OBSTETRIC VIOLENCE OBSERVATORY:

CONTRIBUTIONS OF ARGENTINA TO THE INTERNATIONAL DEBATE

Patrizia Quattrocchi

Abstract

In Latin America, over the past decade, the term "obstetric violence" has become part of the legal framework. Specific laws against obstetric violence – gender-based violence and the violation of human rights – exist in Venezuela, Argentina, Mexico, Brazil and Uruguay. In Europe, the issue is raised by human rights organizations, social movements and academics, but no country has yet passed legislation on the matter. In this article, I focus on the contribution of Argentina to this international debate, particularly with respect to the implementation of the Obstetric Violence Observatory.

Spanish abstract

En América Latina, en la década pasada, se introdujo un nuevo término legal para proteger a las mujeres durante el parto: "violencia obstétrica". Existen leyes específicas contra la violencia obstétrica en países como Venezuela, Argentina, México, Brasil and Uruguay. En estos países la violencia obstétrica se considera un tipo de violencia basada en el género y una violación de los derechos humanos relacionados con la salud reproductiva. En Europa, el tema es discutido por las organizaciones de los derechos humanos, los movimientos sociales y la académia, pero ningún país ha aprobado una legislación al respecto todavía. El objetivo de este trabajo es presentar los aportes de la Argentina al debate internacional. La discusión se centrará en la implementación del Observatorio de Violencia Obstétrica.

Keywords: obstetric violence, childbirth, gender violence, reproductive rights, Argentina

Running title: Obstetric Violence Observatory

Media Teaser: The Obstetric Violence Observatory implemented in Argentina has assumed an important role to promote awareness of and prevent obstetric violence at national and international level. How?

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The Observatory of Obstetric Violence (OVO), implemented in Argentina by the *Las Casildas* civil organization, assumed at local and international levels the role of promoting awareness of and preventing obstetric violence. In discussing this role, I stress the potential of this innovative tool to give visibility to a subject that is still not sufficiently debated by specialists or in lay society, despite specific laws and public strategies. The data derive from ethnographic fieldwork undertaken in Argentina between October 2016 and August 2017.

Over the last century, pregnancy and childbirth have become increasingly medicalized in much of the world. The process of childbirth is often conceived of and treated as a medical event, requiring control, risk management and constant monitoring of the woman's body (Davis-Floyd 1992; Davis-Floyd, Barclay, Daviss and Trietten 2010; Browner and Sargent 2011). In many hospitals, a more humanized model of birth has been introduced in recent decades, including home-from-home rooms, free position during childbirth, and the use of a bathtub. Nevertheless, in many countries, unnecessary and potentially harmful medical interventions such as labor-inducing drugs, lithotomy position, epidurals, manoeuvres, episiotomies and caesarean sections are conducted on a routine basis or overused against evidence-based medicine (Miller, Abalos, Chamillard et. al. 2016). Overmedicalization of normal pregnancy and birth is particularly increasing, despite recommendations by the World Health Organization (WHO), which for more than four decades has been pushing governments and health institutions to implement programs to demedicalize the reproductive process and reduce unnecessary interventions in normal birth, including caesarean sections (WHO 1985, 1996, 2015).

Sometimes women undergo unnecessary medical interventions, often without being asked to consent. In some cases, coercion can be psychological or implicit, i.e., related to the authoritativeness of biomedical knowledge and power issues in the doctor-patient relationship (Davis-Floyd and Sargent 1997, Lock and Nguyen 2010,

Good, Fischer, Willen et al. 2010). The authority of medical-scientific knowledge at times limits a woman's fundamental right to participate actively in the process of pregnancy and childbirth and to decide in a free and conscious manner in relation to her own body. In this sense, the hegemonic medical model becomes an authorized knowledge, "a power that is given not because it is right but because it is the one that counts. (Jordan 1997:131).

In Latin America, over the past decade, the term "obstetric violence" has become incorporated into legislation. In the context of labor and birth, this concept refers to the unjustified use of medical intervention, disrespectful and dehumanizing treatment, an abuse of medicalization, and pathologization of the natural process of birth (Sadler et al. 2016). Establishing obstetric violence as a recognized issue has been complex, as the concept of medicalization does not refer exclusively to the doctor-patient relationship or the medical profession but to broader sociocultural processes in which knowledge is elaborated and legitimized (Fassin 1998, Conrad 2007). In addition to being considered a type of institutional violence and a violation of human rights related to health and reproductive health (WHO 2014b), this type of violence is considered to be gender-based: a form of violence against women within a framework of subordination and discrimination (Castro and Erviti 2015).

