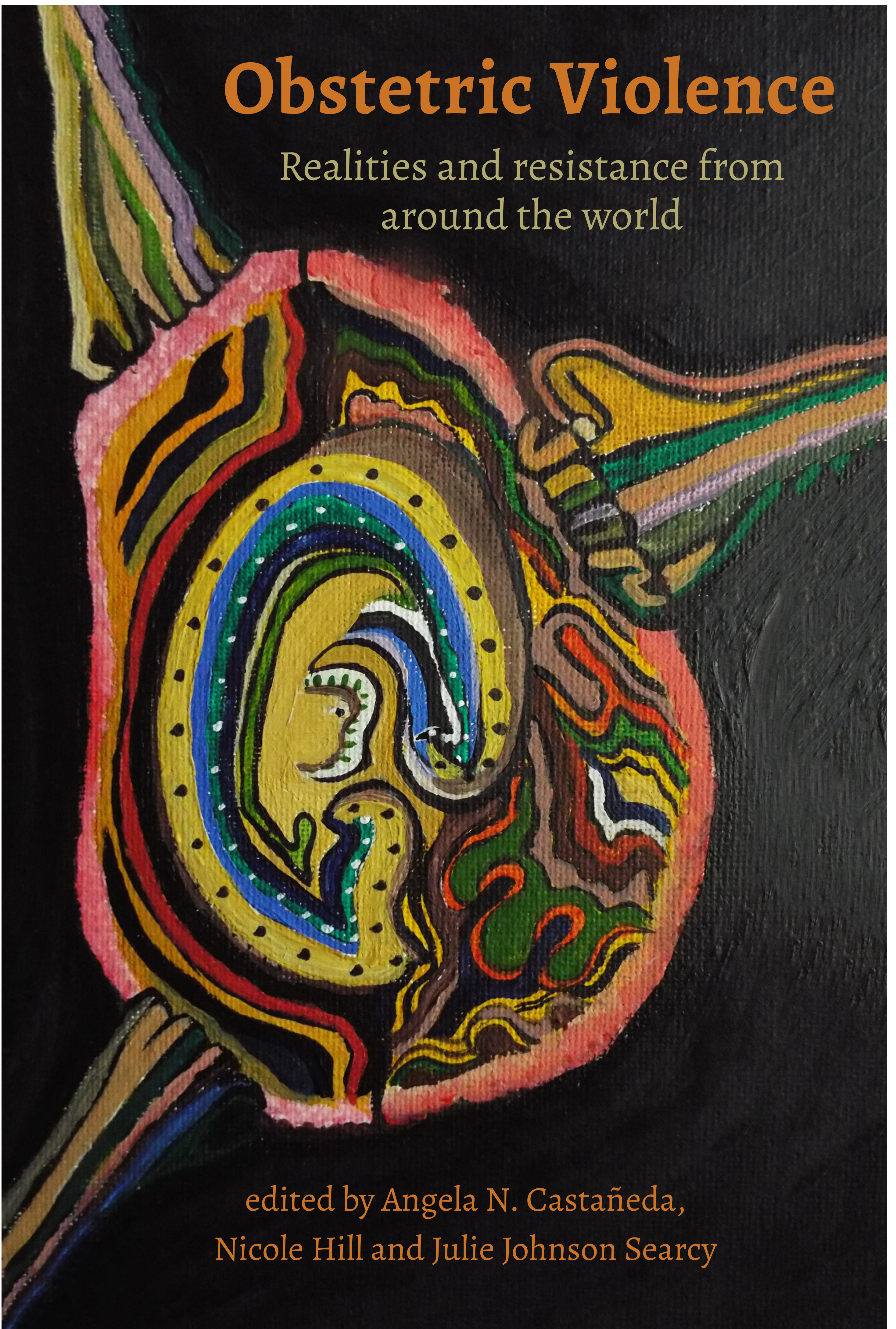
Obstetric Violence

Realities and resistance from around the world

edited by Angela N. Castañeda, Nicole Hill and Julie Johnson Searcy



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Dedicated to all of the birthing people and their supporters who have experienced obstetric violence. Your stories matter.

Acknowledgments

To all of the birthing people, partners, and care providers whose lives and work have inspired us along our academic journey, we acknowledge and appreciate you. To the amazing contributing authors who agreed to give their time, energy, and expertise to this volume, including the talented Karla Hairem Guerrero Moctezuma whose artwork graces the cover, we thank you for sharing your wisdom with us. And to our families for their patience, encouragement, and support. Your love sustains us.

