Obstetric Violence

Realities and resistance from around the world

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

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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 9

"You're in a Hospital, Not a Hotel!": An Ethnographic Perspective on Consumer Culture, Privilege, and Obstetric Violence in Portugal

Catarina Barata

During a talk show on Portuguese television, Susana,[1] a famous TV actress in perfect makeup and shape, was asked by the male host about her recent birth at a private hospital. "It was very smooth!" she exclaimed and went on to share that despite her labour being induced, she was there for a whole day and felt very calm. She mentioned thinking, "I do not feel anything; it is as if I am in a hotel!" She praised the attitude of the whole staff as being nice and discussed how the doctor explained to her at the end of the day that her body was "not compatible with a natural birth" and that they would have to go for a caesarean section. She was visibly satisfied with what she called "a marvellous" experience.

Cláudia described a very different experience of giving birth in a state-owned hospital in the same city. A doctor entered the labouring woman's room, where she found Cláudia's birth companion resting close to her, with his head on the bed. Disturbed by the scene, the doctor woke up Cláudia's partner in a rude manner, ordering him to get

out of the room, and "in an authoritative tone [proclaimed], 'You're in a hospital, not a hotel!'" He refused to leave, and the argument escalated. The doctor called the police, resulting in the man being forced out of the hospital by five officers. About her experience, Cláudia said, "I am willing to speak up so that no mother-to-be feels as lonely as I've felt."

As these ethnographic vignettes show, there is an implicit distinction regarding the status of the user according to the sector of healthcare provision in Portugal. This distinction includes the separation of the user into either a client in the profit-driven private sector— where material comfort is a central strategy in efforts to attract customers—or into patient in the overcrowded public sector, who is often treated there as expendable and not entitled to the most basic of comforts. In this chapter, I draw on my ongoing ethnographic research[2] to address consumer culture as an entry point to understanding obstetric violence, which is the mistreatment of women during pregnancy, birth, and the postpartum period and has been framed as a human rights issue and a manifestation of structural gender violence (Sadler et al.). It assumes many forms, from outright physical violence to subtler forms of symbolic violence and coercion (Bohren et al.; Goberna-Tricas and Boladeras; Miller et al.). The few studies to date about obstetric practices and maternal satisfaction in relation to birth in Portugal reveal the prevalence of various forms of obstetric violence, such as the overuse of interventions, lack of informed consent, and verbal abuse, among others (APDMGPa; APDMGPb; Rohde; see also the edited volume by Fedele and White).

In this chapter, I analyze the ways in which material and consumer culture relate to the intricacies of the public and private sectors of healthcare in Portugal. I discuss issues of power and authoritative knowledge, as the institutional setting of facilities and their materialities allow different grades of appropriation and negotiation by different users, ranked according to a hierarchy of medical expertise. In addition, I unpack what strategies women and couples use to leverage privilege within a system that systematically precludes their agency and involvement in decision making.

The Commodification of Pregnancy and Birth in the Context of Consumer Culture

All objects convey meanings embedded in a cultural and social code, and the act of consumption is a systematic manipulation of meanings. Scholars such as Baudrillard, Bourdieu, and Douglas and Isherwood have explored how individuals expressively use consumption in order to affirm their prestige and social status (Rosales). Despite the ideological opposition between love and consumption in contemporary capitalist Western societies, motherhood and consumption—as ideologies and as patterns of social action—mutually shape and constitute each other in multiple ways (Taylor, Layne, and Wozniak). Rosalynn Vega has looked at how commodity fetishism and inequality operate within the realm of healthcare provision, questioning how a foundational bodily practice, such as birth, became alienated from humanity's physiological repertoire, only to then be commodified and reintroduced into society as a fetish that deepens unequal power relations. The reification of technology plays a major role in the commodification of pregnancy, in which a woman demonstrates her powers and her talents as a consumer and engages in the construction of her identity by the manner in which she consumes her pregnancy and birth (Taylor). What is often presented as women's agency or "co-production" in medicalized birth needs to be understood as an outcome of their exposure to a ubiquitous form of authoritative knowledge (White and Queirós 660) legitimised by a wider cultural setting.

Authoritative knowledge is the knowledge that counts, and healthcare professionals use control and access to medical instruments and procedures to establish their place at the top of the medical and bureaucratic hierarchy (Jordan). Robbie Davis-Floyd has shown how the materialities of hospital births—such as the objects that constitute the maternity ward and the multiple tools and technologies used in the management of labour—serve to normalize a technocratic value system in which the organic aspects of birth are replaced by the technological management of birth. These materialities thus represent a loss of individuality and personal identity.