The process that led to the recognition of this type of violence in Latin America is rooted in the social movements which, since the 1970s, have been fighting for sexual and reproductive rights and against gender violence (Camacaro Cuevas 2013). International conventions such as The Convention on the Elimination of All Forms of Discrimination against Women (1979), The Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (1994), the International Conference on Population and Development in Cairo (1994) and the

World Conferences on Woman (from Mexico City in 1975 to Bejing in 1995) provided the legal framework within which obstetric violence came to be conceptualized as gender violence and a violation of human rights.

An important step in the process of gaining recognition for obstetric violence was the International Conference on the Humanization of Childbirth held in Fortaleza, Brazil in 2000. At this conference, a group of participants from 12 countries decided to found the RELACAHUPAN - *Red Latinoamericana y del Caribe para la Humanización del Childbirth y Nacimiento*. The network was organized in national offices. Because of the favorable political context after Fortaleza, in 2001, the issue began to appear in the national agendas of the involved countries. In this context, the current understanding of the term "obstetric violence" was conceived (Camacaro Cuevas 2010). In 2004, Argentina, with pressure from social movements and civil and non-governmental organizations, enacted Law no. 25,929, also known as the Law on Humanized Childbirth. This law paved the way for Law no. 26,485 on gender violence (2009), in which obstetric violence was defined. Two years prior, in 2007, Venezuela became the first country in the world to define obstetric violence in a national law (2007), which was drafted by activists, professionals and academics, some but not all of whom were feminists. Specific laws against obstetric violence were also enacted in some states of Mexico between 2007 and 2017, and in the state of Santa Catarina in Brazil and in Uruguay in 2017.

In Article 15 of the Venezuela Organic Law on the Right of Women to a Life Free of Violence, obstetric violence is defined as:

> The appropriation of the body and reproductive processes of women by health personnel, which is expressed as dehumanized treatment, an abuse of medication,

> and to convert the natural processes into pathological ones, bringing with it loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting their quality of life. (República Bolivariana de Venezuela 2007:7)

According to this definition (Article 51), the following acts performed by health personnel are considered obstetric violence: 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 his/her mother without a medical cause; altering the natural process of low-risk labor 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 (Pérez D'Gregorio 2010:202). For the perpetrators of obstetric violence, administrative sanctions are foreseen. A similar definition of obstetric violence operates across Argentina, Mexico, Brazil and Uruguay, although with some differences regarding sanctions: in Venezuela, obstetric violence is an administrative offence punishable by a fine; in at least three Mexican states it is an offence carrying the possibility of a prison sentence (GIRE 2015). In other countries, such as Chile, Ecuador, Perú, Uruguay, Colombia and Costa Rica, the issue is under discussion, both socially and politically.

In Europe, the issue has been raised by human rights organizations and social movements fighting for more humane and respectful births (e.g. Amnesty International). In Spain, Italy and France (https://ovoitalia.wordpress.com;https://www.elpartoesnuestro.es; https://www.facebook.com/Observatoire-Violence-Obstétricale) on obstetric violence have been implemented, but no country has yet passed legislation. Despite the activism

of associations (Akrich, Roberts and Nunes 2014; Villarmea, Olza and Recio 2015), public and especially political debate on the subject is still weak. This is despite wide recognition that over-medicalization and disrespect in pursuit of some goal do not benefit women or their children; they deprive women of an active role in childbirth. As a result, the costs to health care systems (through the use of unnecessary resources) and the number of legal disputes also increase. In addition, women are limited to the exercise of their rights to choose the circumstances of childbirth, as established by the European Court of Human Rights in the case of Ternovszky v. Hungary in 2010 (www.freedomforbirth.com). Further, a wide range of possibilities still exist with respect to childbirth, according to the local context and the health care system organization (Europeristat 2010). In some countries, medical intervention during childbirth has shown a downward trend, avoiding interventions that pathologize the process (e.g., Great Britain); in other countries (i.e. Italy and Spain), the medicalization of labor and birth is still widespread.

Although the World Health Organization does not explicitly use the concept of obstetric violence, it affirms that all women have the right to receive the highest level of health care, including the right to dignified and respectful care in pregnancy and childbirth, and the right to be protected from violence or discrimination (WHO 2014). Disrespectful and abusive treatment during childbirth, it argues, "not only violates the rights of women to respectful care, but can also threaten their rights to life, health, bodily integrity, and freedom from discrimination" (WHO 2014a:1). Within this context arose, the research project on which I draw in this article developed. The project objective was to generate new ways to discuss childbirth issues, and from this, to explore the transfer of Latin American experiences on recognising and preventing obstetric violence 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. The first year of research took place in Argentina (National University of Lanus, 2016-2017); the second in Italy (University of Udine, 2017-2018).

