013). Any health-related initiative, including training on the possible health consequences of the procedure, should be mindful of the context to which the woman and her family are connected, as well as the complex set of beliefs that underpins it.

When women choose to refuse FGM in a community in which it is a widespread practice, they are breaking with the traditions of their group of origin, risking ostracism and being seen as victims of external factors. FGM is regarded as a normal stage in a woman's life, an expected step in a girl's path towards adulthood, embedded in the experience of womanhood. As FGM is a tradition that is reinforced by the social pressures that hold a community together, any girl who decides not to conform and rejects FGM may face stigmatisation. Therefore, holistic, woman-centred care should be ensured, through a multidisciplinary approach that may effectively help to support women with FGM. Obstetric counselling and continuity of care, provided by informed health care professionals throughout the journey to childbirth, are even more vital in improving the well-being of mothers, their newborns, and their families, while also contributing to preventing FGM in future generations. Healthcare professionals should be adequately trained to correctly identify FGM and develop appropriate management strategies.

4 Conclusions

The analysis carried out in this paper has highlighted how medical practices and cultural norms have redefined the female body, reshaping the way it is perceived. In the Western world, the modern development of certain medical practices has gradually reduced the central role once played by women during childbirth. By contrast, in various non-Western cultures, childbirth continues to be regarded as a sacred event that, experienced by the community as a whole, cannot be fully medicalised.

Consequently, at least two societal views of childbirth may be identified. On the one hand, a rigid model aims to prevent medical complications during childbirth, despite risking dehumanising the process. On the other hand, community-supported childbirth is prioritised, which humanises the experience, even at the cost of potential health risks.

In the postpartum period, women often face a series of challenges. Mainly caused by a woman's physical, psychological, and emotional transformation, they are also the result of childbirth being considered not only a biological process, but also a cultural event.

Therefore, it seems necessary to both improve birth care, by ensuring respect for pregnant women's physical integrity and moral dignity, and contribute to the self-determination of the female body. Obstetric violence may be more easily prevented if it is acknowledged that it stems from a culture that fails to recognise women's freedom.

References

Alighieri, Dante. 2003. *Purgatorio*. Translated by Robert Hollander and Jean Hollander. Anchor Books.

Arendt, Hannah. 1958. *The Human Condition*. University of Chicago Press.

Associazione Medici di Origine Straniera in Italia (AMSI), Comunità del Mondo Arabo in Italia (CO-MAI), Unione Medica Euro Mediterranea (UMEM), and Accademia Internazionale per lo Sviluppo Economico e Sociale (AISC). 2025. *Statistiche AMSI-CO-MAI-UMEM-AISC*. https://www.immigrazione.com/review/article/10499 (last accessed February 4, 2025).

Beard, McKenzie. 2024. "The Unique Toll of Stress and Depression on Women's Hearts." *The Washington Post*, June 11.

Bills No. 179-183/2019, known as the Born Alive Infant Protection Act. https://www.biodiritto.org/Biolaw-pedia/Normativa/Wisconsin-Stati-Uniti-Bloccati-i-progetti-di-legge-n-179-180-181-182-183-2019-Born-Alive-Infant-Protection-Act (last accessed January 13, 2020).

Buccini, Francesca. 2023. *Genere e Stem: Una prospettiva bioeducativa.* Pensa Multimedia.

Cardano, Mario, and Giuseppe Costa. 1998. "Classi sociali e salute. Le diseguaglianze di mortalità a Torino." *Quaderni di Sociologia* 17: 86–122.