A Message from the Artist

In the center is a baby and a mother nestled together, they wear symbols and colors of protection. The hands pulling back on the cocoon show a multitude of hands that also contribute to the lives of the mother & child. These hands protect, advocate, strengthen but they can also be invasive, unjust and bring violence. The darkness depicts the area that the hands are pulling the cocoon from or are pulling it towards—a commentary on community struggles of care, love & life.

Karla Hairem Guerrero Moctezuma

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Chapter 3

Public Policies and Obstetric Violence: An Anthropological Overview of Achievements and Challenges in Argentina

Patrizia Quattrocchi

Introduction

In this chapter, I discuss the impact of the 2009 legal recognition of obstetric violence on birth care services and the training of the next generation of health providers as well as residents in obstetrics and gynecology and in midwifery in Argentina. Using interview data with caregivers, I analyze the successful case of the public Estela de Carlotto Maternity Hospital (MEC-Maternidad Estela de Carlotto), which was able to implement a healthy and physiologic model of care; the hospital shifted its incidence of medical intervention (for example, caesarean sections and labour inductions) to within and below recommendations from the World Health Organization (WHO) after the enactment of Argentinian laws on humanized birth and obstetric violence. I use data derived from wider ethnographic fieldwork undertaken in Argentina between October 2016 and August 2017 within the project "Obstetric Violence: The New Goal for Research, Policies, and Human Rights on Childbirth" (acronym OBSTETRICVIOLENCE), which was funded by the European Commission for the period 2016–2018.[1]

The starting point for this project was the overuse of medical

intervention during childbirth—even in low-risk births—which has been reported worldwide in the last decades (Clesse et al.). These interventions are sometimes performed against evidence-based medicine and more than thirty years of recommendations from WHO (WHO, "Appropriate Technology"; *Care in Normal Birth*; *Recommendations: Intrapartum Care*). Evidence shows that risky approaches and treating healthy pregnant women as sick can lead to abuse of medicalization and disrespectful practices in facility-based births (WHO, *The Prevention and Elimination*) and prevent women from enjoying a "positive birth" experience (WHO, *Recommendations: Intrapartum Care*).

In Latin America, over the past decade, the term "obstetric violence" (OV) has become part of social movements fighting for women's sexual and reproductive rights since the 1970s and was highlighted at the International Conference on the Humanization of Childbirth held in Fortaleza (Brazil) in 2000. During the conference, the RELACAPHUAN (Red Latinoamericana y del Caribe para la Humanización del Parto y Nacimiento) was founded by a group of participants from twelve countries. Thanks to the work of national RELACAPHUAN networks, the local debate in the different countries emerged, and the issue began to appear on national agendas. Venezuela was the first country in the world to define OV as a legal issue. In Article 15 of the Venezuela Organic Law on the Right of Women to a Life Free of Violence, OV is defined as follows

> The appropriation of the body and reproductive processes of women by health personnel, which is expressed as dehumanized treatment, an abuse of medication, and to convert the natural processes into pathological ones, bringing with it loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting their quality of life. (República Bolivariana de Venezuela 7)

According to this definition, the following acts performed by health personnel are considered OV: giving untimely and ineffective attention to obstetric emergencies; forcing the woman to give birth in a supine position when the necessary means to perform a vertical delivery are available; impeding early attachment of the child with their mother without a medical cause; altering the natural process of low-risk labour and birth by using augmentation techniques; and performing caesarean

sections when natural childbirth is possible, without obtaining the voluntary, expressed, and informed consent of the woman. For the perpetrators of OV, administrative sanctions are foreseen. The court will impose upon the person or persons responsible a fine and must submit a certified copy of the sentence signed by the respective professional body or institution union for the correspondent purposes of disciplinary proceedings (Pérez D'Gregorio 202).

At present, specific laws against OV also exist in Argentina (2009), Panama (2013), some states of Mexico (2007–2017), the state of Santa Catarina in Brazil (2017), Uruguay (2017), and Ecuador (2018). In other countries, such as in Bolivia, Chile, Peru, Colombia, and Costa Rica, the issue is also under discussion, both socially and politically. In all of these countries, OV is conceptualized as a type of gender-based violence and refers to acts in the context of labour and birth that are categorized as physically or psychologically violent due to the unjustified use of medical interventions, disrespectful and dehumanizing treatment, and pathologization of the natural process of birth (Grupo de Información en Reproducción Elegida). International debate and data research underline the institutional and structural dimension of OV and the violation of human rights it involves (White Ribbon Alliance; Castro and Erviti; Sadler et al., Quattrocchi and Alemán).