MATERIALS AND METHODS

The results presented in this article relate to the first objective of this project, to analyse the historical, social and political processes that led to the legal recognition of obstetric violence in some Latin American countries, in particular Argentina. Fieldwork was performed in Argentina during the first year of research (October 2016-August 2017), using a range of qualitative instruments and techniques. The study included 138 persons (key informants, health education program managers, residents, health personnel and students), all adults and healthy people. Semi-structured interviews were conducted with a total of 33 informants (activists, doctors, obstetricians, government officials, academics, training managers in health issues, teachers). A survey was conducted with 70 residents and 35 health personnel in Obstetrics-Gynaecology and Midwifery in six public hospitals, and 35 nursing degree students. Thirteen public events (debates on obstetric violence, health personnel training events, dissemination events) were observed. In mapping the history of the concept of obstetric violence, on which I focus here, interviews were conducted with people who had a role in the design and implementation of the law or were involved, by profession or activism, in the promotion of actions to recognize and prevent obstetric violence (activists, politicians, doctors, midwives, government officials, lawyers, and academics). Participation was voluntary. All interviewees signed the informed consent form and were assured anonymity. I conducted all interviews in Spanish; each lasted around one hour to 75 minutes, and were audio-recorded and transcribed literally. An observation guide was

also prepared to observe the 13 public events held by Las Casildas and other events at which its members were present, with notes of the 28 hours of observation kept in a field diary.

The transcribed interviews were coded (open coding) using ATLAS.ti qualitative research software. For the analysis of data units, categories, themes and macro-issues were identified, compared and contrasted, as per ethnographic method and text analysis (Hernández-Sampieri, Fernández Collado and Pilar Batista 2006). The data collected through the observation guide for public events were analysed through qualitative and quantitative indicators, including type of event, organization and organizers, visibility/publicity, setting, number of participants, number of interventions, and topics discussed, and the analysis of the field notes.

BACKGROUND: THE LEGAL FRAMEWORK AND CHILDBIRTH CARE IN ARGENTINA

Following the International Conference on the Humanization of Childbirth held in Fortaleza in 2000 and the First International Conference on Homebirth (Jeréz de la Frontera, Spain, 2000), Argentinian social movements fighting for women's sexual and reproductive rights and for more respectful births (e.g., the civil organization *Dando a Luz,* the newly established RELACHAPUAN-*Argentina,* and the network *Ama de Casa*) fomented the debate on how to change policies and practices related to birth. A humanized model of birth, in contrast to a technocratic model of birth (Davis-Floyd 1992), was introduced to decision makers and the public at conferences and public events. Social movements –feminist movements that had already been active for some time in Argentina (Gonzáles et. al 2017) – together with groups of women supporting pregnant or breast-feeding women or women who were victims of violence, were key

elements in the process of implementing Law no. 25,929, also known as the Law on Humanized Childbirth. A favorable political environment (a Peronist government) allowed activists to participate in the political debate and address the issue of respectful birth in the political agenda. The law was passed in 2004, but the regulations were not elaborated until 2015, with Decree 2035/2015 of President Cristina Kirchner. It was the first Argentine law to address childbirth and birth.

The *Encuentro Nacional de las Mujeres* (Women's National Meeting) – an annual meeting that began taking place in Argentina in 1986, whose original participants had attended the world conference in Nairobi in 1985 – played an important role in catalysing these efforts. The movement influenced not only the political discussion of the Law on Humanized Childbirth, but also promoted a long debate that, in 2009, led to the approval of the Law 26,485 and Article 6, which defines obstetric violence.

The Law on Humanized Childbirth declares that a pregnant woman has, among others, the right to be treated with respect of her person, intimacy and her cultural customs; to be considered as a healthy person, in such a way that she can participate actively in her own delivery; to have a natural birth, according to her biological and psychological timing; to be informed about the different possible medical interventions, to choose freely among the alternatives, and to avoid invasive and unnecessary practices; to be accompanied by a trusted person chosen by her during the labor, delivery and postpartum period; to have her baby with her during her stay at the care facility; and to be informed on and to receive assistance with the 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. This and subsequent laws, enacted to protect the rights of women and patients (Law no. 25,673 for the

implementation of the National Programme of Sexual Health established in 2006 and the National Law on Patients' Rights (2009), constitute the legal framework establishing Argentine's definition of obstetric violence. The term entered into the legal framework in 2009, when Argentina sanctioned and promulgated Law 26,485, the Law of Comprehensive Protection to Prevent, Sanction and Eradicate Violence Against Women. Article 6 defines obstetric violence 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 2009:3). The definition includes as health care personnel not only doctors but all professionals who provide care for women during pregnancy, childbirth, and birth.