I argue that the organizational culture of institutions, more or less ruled by economic goals and technocratic imperatives, accounts in great measure for the institutional gender violence that prevails in both the state-owned and private sectors of healthcare provision in Portugal.

In this context, the physical environment and the materialities per se are not key to users' perceptions of obstetric violence. Instead, what constitutes exper-iences of obstetric violence is both the use of objects, which mediate issues of power and authoritative knowledge, and the sense of appropriation of the space that results from the negotiation between professionals and users.

State-Owned and Private Healthcare Sectors in Portugal

In Portugal, the public and private sectors of healthcare services coexist and are intertwined in multiple ways[3]. Although the public sector provides the bulk of care, private assistance remains a sign of social capital and distinction in a country where there is a widespread notion that paying more automatically guarantees the best quality service (Soares). Most people cannot afford private services. An appointment at a private clinic can cost roughly ninety euros, and all treatments and examinations are charged separately. Birth costs vary depending on the type of birth and institution, ranging from three thousand euros (vaginal birth) to six thousand euros (caesarean section) (Deco Proteste). Most clients of private services have insurance[4] that partially covers the costs, but a large share of the population cannot afford health insurance4. Despite the rising tendency of birth rates in private facilities in the early twenty-first century (from 5955 in 1999 to 13249 in 2019), only 14% of all institutional births in the last decade (2010-19) happened at private facilities (INE, *Estatísticas*). As most private facilities with maternity wards are in urban, higher income areas, there are huge variations across regions.. Apart from the most obvious differences between the two sectors—namely hotel-like conditions and the generalized financial drive that accounts for attitudes and decision making in the private sector but purportedly not in the public one—I show that the continuities between these two sectors are more significant than the differences. The public and private spheres merge in the human resources shared between the two. It is common (and morally accepted) that health professionals work both in the public and private sectors. In private institutions, physicians have more autonomy, working conditions are less stressful, and income is higher, albeit dependent on productivity regarding the number of appointments and number and type of interventions. Some users resort to both private

and public sectors, motivated either by economic reasons, such as not being able to pay for care in the private sector, or by the judicious selection of where to find the best service for a particular issue, or both. Whereas some women choose to have prenatal care in the public sector because it is free, and to give birth in the private because it is more comfortable, others opt to have prenatal care in the private sector and give birth in the public, as state-owned facilities are generally deemed to be better equipped than private ones in terms of technology and the skills needed to attend to emergencies (Deco Proteste)—an opinion that was shared by some of my interlocutors.

Does OV Only Happen in the Public Sector?

In the media and in the public opinion in Portugal, obstetric violence is more readily associated with state-owned facilities, whose users often complain about verbal abuse, lack of privacy, and the overreliance on medical interventions. Some users also report neglect as a form of obstetric violence, citing such examples as the dismissal of women's complaints by health personnel and the underuse of interventions when these would have been clinically appropriate. Upon closer scrutiny, however, obstetric violence is just as prevalent in private facilities, perhaps even more so, albeit in a more hidden form. Lack of information provision and consent remains a major problem in both sectors but are even more so in a context where women are offered caesarean sections and other interventions as primary options, regardless of their clinical justification, for financial reasons and convenience. Although the private sector is a class marker associated with social status, affluency, and quality, it becomes clear that neither the commercial relationship between users and providers nor the hotel-like conditions of private facilities are enough to prevent obstetric violence.

The Impact of the Physical Environment on Birth

Research has shown that the physical environment affects childbirth outcomes in direct and indirect ways through the impact it has on the health and well-being of women, birth companions, and health professionals (Setola et al.). Among other authors, Michel Odent has systematically underlined that physiological birth depends on the

neurohormonal release of so-called love hormones, such as oxytocin, that are highly dependent on a reduction in the activity of the neocortex, which is influenced by environmental factors. The main stimulants of the neocortex are language, light, feeling observed, and the perception of danger. Thus, research indicates that the optimal birth room would be a quiet and dark private space without onlookers. Bec Jenkinson, Natalie Josey, and Sue Kruske confirm that an environment in which women are more likely to feel safe and relaxed during labour and birth is characterized by privacy and homeliness, providing women with a sense of personal control rather than a clinical environment that is foreign and provokes fear and anxiety. But research has also shown that the caregivers' attitudes and behaviours appear to be the most important factors in birth satisfaction (Hodnett), and many women are usually more concerned with staff and relational issues than facilities (Jenkins et al.). A pleasant physical environment easily becomes disagreeable if mistreatment takes place, whereas an austere room may become emotionally warm due to supportive care.