In Europe, despite the activism of social movements and observatories on OV established in Spain, Italy, France, and Greece (Akrich, Roberts, and Nunes; Villarmea, Olza, and Recio), public and, above all, political debate on the subject is still weak. No country has yet (as of June 2020) passed legislation on the matter. Nevertheless, abuse of medicalization and unnecessary interventions are reported, with variations arising according to the local context and the healthcare system organization (Europeristat). In some countries, medical intervention during childbirth has shown a downwards trend, fostering a physiological approach (e.g., the Netherlands), whereas in other countries (e.g., Italy and Spain), the medicalization of labour and birth is still widespread. It is, however, widely recognized in Europe that overmedicalization and disrespect do not benefit women or their children. Women are also limited as to the exercise of their rights to choose the circumstances of their childbirth, as established by the European Court of Human Rights in the case of *Ternovszky v. Hungary* in 2010 (Women's Link Worldwide). Better understanding and

prevention of these processes in terms of maternal and perinatal clinical outcomes, benefit-risk ratio, health costs, and—from a comprehensive perspective—in terms of the well-being of the mother and baby are urgently needed, as recently underlined by the European Council in the resolution of 3/10/2019 (Council of Europe Parliamentary Assembly).

The OBSTETRICVIOLENCE Project's main objective was to explore the transfer of the Latin American experiences on recognizing and preventing OV to the European context in order to provide decision makers with an innovative theoretical and methodological tool for rethinking the quality of birth care services. Specific objectives for the project included the following: first, analyzing the historical, social, and political processes that led to the legal recognition of OV in some Latin American countries, focusing on Argentina; second, analyzing the impact that this recognition has had on Argentinian birth care services and on the training of the next generation of health providers; third, identifying and transferring good practice and tools from the Argentinian and Latin American experience and supporting a process of social and political recognition of OV in the European context, especially in countries where medical intervention in child labour and childbirth is common, such as Italy and Spain; and fourth, designing and implementing a platform on OV as an innovative point of reference for decision makers and training managers in health issues.[2]

The Legislative and Policy Framework on Childbirth in Argentina

In 2004, Argentina sanctioned Law 25,929, also known as the Law on Humanized Childbirth. The law was the result of a wide social and political debate, promoted by social movements fighting for sexual and reproductive rights. The civil organization *Dando a Luz*, the newly established RELACHAPUAN-Argentina, the network *Ama de Casa*, and the Annual Meeting of the Encuentro Nacional de Mujeres, among others, took part in the process (Quattrocchi). In accordance with the Global Safe Motherhood Initiative promoted globally and in Argentina by OMS-UNICEF since the 1990s, the law addressed women's rights in childbirth for the first time in the national agenda. The UNICEF model Safe and Family-Centered Maternity Hospitals (Maternidad Segura y Centrada en la Familia [MSCF]) was inspired by a respectful

approach to childbirth, including the physical, emotional, psychosocial, and cultural needs of women, newborns, and families, as well as women's choices and preferences. Clinical guidelines for implementation of the model were enacted by the Ministry of Health in 2004, 2007, 2008, and 2011 (Herrera Vacaflor). It was implemented, for instance, in the Pediatric-Maternal Hospital Sarda in Buenos Aires (Larguía).

Although the regulations of the Law on Humanized Childbirth were not installed until 2015, with President Cristina Kirchner's Decree 2035/2015, the key role of the law in legitimizing a women's rights perspective in childbirth should be stressed. The law declares that pregnant women have the right to be treated with respect in terms of their person, body, and culture; to be considered a healthy person such that she can participate actively in her own birth; to have a natural birth, according to their biological and psychological needs; to be informed about the different possible medical interventions; to choose freely among the alternatives; to avoid invasive and unnecessary practices; to be accompanied by a trusted person of their own choosing during the labour, delivery, and postpartum period; to have her baby with her during their stay at the care facility; and to be informed on and to receive assistance with breastfeeding. The law also defines the right of the newborn to be treated in a respectful and dignified manner and the rights of parents to participate in the child's care.