In 2011, CONSAVIG (*Comisión Nacional Coordinadora de Acciones para la Elaboración de Sanciones de Violencia de Género*) was implemented by the state with the aim of drawing up sanctions against gender violence, including obstetric violence. Since 2013, CONSAVIG has coordinated a working group on obstetric violence, and in 2017, it began receiving complaints from women -- 89 that year (CONSAVIG 2017). The statistics of the CONSAVIG do not include the number of proceedings, and a comprehensive tool to collect data at the national level has not yet been implemented. The complaint process is not an easy process for women, whether bureaucratically or in terms of finding psychological or legal support. The *Defensoria del Pueblo* (Ombudsman Service) – a public body responsible for controlling the quality of the public administration service – is assisting women at any stage of the complaints process. It receives complaints, accompanies the victims, and refers them to other bodies (e.g. Ministry of Health or Ministry of Human Rights). Since the end of 2016, the Ministry of Human Rights and Cultural Pluralism has also addressed obstetric

violence through a working group that organizes training and awareness activities on the topic.

Despite the implementation of these laws and strategies, and the implementation of more humanized childbirth in some hospitals, the model of care for childbirth in Argentina continues to be highly medicalized, as confirmed by health institutions and international organizations (Herrera Vacaflor 2016). According to the Second National Epidemiologic Report, on average caesarian section accounts for 30.6 percent of all births in public hospitals registered in the country between 2010 and 2013, and between 60 and 70 percent in the private sector (*Ministerio de Salud de la Nación* 2015). Recall that caesarean rates above 10 percent are not associated with a reduction in maternal and neonatal mortality rates (WHO 2015). Standardized and routine practices - such as labor-inducing drugs, manoeuvres, use of the supine position, routine use of enema and pubic shaving, rectal examination, restriction of food and fluids during labor, manual exploration of the uterus after delivery, electronic fetal monitoring, episiotomies and c-sections - are maintained also despite international evidence against these (WHO 1996) and despite consistent opposition to them over the last decade, particularly by civil organizations (Chiarotti et alt. 2003; Chiarotti, Shuster and Armichiardi 2008).

FINDINGS

I have briefly reconstructed above the process that led to the implementation of the legal framework regarding the care of pregnancy, childbirth, and birth in Argentina. I turn now to the experiences of people who played a key role in the writing of the Law on Humanized Birth and Law on Gender Violence, and to those people who are now

working for the recognition, prevention, and reporting of obstetric violence. Among these, the activity of Las Casildas is significant.

Las Casildas

Located in Buenos Aires, Las Casildas is a civil organization considered to be feminist by its members. It presents itself as a "group formed by people who from different areas generate strategies and contributions with the aim of disseminating information about pregnancy, delivery, childbirth, and the raising of children, in addition to gender issues" (www.lascasildas.com.ar). The members of Las Casildas come from different backgrounds. The core group is composed of the founder (a social psychologist who was working in advertising when the group was founded and is currently employed as a neonatal nurse), a biologist, a male midwife, four actresses, two psychologists and two lawyers. It was established in 2011 from the founder's experience of motherhood and, using social networks, her willingness to share with other women her own trajectory as a pregnant, birthing, and first-time mother:

> The birth of my daughter was a childbirth very much within the system, in an affluent upper-middle-class facility of Buenos Aires. It was a vaginal birth … At the time when I started screaming, I screamed, and the doctor came in and said, "Why are you screaming?" That was the break, that kind of intervention stayed with me. How could it be that in a place like this, a doctor is alarmed when a woman screams? It came as a click, I began to read, so I discovered Casilda [Casilda Rodrigañes Bustos is a Spanish feminist writer]. In 2011, through Facebook, I created Las Casildas. (Julieta, the founder)

From then on, her personal experience spread on the network, and – later – from a media campaign on Facebook, the historical core of the organization emerged;

> The truth is that the years that I had been working in advertising played in my favor regarding how fast the material I uploaded was viewed. Through this profile, I met many people. (Julieta)

In a few years, the group has become a national reference point on respectful childbirth and reproductive rights, through the process of the resignification of private experience (giving birth) to the public arena. This process characterized women's activism surrounding labor and childbirth and constituted a new form of citizen participation virtually and face-to-face, individually and collectively (Reiger 2000; Apfel 2016; Davis Floyd 2017).