Cavarero, Adriana. 2023. *Donne che allattano cuccioli di lupo: Icone dell'ipermaterno*. Castelvecchi.
Chervenak, Frank. A., and Laurence. B. McCullough. 2001. "The moral foundation of medical leadership: the professional virtues of the physician as fiduciary of the patient." *American Journal of Obstetrics and Gynecology* 184 (5): 875–880.
"Cos'è la violenza ostetrica." n.d. Nurse24.it. https://www.nurse24.it/ostetrica/professione-ostetrica/cos-e-violenza-ostetrica.html (last accessed February 16, 2025).
"Depressione post partum: sintomi, cosa fare e come si cura". *MyPersonalTrainer.it.* https://www.my-personaltrainer.it/salute/depressione-post-parto.html (last accessed February 2, 2023).
De Sanctis, Davide, Sara Fariello, and Irene Strazzeri. 2019. *Sociologia della maternità.* Mimesis Edizioni.
Farouki, Leen, El-Dirani Zeinab, Abdulrahim Sawsan, et al. 2022. "The global prevalence of female genital mutilation/cutting: A systematic review and meta-analysis of national, regional, facility, and school- based studies." *PLoS Med.* 19 (9). https://doi.org/10.1371/journal.pmed.1004061.
Ferrante, Elena. 2016. *Frantumaglia: A Writer's Journey*. Translated by Ann Goldstein. Europa Editions.
Fortuna, Stefania. 2021. *Ippocrate. Il dovere della cura. Giuramento di Ippocrate.* Garzanti.
Foucault, Michel. 2010. *The birth of biopolitics: lectures at the Collège de France*, 1978-1979. Picador.
Foucault, Michel. 1978. *The History of Sexuality: Volume 1. An introduction*. Translated by Robert Hurley. Pantheon Books.
Giarelli, Guido. 2008. "Il contesto della mediazione. La sfida dell'interculturalità nella società multietnica." In *Immigrazione, mediazione culturale, salute*, edited by Claudio Baraldi, Valentina Barbieri, and Giudo Giarelli. FrancoAngeli.
Horsch Antje, Susan Garthus-Niegel, Susan Ayers, et al. 2024. "Childbirth-related Posttraumatic Stress Disorder: Definition, Risk Factors, Pathophysiology, Diagnosis, Prevention, and Treatment." *American Journal of Obstetrics and Gynecology*.doi: 10.101610.1016/j.ajog.2023.09.089.
Jäger, Fabienne, and Schulze Sylvie. 2002. "Female Genital Mutilation in Switzerland: A Survey among Gynaecologists." *Swiss Med Wkly* 132 (19-20): 259–264. https://doi.org/10.4414/smw.2002.09912.
Jordan, Brigitte, and Robbie Davis-Floyd. 1993. *Birth in Four Cultures: A Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden, and the United States*. 4th ed. Waveland Press.
Kerény, Karoly. 1949. *Niobe: Neue Studien über Antike Religion und Humanität*. Rhein-Verlag.
Maffi, Irene. 2012. "Recensione di Patrizia Quattrocchi, *Corpo, riproduzione e salute tra le donne maya dello Yucatan (Messico)*, Pacini Editore, 2011." *Confluenze: Rivista di Studi Iberoamericani* 4 (1): 291–296. https://confluenze.unibo.it/article/view/3264.
Manfroni, Alice. 2022. "Il corpo della donna: ripensare una categoria plurale." *La Rivista Culturale*. https://larivistaculturale.com/2022/07/29/antropologia-culturale-teoria-corpo-analisi-donna-attualita/ (last accessed February 14, 2025).
Marone, Francesca. 2003. *Narrare la differenza: Genesi, saperi e processi formativi nel Novecento.* Unicopli.
Melandri, Lea. 1993. *Il corpo: Una geografia di confine*. Lapis.
Meo, Milena. 2014. "La medicalizzazione del corpo femminile." In *Ripensare il corpo. Rappresentazioni, medicalizzazioni, decolonizzazioni*, edited by Milena Meo. Aracne.
Morrone, Aldo, and Alessandra Sannella. 2010. *Sessualità e culture. Mutilazioni genitali femminili: risultati di una ricerca in contesti socio-sanitari.* FrancoAngeli.
Morrone, Aldo, and Gioia Di Cristofaro Longo. 1995. *Cultura, salute, immigrazione. Una analisi interculturale*. Armando Editore.
Morrone, Aldo, and Pietro Vulpiani. 2004. *Corpi e simboli. Immigrazione, sessualità e mutilazioni genitali femminili in Europa*. Armando Editore.
Nietzsche, Friedrich. 1889. *Dionysos-Dithyramben*. Zeitschrift für Germanistik 2025, 35 (3): 563-57.
Quattrocchi, Patrizia. 2001. "Parteras gracias a Dios. Il sistema di nascita lenca (Honduras) fra tradizione e modernità." *La Ricerca Folklorica* 44: 127–138.