In subsequent years, other laws addressed the rights of women and patients: in 2006, Law No. 25,673 for the Implementation of the National Program of Sexual Health and in 2009 the National Law on Patients' Rights (2009). Finally, in 2009, Argentina sanctioned and promulgated Law 26,485, the Law of Comprehensive Protection to Prevent, Sanction, and Eradicate Violence against Women. Article 6 of this law defines OV as "the violence that health care personnel exercise on women's bodies and reproductive processes, expressed by dehumanizing treatment, excessive medicalization and pathologization of natural processes, in accordance with Law 25,929" (República de Argentina 3). The definition includes as healthcare personnel not only doctors but all of the professionals who provide care for women during pregnancy, childbirth, and postpartum. Starting from the law, public policies on OV were implemented in the following years. In 2011, the Comisión Nacional Coordinadora de Acciones para la Elaboración de Sanciones

de Violencia de Género (CONSAVIG) was created to draw up sanctions against gender violence during pregnancy and childbirth and to receive complaints from women. The Defensoria del Pueblo (Ombudsman Service) is the public body responsible for controlling the quality of the public administration service; it receives complaints, accompanies victims, and refers them to other agencies (e.g. Ministry of Health or Ministry of Human Rights). Since 2018, the Defensoria del Pueblo has worked with Las Casildas, a civil organization, that in 2015 founded the OVO-Observatorio de Violencia Obstétrica (Quattrocchi). At the end of 2016, the Ministry of Human Rights and Cultural Pluralism also addressed OV through a working group (Área de Protección de los Derechos en el Embarazo, Parto y Nacimiento) that organizes training and awareness activities on OV targeting health professionals and women. Together with the Ministry of Health and Social Development trainings were organized in hospitals in more than fifteen provinces in the country. Workshops and talks were organized also in Buenos Aires and metropolitan area hospitals. More than three thousand professionals, including health professionals, technicians, and administrative staff, participated in the events (García Conto). A telephone number to report OV acts was also launched.

The impact of public policy has not yet been analyzed in detail in Argentina. Despite the existence of laws and strategies and the implementation of more humanized childbirth in some hospitals, the model of care for childbirth in the country continues to be highly medicalized, as confirmed by health institutions and international organizations. According to the Second National Epidemiologic Report, on average, caesarean sections account for 30.6 per cent of all births in public hospitals registered in the country between 2010 and 2013 and between 60 percent and 70 per cent in the private sector (Ministerio de Salud de la Nación). Unnecessary interventions and disrespectful births have been increasingly denounced over the previous and present decade, particularly by civil organizations (Chiarotti et al.; Chiarotti, Shuster and Armichiardi; Las Casildas).

Methodology

The results presented in this chapter relate to the analysis of the impact that the legal recognition of OV has had on Argentinian birth care services and on the training of the next generation of health providers. The research included 173 adult participants including key informants, health education program managers, residents, health personnel, and students. Participation consisted in answering a semi-structured interview (thirty-three persons) or a questionnaire (140 persons). Other qualitative instruments and techniques—such as observation and participant observation as well as a fieldwork diary—were employed.[3]

Healthcare providers involved in the research included fifteen training managers and teachers, seventy residents in gynecology and obstetrics and midwifery, thirty-five health professionals, and thirty-five students. Specifically, I conducted fifteen semi-structured interviews with training managers in health issues, teachers, and directors of residency programs in obstetrics and gynecology and in midwifery. I contacted thirteen public hospitals in the city and province of Buenos Aires through e-mail and presented them a summary of my research project and a letter of invitation to participate in the study. Six public hospitals agreed to participate. I visited the hospitals and organized a formal talk with the heads of department, directors, and other gatekeepers.

The following hospitals participated in the study: Hospital General J. A. Fernández (Buenos Aires), Hospital General Dr. T. Alvarez (Buenos Aires), Hospital General P. Piñero (Buenos Aires), Hospital Interzonal General Evita (Lanús), Hospital Maternidad de Moreno Estela de Carlotto (Moreno), and Hospital Nacional Prof. A. Posadas (El Palomar). A survey was conducted in these hospitals on the legal definition and knowledge about OV and humanized childbirth (according to Law No. 25,929 enacted in 2004 and Law 26,485 promulgated in 2009). The survey consisted of a thirty-one-item questionnaire administered after a brief talk with participants to present the research purpose and to explain the consent form and information sheet. Official data on hospital organization, performance, and training on childbirth were also collected.

All information was kept confidential to ensure participant safety and to respect their privacy issues, in accordance with European Union

and national laws. Interviews were recorded and a literal transcription was made by the researcher; transcripts were coded by ATLAS TI-Qualitative Analysis software, according to the project methodology. To analyze the data, I connected, contrasted, and crossed themes and categories emerging from the interviews to reconstruct what interviewers thought or experienced about the topic, as per ethnographic method and text analysis (Hernández-Sampieri, Fernández Collado and Pilar Batista). Questionnaire data were analyzed using SPSS-Statistical Package for Social Science.