The organization does not receive public or private funding for its daily activities; it is completely self-financed, and its members do not receive a salary. Private or public funding is sought for specific projects, however; for example, for the production of the documentary *Parir*, screened for the first time in May 2017 in Buenos Aires. Las Casildas collaborates with other civil organizations, such as *Dando Luz (Mothers Association)*, *Asociación Argentina de Parteras Independientes* (Independent Argentinian Independent midwifery Association) and the *Asociación de Puericultoras* (Pediatric Nurse Association) and with government organizations. A few years ago, the *Consejo Nacional de las Mujeres*, a public institution working on gender issues, asked Las Casildas to collaborate to publicize the 144 gender violence telephone hotline. A collaboration with CONSAVIG was also undertaken, although within the last year, Las Casildas members have more closely aligned with the activities of *Defensoria del Pueblo* in order to support women in the complaint process. An agreement between

Las Casildas and the *Defensoria del Pueblo* organizations was signed in July 2017, when I was undertaking fieldwork. A strong collaboration is also in place with the public maternity hospital "Estela de Carlotto" in Moreno (one hour from Buenos Aires City), where the founder of Las Casildas coordinates a pediatric nurses group and works as a pediatric nurse herself. The hospital opened in Moreno in 2013 according to the *UNICEF - Safe And Family-Centered Maternity Hospitals Program*, and is considered an excellent and unique experience in the national landscape, offering women with low-risk pregnancies a respectful birth experience according to the Law of Humanized Childbirth (Maternidad "Estela de Carlotto" 2016).

The Observatory of Obstetric Violence in Buenos Aires

The Observatory of Obstetric Violence (OVO) was established in October 2015 as an activity of Las Casildas. The objectives are well defined in its website (www.lascasildas.com.ar): to collect and systematize data and statistics related to obstetric violence; to follow up on complaints; to monitor public policies; to make recommendations to the agencies and institutions involved; to create spaces of dissemination and debate with professionals and citizens in general; to promote research projects; and to articulate work and actions with other national and international observatories. The OVO founders are both members of Las Casildas (the founder of Las Casildas and one of the actresses), who were encouraged by the idea of building a national network that, through different mechanisms, would expose and so address obstetric violence in the country: "Actually, everyone told us 'You are crazy! They will not be able to!' This gave us more momentum, and we launched the observatory in October 2015." (Julieta)

One of the first actions of those involved in the OVO was to design a survey on childbirth and/or caesarean delivery and to upload it, so that any woman could access the survey, complete it, and send it to the organization. The instrument was designed by the core group, and provided 55 closed-ended questions or semi-structured questions related to treatment; practices performed with regard to the body of the woman and the new-born; and information provided by health professionals. The topics explored were broad and refer to the content of Law 25,929: the presence of a companion, comments, jokes, nicknames, criticisms against women, discrimination, intimidation (for example, through phrases such as "you are putting the life of your baby at risk"), umbilical cord cutting, initial contact and attachment, breastfeeding, and practices performed on the baby. The survey was launched at the national level along with the implementation of the OVO through the Las Casildas website; the instrument was also administered in person in several provinces of Argentina with the collaboration of activists following theLas Casildas activities. Data collection took place from September 2015 to August 2016, resulting in 4939 surveys submitted. The purpose was to have quantitative data that could shed light on the problem and draw the attention of public institutions and decision makers. One OVO member (a biologist with statistical expertise) analysed the data: "We interviewed women who are informal garbage collectors, we went into *Villa Miseria* (a shanty town around Buenos Aires), we were in the primary care centers, and we interviewed people of the upper-middle class" (Ester). In October 2016, the data were presented at the *XXXI Encuentro Nacional de Mujeres* (The 31st Women National Meeting) held in Rosario. The Meeting dates back to 1986, when the first Meeting was held in Buenos Aires according to the participatory model tested in the Nairobi World Conference on Woman (1985). . In Rosario, thousands of women from across the country met to discuss issues of gender violence and women's

rights violations. For the first time, the country had data related to what Law 26,485 defines as "obstetric violence." Failure to comply with the law is evident in the data presented in Table 1 (Las Casildas 2015).

Insert Table 1 about here

The "Parir(NOS)" play

The OVO and the survey results were presented in public talks and workshops with women, organized by Las Casildas, other civil organizations, and at other events (i.e., talks in hospitals or at cultural centers) where one or more members of the core group were invited to speak. Media and social media (e.g., Las Casildas Facebook page)[1] were also used as a forum in which to discuss related issues.

On the occasions in which I have participated, the presentation was part of a larger event, which contemplated the use of another instrument, designed and implemented by Las Casildas: the play *Parir(NOS)*. During the play run of 45 minutes, four actresses (all members of Las Casildas) report on four different experiences of births: a caesarean delivery, a home delivery, an operative vaginal delivery (forceps and ventouse), and a respected delivery. Within this framework, different models of care are explored. What these experiences have in common is the dramatic cry of the protagonists: "Something is not right." The objective of the play is to make obstetric violence visible through the narrative, and to promote a public debate on the subject so that women can know and, above all, recognize this type of violence, of which they have often been silent victims.