Quattrocchi, Patrizia. 2011. *Corpo, riproduzione e salute tra le donne maya dello Yucatan (Messico)*. Pacini Editore.

Purchase, Thomas C.D., Maya Lamoudi, Sarah Colman, et al. 2013 "A survey on knowledge of female genital mutilation guidelines." *Acta Obstet Gynecol Scand* 92 (7): 858–861. https://doi.org/10.1111/aogs.12144.

"Quale impatto ha avuto la campagna #bastatacere?". 2019. *Osservatorio sulla Violenza Ostetrica Italia (OVOItalia)*. https://ovoitalia.wordpress.com/2019/04 (last accessed February 16, 2025).

Rich, Adrienne. 1976. *Of Woman Born: Motherhood as Experience and Institution*. W. W. Norton & Company.

Rizzo, A. Maria. 1999. "Storie di donne." *Palaver: Culture dell'Africa e della Diaspora* 11/12: 141-156.

Rush, Benjamin. 1830. *Medical Inquiries and Observations Upon the Diseases of the Mind*. 4th ed. Grigg.

Sarti, Simone. 2006. "La classe sociale in buona salute." *Polis* 20 (3): 317–346.

"Servizi dedicati alle MGF — Mutilazioni Genitali Femminili". 2023. *SaperiDoc.it*, Direzione Generale Cura della Persona, Salute e Welfare. https://www.saperidoc.it/flex/cm/pages/ServeBLOB.php/L/IT/IDPagina/864 (last accessed March 2025).

Smith Helen, and Karin Stein. 2017. "Surgical or medical interventions for female genital mutilation." *International Journal of Gynecology & Obstetrics* 36 (S1): 43–46. https://doi.org/10.1002/ijgo.12053.

Strazzeri, Irene. 2014. Post-patriarcato. L'agonia di un ordine simbolico. Roma.Terraneo, Marco. 2018. *Salute negata: Le sfide dell'equità in prospettiva sociologica*. FrancoAngeli.

Tolstoj, Leo. 2007. *War and Peace*. Translated by Richard Pevear and Larissa Volokhonsky. Vintage Classics.

Thomas, Hannah S., Nnenaya A. Mmonu, Gregory Amend, et al. 2022. "Awareness, Clinical Experience and Knowledge of Female Genital Mutilation/Cutting Among Female Pelvic Medicine and Reconstructive Surgeons in the United States." *Urology*. doi: 10.1016/j.urology.2021.10.023. Epub 2021 Nov 7.

Ulivieri, Simonetta. 1995. *Educare al femminile*. Edizioni ETS.

UNFPA. n.d. "Female Genital Mutilation." https://www.unfpa.org/female-genital-mutilation (last accessed February 15, 2024).

UNICEF. n.d. "What is Female Genital Mutilation?" https://www.unicef.org/protection/female-genital-mutilation (last accessed February 15, 2024).

Weny, Kathrin, Romesh Silva, Rachel Snow, et al. 2020. "Towards the elimination of FGM by 2030: A statistical assessment." *PLoS One* 15 (10): e0238782. https://doi.org/10.1371/journal.pone.0238782.

World Health Organization (WHO). 2023. "Female Genital Mutilation." https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation (last accessed February 15, 2025).

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