Survey Results

The survey—administered to 105 health professionals and residents in gynecology and obstetrics and in midwifery working in the six aforementioned public hospitals of the city and the province of Buenos Aires—indicated a lack of knowledge about the contents of the Law on Humanized Childbirth and Law 26,485 against gender violence. The results demonstrate that health professionals' knowledge of the content of the laws concerning humanized childbirth and OV is generally superficial and sectoral. In particular, it is interesting that among the practices less connected to OV are routine medical interventions in low-risk deliveries, including induction, episiotomy, enema, shaving of the pubic area, and oxytocin to accelerate delivery. The study found that 26.7 per cent of health professionals and 31.8 per cent of residents in gynecology did not consider these standardized practices as abuse, as an act attributable to lack of respect, or as a violation of human rights in childbirth. Most of the time, in the health professionals' perspective, these practices are so naturalized that their abnormality is not seen. Such practices are part of what health professionals normally do, situated as they are within mechanisms of authoritative knowledge, which are familiar to medical anthropologists (Davis-Floyd and Sargent; Jordan; Lock and Nguyen). The term "OV" is more often connected by professionals and gynecologists to disrespectful language that disparages women and their body or to prohibiting the presence of a companion—that is, to individual behaviour, not to a systemic and structural dimension regarding power issues and biomedical paradigms and assumptions. The survey also reveals a greater knowledge and awareness of some legal information among midwives, compared to

gynecologists, which supports international research (Gray et al.). It is important to point out that all of the participants said they needed more information and training on the subject. Specifically, 67.7 per cent of health professionals, 79.5 per cent of the residents in gynecology and obstetrics and 62.2 per cent of the residents in midwifery asked for more information on OV. The development of innovative training programs based on gender and human rights perspectives is necessary to improve the knowledge of health professionals who are actively involved in the management and decision-making process related to childbirth.

La Maternidad Estela De Carlotto: rethinking the birth model

Estela de Carlotto, a public maternity hospital, presents a positive case study for rethinking the birthing model and training of health professionals according to the national laws and international recommendations for respectful childbirth. This hospital lies in the Municipality of Moreno, thirty-six kilometres from Buenos Aires, in a municipality with five hundred thousand inhabitants, approximately 12.9 per cent of whom are considered from vulnerable populations (Instituto Nacional de Estadistica y Censos). The hospital was established in 2013 to support the high number of births—more than ten thousand per year—carried out in the nearby local Hospital Mariano y Luciano de la Vega. The main objective of the new maternity hospital was to offer the community an additional place in which women with low-risk pregnancies could birth in a respectful, women- and family-centred manner. The hospital employs about three hundred people, including health professionals and administrative, technical, and auxiliary staff. There are forty beds, nine clinics, three surgeries, a neonatology department, a residence for mothers, and four UTPRs (Unidad de trabajo de parto y recuperación), which are multi-use spaces where the whole birthing process takes place, from labour to postpartum, without the need for the mother to move from one environment to another.

During pregnancy, women are attended in the forty primary health care clinics available in the area of Moreno. At week thirty-five or thirty-six of pregnancy, women are submitted to an integral check

(tamizaje). If a low-risk pregnancy is confirmed, the opportunity for birth in the facility is affirmed. Women with medium- or high-risk pregnancies are actually not attended in Moreno but are sent to the Mariano y Luciano de la Vega Hospital or to the national Hospital Prof. Alejandro Posadas, located twenty kilometres northwest of Buenos Aires. Estela de Carlotto Maternity Hospital is based on a physiological and noninterventionist approach to childbirth, which includes lower rates of intervention. For example, the caesarean rate is 13 per cent, which is below the range indicated as appropriate by the WHO (15 per cent maximum); the rate of episiotomy is 8 per cent, the rate of induction is 1.6 per cent, and the percentage of women accompanied by a person of their choice is 93 per cent (Informe anual de gestión).

How did Estela de Carlotto Maternity Hospital achieve such positive results? An innovative vision was part of the initial creation of the facility: A social and medical perspective on childbirth was stressed by the founders. As one of the codirectors affirmed, "Childbirth is not a medical event, but a life process" (P., Maternity Hospital director). And as C., another codirector of the hospital observed: "The maternity hospital was opened in 2013, but its development process began much earlier. We are all part of the group [colectivo] of the Ministry of Health of Moreno, for twenty years we had been carrying out collective participatory processes and health professionals training in a different way." An organizational and community-based perspective rooted in political management plays an important role in the success of this hospital.