Las Casildas places on the agenda the naturalization of obstetric violence, through a collective process of normalizing events that occur systematically during childbirth in medical facilities. As a product of the complex mechanisms of legitimizing knowledge and power hierarchies, naturalization transforms these events into "normal"

events. As a consequence, they are conceived by social actors as "naturally" correct and beyond criticism. This rejects awareness and possible critiques of these processes by women, their partners, and society as a whole, and affects gender violence in this and other aspects of women's life (Segato 2010).

In this context, the play is conceived as a "trigger" (in the words of the co-author of the text Violeta, who acts on stage as well) to capture the attention both of people who already know about or are involved in the subject, and of people who are approaching this type of violence for the first time: "There are women who recognize for the first time that there is violence; that is, it can be named. What happened to me is violence, it's called obstetric violence, and it's expressed in this way" (Violeta).

The reflection that the work provokes also extends to health professionals, who do not – in their career – have many opportunities to develop a critical sense of their own practices, knowledge, attitudes, habits, and protocols: "Some professionals when finishing the work said: 'Well, I never realized that what I did could generate that. Recognizing this as violent practice. It never occurred to me'" (Violeta).

Additionally, no less important in the narrative of the co-author of Parir(NOS), is her comment about the partners of women who suffered some type of violence, highlighting the multiple consequences of obstetric violence in the medium and long term, both individually and socially:

> It has also happened with the partners, who say: 'Of course, now I understand, when she told me about this she had experienced, oh…it's this, this is what she felt.' ... Because it is not the same to go be able to go through an experience so intense regarding pleasure, autonomy, recognition of the body, and for this partner to witness this, to witness a scene of violence (Violeta).

The efficacy of the work is to give voice to the many women who have had no voice to relate their experiences of suffering, and to resurrect feelings and/or emotions experienced that were never signified and/or elaborated. The incorporation of the suffering expressed through the words, the corporeality, and the gestures of the actresses, makes it possible for audience members to develop feelings of identification and empathy, or at least doubts and curiosity. The "trigger" acts not only for women but also for all people who attend the performance. At the conclusion of the play, a debate – in which Las Casildas members respond to audience questions -- makes it possible to share reflections with the audience, developing an empathic learning process that leads to a process of introjection of information through emotion and identification.

The play, according to members of Las Casildas, makes it possible for women to present and discuss issues of obstetric violence in different places (inside and outside Argentina) and in spaces that are sometimes difficult for a civil organization to reach:

> Every month, we have at least one function. We travelled to Paraguay, travelled to Chile with the play, in primary care rooms, in different places. We were allowed to enter places where we would not be able to give a talk... We were not going to enter a hospital, they were not going to ever invite us to give a talk. Never. (Violeta)

During my stay, the play was performed in different settings. Usually, Las Casildas members are invited to perform. The play is increasingly well known, at least in Buenos Aires City and in the surrounding areas, and the issue is widely debated publicly and in the media. For instance, I attended two performances in the atrium of the main building of the Buenos Aires Faculty of Medicine, where students, health professionals and professors walked through. The performance – followed by the presentation of survey data and a public debate – was organized

by a group of medical students. Another performance I attended was at the *Festival de Parto Respetado (Respectful Birth Festival)*. This was organized in March 2017 by different civil associations in the city of Buenos Aires and targeted at families, and comprised a full day of discussion on childbirth issues and the sharing of experiences. I also attended performances at the Ministry of Human Rights and in the Maternity Hospital "Estela de Carlotto" in Moreno, where health professionals were invited to participate.

DISCUSSION

The legal definition of obstetric violence in Argentina – as in Venezuela – refers to gender inequality, which reproduces (and is a product of) the naturalization of female subordination to a system of social organization. From a feminist perspective, this has been defined as "patriarchal," and this includes the health systems of nation states (Martin 1987, Lewin 2006). However, the legal definition does not allow us to understand and explain the historical, social, political, and economic roots that produce and legitimize this kind of violence An anthropological perspective allows us to locate obstetric violence within its socio-historical context and unravel the many aspects and dimensions that appear when we speak of this type of violence. In addition, we can problematize the different definitions of this violence, and understand the logics, trajectories, and degree of appropriation and/or rejection on the part of the different social actors involved, both individually and institutionally (women and men, health professionals, officials, politicians, researchers, institutions, groups, associations, etc.). In this sense, the construction of the concept of obstetric violence becomes a "site of contestation" (Castrillo 2016), in which different subjects interact and different

strategies of the legitimization or delegitimization of this violence are set in motion, from the perspectives and interests of each actor.