Lack of Privacy at Public Facilities

While similarities to a hotel are openly valued in private facilities, an austere environment prevails in public hospitals, where it is considered inappropriate to try to resemble a hotel. Many public maternity wards are in relatively old buildings, and conditions are old fashioned. There might, for example, be large collective labour rooms where there is no privacy or individual rooms so small that nothing but a bed fits in. In these cases, the presence of birth companions is highly compromised due to the lack of physical space to accommodate them. Many women are also deprived of the company of their partners immediately after birth, when they are moved to the infirmary, because companions are only allowed in the facilities for a limited daily time span. In such settings, investment in renovations is not considered a priority. For example, it took over a year for Hugo, the department director of one of the largest hospitals in the country, to transform collective labour rooms into individual ones. He pointed to the difficulty of convincing hospital managers and political decision makers about the practical needs in obstetric care. He explained the delay by sharing, "They don't have the faintest idea what birth is like.... They are too old to remember their own wife's birth."

The lack of privacy has real consequences for birth experiences, as seen in the following story. In the public hospital where Carolina gave birth, labour rooms are collective, accommodating up to four women, whose beds are separated by curtains. Carolina shared how she could hear the neighbouring woman groaning in labour and the nurses telling her to be quiet. She feared she would be the next one to "misbehave"and be reprimanded, so although she did not feel much physical pain, she eventually accepted the epidural that had been offered by the staff more than once. Carolina explained how she regretted this decision, which consequently confined her to bed and resulted in a cascade of interventions. This kind of story is quite common.

The public hospital where Carla gave birth serves a large rural area and has only two delivery rooms. Some women have to travel over one hundred kilometres to give birth there, and sometimes women have even arrived to find the obstetric department closed due to staff shortages and have been forced to travel eighty kilometres further to the next nearest hospital. Except in the few hospitals that have been built in recent years, a woman is in the labour room—a room frequently shared with other labouring women—during dilation and is then moved to the delivery room for the birth. The day Carla gave birth, there were ten women in labour at the hospital, and she was constantly worried that a delivery room might not be available to her. Noticing her preoccupation, the doctor told Carla she could give birth in the labour room. Although the intention was to reassure Carla that everything would be fine and the baby would be born anyway, she felt uneasy with the prospect of having to give birth in front of other labouring women and their birth companions. Besides that, Carla was denied epidural anaesthetic, for this type of anaesthetic is only provided in the delivery room. She had been going through a labour induction for two days (due to high blood pressure) and constantly begged for pain relief. Carla was finally given a spinal anaesthetic,[5] after much insisting, which can be administered in the infirmary and is usually used for caesareans. It had the effect of severely curtailing her mobility.

Both Carolina's and Carla's stories exemplify how a lack of privacy can contribute to women feeling observed and feeling the need to police their own behaviour. System constraints regarding staff shortages and poor physical conditions (often found in state-owned facilities) have been identified as a contributing factor to the mistreatment of women during childbirth (Bohren et al.).

Hotel-like Conditions at Private Facilities

Private facilities highly value the creation of hotel-like conditions in their marketing strategies. The wellbeing of clients is considered a priority, and resembling a hotel environment, which is comfortable and private, is an asset. At the prenatal visit to the private clinic where Andreia had her baby, great emphasis was given to the physical conditions of the facility. But the nurse showing Andreia round was quite surprised when she asked to see the delivery room too and even more surprised when she asked whether a birthing ball was available.

This was a question the nurse did not know how to answer. Private clinics also commonly allow more than one birth companion and provide overnight accommodation for a companion after the birth for an additional payment. Labour and postpartum always take place in individual rooms, which allows for the constant presence of companions chosen by the woman. For example, Alda had two birth companions, and her parents were also allowed to visit her once she came back from the delivery room. However, neither the comfort of the facilities nor the presence of birth companions was enough to guarantee an OV-free birth experience for either woman.