The Maternity Hospital was planned according to the UNICEF recommendation MSCF, which was implemented in Argentina through specific guidelines. The law on humanized childbirth, human rights, gender, and a healthy community perspective constituted the framework in which the mission and the vision of the facility were conceived. As P. noted in an interview:

> The Maternity Hospital exists thanks to the law and civil organizations, groups of women who fought for their rights, for all that happened in Moreno. It was established in a moment when the law existed, but many years were needed for its regulation.... There were few places where you could really see the fulfillment of the law. So, we [the maternity] arrived with a strategy that was taken both by women and by the Ministries:

> the UNICEF strategy [which] has a lot to do with the law of humanized childbirth and with the law against gender violence. Thanks to this strategy there were many advances in many places.

National legislation and international directives provided the conceptual framework within which local protocols were implemented. This was also observed by P.: "This MSCF strategy has really modified many practices and protocols….When it says that 'the routine episiotomy does not have to happen,' nobody can say 'I did not know!' There is no discussion: you don't have to do routine episiotomy! It is done."

The positive outcomes at Estela de Carlotto Maternity Hospital are found in the implementation of an innovative model of childbirth care, based on reducing unnecessary medicalization and on respecting physiology as well as human rights in childbirth. This means, first of all, respect for the physiological needs of the mother and the child, respect for the body and the whole process, and respect for the privacy, autonomy, and free choice of women, for example regarding the labour position or the presence of a companion. It also means respecting the choices of women and their partners and complying with the existing legislation, including on abortion. The Maternity Hospital offers a protocol on not punishing abortion, as prescribed by law (Bergallo and Ramón).

Estela de Carlotto Maternity Hospital has a different organizational model, one in which the hierarchy of roles and tasks is reworked through a transversal perspective. For this reason, innovative training focused on ensuring a respectful and human rights centred experience was offered to all members of the hospital staff, not only health professionals but also administrators, technicians, and general staff. As Patricia shared: "The transversal nature of the process seems to me to give the team a plus … that transversality caused power to be handed out, [as] professionals lost some of their power." In this context, both Estela de Carlotto Maternity Hospital codirectors, P. and C., considered one specific example to be significant for understanding the adoption of a new perspective by staff members: "We had the harness for a vertical birth, but we couldn't hang it on the ceiling; the roof wasn't strong enough for that. The maintenance team came up with a pole to hang the harness, attach it…. Nobody asked them to do it. They are seven

guys—workers, do you understand? That's it.... This novel 'culture' allows them to act as 'guardian of rights' themselves" (P.).

This example illustrates the holistic approach to sharing power and agency at the Estela de Carlotto Maternity Hospital. The hospital has cultivated a growing awareness that the health of mothers and babies is a common good, to which everyone can and must contribute. The "horizontal knowledge" that P. talks about in our interview—opposite to the authoritative knowledge of biomedical approach (Jordan)—is pursued with various initiatives that involve hospital staff, pregnant women, mothers, parents, and citizens in general. Every Saturday, for example, the storytelling sessions are organized in the hospital. These are workshops in which mothers and fathers who gave birth at the Maternity Hospital share their experience with future parents and healthcare staff. Sometimes their perspective is collected by health professionals and becomes experience-based data, used to influence institutional practices. A nonhierarchical approach was evident during the team meetings. In the team meetings I attended, all the professionals involved in the management of the hospital (from the cleaning staff to the doctors) were represented; all had a voice during a structured and scheduled time in order to highlight the strengths and weaknesses of the work carried out, according to their perspective. The team meetings aimed at enhancing collective thinking and rethinking of care practices and institutional organization from a comprehensive point of view and from a participatory approach. In this sense, the Estela de Carlotto Maternity Hospital is organized and managed as an interesting and innovative cooperative model, based on the idea that health is a common good—"un bien social" (a social good) in the words of E., coordinator of the gynecology and obstetrics ward, which involves not only those who work in the hospital, but the whole community of Moreno. The model has created a successful collaborative learning environment, where the members (inside and outside the hospital) are engaged in a common task in which each individual is accountable to each other.

Conclusion

In this chapter, I discuss the impact of legal recognition of OV on birth care services and the training of the next generation of health providers

in Argentina. I also address the lack of knowledge on respectful birth and OV emerging from the survey administered to healthcare professionals. Despite the laws, the implementation of public policies, as well as the increase in the number of governmental and academic seminars on this issue, disrespectful birthing practices are not sufficiently explored in health professionals' institutional educational training.