From a biomedical perspective, the concept of "obstetric violence" is not seen as a tool contributing to the design of new strategies to reduce medicalization. On the contrary, sometimes it is wrongly perceived as a "controversial" issue or as an accusation or judgemental concept directed at an individual (health professional), institution (hospital) or discipline (biomedicine). In Italy, for instance, the Association of Hospital Obstetricians and Gynecologists has recently published a document on the issue. The draft states that "pulling the terms 'violence' and 'obstetrics' together results in a serious disparaging effect for health professionals" (AOGOI 2017:2). It is also "an offensive tool of the reputation of health professionals, a blatant attack and aggression on the moral sphere"(AOGOI 2017:2). This debate was provoked by the recent publication of the national "Women and Childbirth Survey" conducted by Doxa, a research and statistical analytics institute, commissioned by the Italian Obstetric Violence Observatory and other civil organizations (Ravaldi et al. 2018). Four hundred twenty-four mothers were interviewed; 21 percent declared that they had experienced obstetric violence while giving birth, and 41 percent declared they were subjected to practices that violated their dignity and psychophysical integrity. The data have generated a strong debate between the OVO and the different scientific and professional societies of Italian obstetrics/gynaecology and midwifery. The latter cite the "methodological weaknesses of Doxa research" (Lauria et. al 2018), avoiding a real debate on the issues.

Research data show that midwives seem to be more conscious than doctors of obstetric violence. Spanish midwives, for instance, report being traumatized by witnessing obstetric violence or depressed from feeling like accomplices; some leave

their jobs because of trauma and burnout (Olza-Fernández 2014). Even so, the term "violence" is generally not appreciated by health professionals or is misunderstood. Alternative (but sometimes quite different) expressions such as the "violation of human rights during childbirth," "disrespect or abuse," "mistreatment" or "abusive care" are also reported in the literature (Bowser and Hill, 2010, Bohren 2015, Pickless 2015). A lack of consensus on the terminology and tools persists, as does the lack of data to compare high and middle-income countries (Savage and Castro 2017).

On the other hand, trials and court judgments on obstetric violence around the world, are also increasing, as shown by the Josephine case in Kenya (https://www.reproductiverights.org/press-room/kenya-high-court-rules-in-favor-of-woman-physically-abused-during-delivery) and Augustina's case in Argentina (https://www.infobae.com/sociedad/2017/06/28). In this arena, the power relations between doctors and patients come to light, based on who supposedly has the knowledge; the topic of medical training, both in the academic curriculum and in the hidden curriculum; the organization of health services and the working conditions of health professionals; variables of class, ethnicity, and gender as social determinants of health; and the commodification of pregnancy and childbirth, the birth process and the new-born "product." This draws attention to how social relations and power are produced and reproduced between individuals and between individuals and institutions; and how these relations produce social structures and ideologies that become carriers of "authorized knowledge," socially legitimized, unquestionable, and unquestioned, as biomedical knowledge and "obstetric power" (Arguedas Ramirez 2014). This "authorized knowledge" leads to the displacement and systemic devaluation of other forms of knowledge, including women's knowledge (Franklin and Ragoné 1998; Lock and Kaufert 1998; Lock and Farquahar 2007). Women areconsidered patients or users

of health services but are not conceived and treated as people who are bearers of rights (Belli 2013; Khosla et al. 2016).

Human rights in general (the rights to personal integrity, privacy, and intimacy, information and autonomy and freedom in decisions, respectful treatment, and non-discrimination, among other things (White Ribbon Alliance 2011) are intertwined with rights related to gender, health, and reproductive health, as noted in various international conventions, such as the Convention on the Elimination of All Forms of Discrimination against Women (1979) and the Convention of Belén du Pará (1994). These rights constitute a cross-cutting axis to understand the processes, noted above in terms of "violation" and reproduction – at their different levels – of inequality, inequity, and injustice (Cook, Dickens and Fathalla 2003). Childbirth without violence is a human right and a right to reproductive health that all women possess and can/should exercise whatever their origin, culture, physical and psychological state, and trajectory. This perspective makes it possible to insert the issue of obstetric violence in a transcultural, structural, and relational process. Obstetric violence is not only a problem for women or the State; nor does it prove to be only a problem of the quality and organization of health services or the training of professionals. It is a broader issue, in terms of "structural violence" (Magnone 2011; Sadler et al. 2016). It requires different perspectives of analysis and different tools of action, some of which must be promoted by the State (such as the law and the human rights perspective, as occurred in Argentina) and others that emerge from society, such as group militancy and associations that claim and defend reproductive rights.

Gender, power, and human rights in childbirth are also the focus of discussion and analysis in the activities of Las Casildas, the organization that launched the OVO in Argentina and conducted the first national survey on the subject. The results of the

survey, demonstrating non-compliance with the Law on Humanized Childbirth, outline the perpetuation of a hegemonic model that draws neither on scientific evidence nor international guidelines. On the contrary, it is a model that is self-sustaining and self-legitimizing through the dynamics of power and biopower (Foucault 1963). In this sense, through more or less coercive "dispositives" (such as "routine" practices), pregnant women and those in labor become docile, controlled bodies, moulded by the institution and its ideal: anesthetized body-objects, paralysed and mutilated (real or symbolic), objects of intervention. The subjective dimension of "being" and "being able" disappears in the process of the naturalization and mystification of the need to "act" and, frequently, of "being acted upon" by the professional, the only person legitimized to handle the process.

In this context, the "format" proposed by Las Casildas (the play, the presentation of the OVO, and debate) plays an important role in visibility and denunciation in different areas, for different reasons. In particular, the OVO serves as a mechanism of awareness, visibility and action towards pregnancy, childbirth, and violence-free birth. However, it also allows audience members to draw out possible connections and interconnections with experiences, recently implemented or in implementation in other European countries. In 2016 France held the First International Congress *Droith Humains and Femmes Encientes*. As a result of the meeting, an international network of watchdog organizations of obstetric violence (InterOvo), which links European Observatories with Latin American Observatories in Argentina, Chile, Colombia, Brazil, Puerto Rico, Costa Rica, Uruguay and Paraguay, was created. The purpose of the network is to exchange information, data and expertise, and to channel data to decision makers and wider publics (www.elpartoesnuestro.es).

The OVO allows the construction and dissemination of a critical discourse with regard to the mechanisms of the legitimation of power relations between women and men and between individuals and institutions. It makes it possible to address issues related to the conception of delivery and childbirth (normal process vs. medical act/event), with the authority of medical knowledge and with the symbolic meaning of certain practices related to hospital delivery. Additional, it allows for the recognition and denaturalizing of situations of violence present in everyday life, both against women (gender violence in its different forms) and against the general public (institutional violence and human rights violations, among others). As a political mechanism, the OVO is an instrument for channelling the data collected and produced (for example, statistics) and bringing these to the attention of decision makers. It is also a mechanism for citizen participation, as an instrument implemented by a civil organization and as a space through which citizens in general (women, but not only women) can know, affirm, and exercise their rights. Las Casildas provides counselling and support in case of complaint. As a transcultural and transdisciplinary mechanism, the OVO is playing an important role at the international level, as a "format" inspiring the implementation of similar programs in other countries. In both Latin America and Europe, the Argentine experience is a reference point.

CONCLUSION

I have analysed the role of the OVO in Argentina in its different dimensions. As a social, cultural, political, transcultural, and transdisciplinary mechanism, the instrument implemented by the Las Casildas social organization has been effective for recognizing, at times preventing, obstetric violence in the country. The tools created by Las Casildas and accompanying OVO activities, i.e., the play ParirNOS and the survey, the public

talks and the documents produced, have strongly contributed to foster the de-naturalization of this kind of violence and to promote debate at social, political and health professional levels. Using OVO as a tool to speak to women and to let them speak about their experiences *through* OVO – as happened at the event I attended – provides visibility to the argument. OVO represents, from this perspective, an important tool that functions as a potential partner of public strategies, even if it is independent of the state.

Public policies in Argentina (including laws) have not been sufficient to approach the issue of obstetric violence in its multidimensionality, leading to the failure of the implementation process (Vacaflor 2015). The women-centred perspective on respectful and disrespectful birth promulgated by OVO activities represents an added dimension to the state perspective and constitutes an innovative critical participatory experience-based approach to the topic. This approach seems to be capable of making human rights issues more tangible and concrete in individuals' lives—a near-distant concept (Geertz 1974) that contributes to making visible "forms of mistreatment [that] remain unaddressed or inadequately analysed under international human rights law and standards" (Khosla et al. 2016:2). In addition, the OVO has inspired action in other countries. In Europe, the role of social movements to channel data collected (statistics, qualitative data on women's experiences, etc.) to decision makers have been reported in a few cases (Villarmea et al. 2015), showing the potential of using innovative tools (Observatories) as a channel of communication with decision makers. OVO can also become a pedagogical mechanism in obstetric medicine, a learning scenario, which, based on concrete data, contributes to innovative methods of training/updating health personnel. The dimensions noted above (social, cultural, political, transcultural, transdisciplinary, and pedagogical) are intertwined in the

construction of a critical metadiscourse on how we want to be, both as individuals and as a society.

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NOTES

[1] https://web.facebook.com/las.casildas.3/?__tn__=%2Cd%2CP-R&eid=ARA1doYe-H7oAYqW2Ut6gURnH4L0ZhoWjvQHvDNtV8Wwxq1Xb93GlFJ0AIsxKJa54s674xzGHtIDcCnf