In particular, I analyze how the Estela de Carlotto Maternity Hospital provides a different model for giving birth in Argentina. The proactive leadership, a strong community-based experience, and a favourable political context (the Peronist government of Cristina Kirchner) built, within a few years, a model with a strong identity at the political and social level. The approach implemented through and within the facility (starting from its name)[4] have certainly helped to make the Estela de Carlotto Maternity Hospital not only an innovative healthcare institution but also a terrain for comparing different ways of building relationships between institutions and citizens.[5] Laws are necessary tools to provide a framework in which individual and collective action can be put in place. But laws alone are not effective; they must be socialized, contextualized, and realized in the daily practice, as the Estela de Carlotto Maternity Hospital demonstrates.

Endnotes

1. This project received funding from the European Union's Horizon 2020 research and innovation program under the Marie Skłodowska-Curie grant agreement No 700946. The first year of research took place in Argentina (National University of Lanús, Institute of Community Health) and the second in Italy (University of Udine).
2. Project results are available on the project website: www.obstetricviolence-project.com.
3. Participants' involvement in the study was on a voluntary basis and written informed consent was obtained. Approval from the local ethics committee (Comité de Etica de la Investigación y Docencia) was obtained.
4. Estela de Carlotto is the president of the Association of Grandmothers of Plaza de Mayo, which was founded in 1977 and aims to

find the children stolen and illegally adopted during the Argentine dictatorship. As of 2019, 130 grandchildren have been found.

5. A few weeks after my first interview with the management staff, the two codirectors were removed from their posts "for political reasons", provoking protests both among politicians and among the community (Arredondo).

Works Cited

Akrich, Madelaine, Leane, Máire Cecilia Roberts, and João Arriscado Nunes. "Practising Childbirth Activism: A Politics of Evidences" *BioSocieties*, vol. 9, no. 2, 2014, pp. 129-52.

Arredondo, Alicia. "Despedido politico en la Maternidad Estela de Carlotto." *Pagina*, 8 Feb. 2017, www.pagina12.com.ar/18929-despidos-politicos-en-la-maternidad-estela-de-carlotto. Accessed 6 Dec. 2021.

Bergallo, Paola, and Michel Agustina Ramón. *El aborto no punible en el derecho argentino. Problemas de implementación en el acceso al aborto no punible*. Feim-Fundación para estudios e investigación de la mujer, 2009.

Castro, Roberto, and Joaquina Erviti. *Sociología de la práctica médica autoritaria. Violencia obstétrica, anticoncepción inducida y derechos reproductivos*. CRIM-UNAM, 2015.

Clesse, Christophe, et al. "The Evolution of Birth Medicalisation: A Systematic Review." *Midwifery*, vol. 66, 2018, pp. 161-67.

Europeristat. "European Perinatal Health Report. Health and Care of Pregnant Women and Babies in Europe 2015." *Europeristat*, 2018, www.europeristat.com/. Accessed 6 Dec. 2021.

Instituto Nacional de Estadistica y Censos. "Censo nacional de población y hogares y viviendas. Argentina. 2010." *Instituto Nacional de Estadistica y Censos*, 2019, www.indec.gob.ar/indec/web/Nivel4-Tema-2-41-135. Accessed 6 Dec. 2021.

Chiarotti, Susana, et al. *Con todo al aire 1. Reporte de derechos humanos sobre atención en salud reproductiva en hospitales públicos*. INSGENAR, CLADEM, 2003.

Chiarotti, Susanna, Schuster Gloria, and Armichiardi Susana. *Con todo*

al aire 2. Reporte de derechos humanos sobre atención en salud reproductiva en hospitales públicos. BINSGENAR, CLADEM, 2008.

Council of Europe Parliamentary Assembly. "Obstetrical and Gynaecological Violence." *Council of Europe*, 2019, assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-en.asp?fileid=28236&lang=en. Accessed 6 Dec. 2021.

Davis-Floyd, Robbie, and Caroline Sargent, editors. *Childbirth and Authoritative Knowledge. Cross-Cultural Perspectives*. University of California Press, 1997.

García Conto, Silvina. *Resumen de informe. Secretaria de Derechos Humanos y Pluralismo Cultural*. Dic 2015/Dic 2019, 2020. Unpublished.

Grupo de Información en Reproducción Elegida. *Obstetric Violence*. GIRE, 2015.

Hernández-Sampieri, Roberto, Carlos Fernández Collado, and Maria del Pilar Batista. *Metodología de la investigación*. McGraw Hill, 2006.

Herrera Vacaflor, Carlos. *Obstetric Violence in Argentina: A Study on the Legal Effects of Medical Guidelines and Statutory Obligations for Improving the Quality of Maternal Health*. Thesis. University of Toronto, 2015.

Jordan, Brigitte. "Authoritative Knowledge and Its Construction." *Childbirth and Authoritative Knowledge. Cross-Cultural Perspectives*, edited by Robbie Davis-Floyd and Carolin Sargent, University of California Press, 1997, pp. 55-88.

Larguía, Miguel A., Cecilia L. Lomuto, and María Aurelia González. *Guía para transformar Maternidades tradicionales en Maternidades Centradas en la Familia*. Ministerio de Salud-UNICEF, 2007.

Las Casildas. *Observatorio de violencia obstétrica. Informe final*. Las Casildas, 2015.

Maternidad Estela de Carlotto. *Informe anual de gestión*. MEC, 2016.

Lock, Margaret, and Vinh Kin Nguyen. *An Anthropology of Biomedicine*. Wiley-Blackwell, 2010.

Ministerio de Salud de la Nación. *Segundo informe nacional de relevamiento epidemiológico*. Ministerio de Salud de la Nación, Organización Panamericana de Salud, 2015.

Olza-Fernandez, Ibone. "Estrés postraumático secundario en profesionales de la atención al parto. Aproximación al concepto de violencia obstétrica." *Cuadernos de Medicina Psicosomática y Psiquiatría de Enlace*, vol. 111, 2014, pp. 79-83.

Quattrocchi, Patrizia. "Obstetric Violence Observatory: Contributions of Argentina to the International Debate." *Medical Anthropology*, vol. 38, no. 8, 2019, pp. 762-76.

Quattrocchi, Patrizia, and Natalia Alemán. *Violencia obstétrica en América Latina. Conceptualización, experiencias, medición y estrategias.* Universidad Nacional de Lanús, 2020.

Pérez D'Gregorio, Roger. "Obstetric Violence: A New Legal Term Introduced in Venezuela." *International Journal of Gynaecology and Obstetrics*, vol. 111, no. 3, 2010, pp. 201-02.

República Bolivariana de Venezuela. "Ley Orgánica sobre el derecho de las mujeres a una vida libre de violencia." *Asemblea nacional de Venezuela. Gobierno del Estado*, 2007, venezuela.unfpa.org/sites/default/files/pub-pdf/Ley_mujer%20%281%29_0.pdf. Accessed 6 Dec. 2021.

República de Argentina. "Ley nº 25.929—parto humanizado. Ley nacional nº 25.929 de derechos de padres e hijos durante el proceso de nacimiento." *Boletín Oficial 30489*, 2004, www.argentina.gob.ar/sites/default/files/ley_25929_parto_humanizado_decreto_web_0.pdf. Accessed 6 Dec. 2021.

República de Argentina. "Ley 26.485 de protección integral para prevenir, sancionar y erradicar la violencia contra las mujeres en los ámbitos en que desarrollen sus relaciones interpersonales." *Boletín Oficial 17.31.632*, 2009, www.argentina.gob.ar/noticias/comienza-el-proceso-de-reforma-de-la-ley-26485-de-proteccion-integral. Accessed 6 Dec. 2021.

Sadler, Michelle, et al. "Moving beyond Disrespect and Abuse: Addressing the Structural Dimensions of Obstetric Violence." *Reproductive Health Matters*, vol. 2, 2016, pp. 1-9

Villarmea, Stella, Ibone Olza, and Adela Recio. "El parto es nuestro: El impacto de una asociación de usuarias en la reforma del sistema obstétrico de España." *Dilemata. Revista Internacional de Éticas Aplicadas*, vol. 7, no. 18, 2015, pp. 157-83.

White Ribbon Alliance. *Respectful Maternity Care: The Universal Rights of Childbearing Women*. White Ribbon Alliance, 2011.

World Health Organization. "Appropriate Technology for Birth." *Lancet*, vol. 24, 1985, pp. 436-37.

World Health Organization. *Care in Normal Birth. A Practical Guide, Reproductive Health and Research. Report of a Technical Working Group.* WHO, 1996.

World Health Organization. *The Prevention and Elimination of Disrespect and Abuse during Facility-Based Childbirth*. WHO, 2014.

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

Women's Link Worldwide. "Hungary, European Court of Human Rights: Ternovszky v. Hungary." *Women's Link*, 2013, womenslinkworldwide.org/en/gender-justice-observatory/court-rulings-database/ternovszky-v-hungary. 2013. Accessed 6 Dec. 2021.