In the private facilities, the exclusive, less clinical environment might be expected to facilitate physiological birth. However, institutional modus operandi and professional habitus—motivated by profitmaking and personal convenience—as well as women's expectations when resorting to private facilities, contribute to statistics that show that physiological birth is also hindered at private hospitals. Taking the year of 2019 as an example, the percentage of dystocic deliveries (caesarean sections and instrumental vaginal births) in the private sector was as high as 84.2 per cent; 48.9 per cent were dystocic deliveries. The national CS rate was 36 per cent. In the public sector, it was 30.1 per cent, whereas in the private it was more than double, 68.5 per cent (INE *Estatísticas*). Taking into account that high-risk births mostly take place in the public sector, no clinical justification seems to account for the high percentage of dystocic births in private facilities over the years. This may be a consequence of the "booking in" of CSs and labour inductions, which is a common practice for convenience-related reasons (White and Queirós). The physicians I interviewed also pointed out financial motivations because doctors are paid more for caesarean sections than physiological births.

Overuse of medical interventions in childbirth is one of the most obvious and widely discussed forms of obstetric violence, and Portugal has one of the highest rates of birth interventions in Europe (APDMGPa; Euro-Peristat; Fedele and White). Although this type of OV is prevalent in both the public and private sectors in Portugal, the above-mentioned statistics show it is more significant in the private sector. It becomes clear that the physical environment of facilities in itself does not directly prevent obstetric violence.

Seeking Continuity of Carer

Guaranteeing Preferences in the Private Sector?

The ability to remain under the care of the same health professional, the hotel conditions—such as comfort and privacy—and the constant presence of a birth companion during birth and postpartum are the main motivations for women who choose to give birth in private facilities in Portugal (Deco Proteste). The will to control the variables through continuity of carer was the main reason why Andreia chose a private hospital. Similar reasons motivated Alda: "I opted for a private hospital because I wanted to be sure that the team … would know me and my choices, what my options were, so they would be respected. Because that continuity of care is not possible in the public [hospital], I went private."

Both Alda and Andreia managed to guarantee that their doctor, who was acquainted with their preferences, attended the birth. However, this did not guarantee that their preferences—for a physiological birth with minimum intervention—would be respected. "This is the last time! Don't ever ask me to attend a birth of yours again" were the words Alda heard after her daughter was born and placed on her chest. Although Alda's doctor had apparently agreed on a natural birth, on the day of the birth, she was visibly angry with Alda because she had arrived at the hospital already fully dilated. She made Alda come out of the bathtub and lie down for the delivery and displayed an aggressive attitude towards her and her birth companions throughout the process. A birth that until then had progressed smoothly ended up in a vacuum extraction. Alda, who is a midwife, identified the aggressive attitude of the obstetrician as the trigger that undermined her self-confidence and led to a devastating effect on her capacity to push and birth her baby.

Andreia said that in her case, the problem was not the obstetrician but the rest of the team. Upon admittance to the hospital, Andreia and her husband, both lawyers, refused to sign a blank consent form. When they asked what interventions they would be consenting to, an experienced older midwife dryly replied, "birth." They retorted that birth was not a medical act, and the midwife expressed shock because no one had ever refused to sign a consent form. From that moment on, the midwife treated them rudely. She also administered drugs without consent and affirmed when the birth was over that they were "very weird" and that she would never attend a birth with them again. Andreia added: "My husband, a very conventional lawyer, said he had never felt like a target of prejudice before." Dignified care is usually taken for granted in private facilities, but what Andreia's and Alda's stories reveal is that if a woman's choices for childbirth are not considered conventional or normal, this may trigger aggressive reactions and disrespectful treatment from the professionals, even in contexts where there is a commercial relationship.

Seeking Privilege in the Public Sector

Women tend to associate continuity of carer with respect and quality of care, sometimes mistakenly, and they try to guarantee it, even if the system does not require it, as is the case of the public sector. Women giving birth at public facilities thus engage in strategies to leverage social capital by using preestablished contacts with the doctors whom they see in the private sector for prenatal care but who also work in public institutions. This strategy, however legitimate, often proves faulty. As pointed out by Teresa (OB/GYN), it will likely end up in an induction of labour and most probably in a caesarean section because that is the only way to make sure the birth will happen when the chosen doctor is on duty at the public hospital. Official data on induction rates is not available, but women's testimonies confirm that induction is a common practice in both the public and private sectors (APDMGPa; APDMGPb; Rohde; White and Queirós). With inductions as with other interventions, women are usually not informed about additional risks, and they would rather be subjected to interventions by their own doctor than have a spontaneous labour with a team they have never met before.

However, women's expectations may be frustrated, as despite their

efforts, they may not end up being attended by their private doctor during childbirth or benefit from any special treatment due to their connections, as was the case with Raquel. She hoped that by knowing the doctor from private prenatal care she would be accorded special status that would protect her during birth at the public hospital where he also worked. The moment when Raquel was induced (at forty weeks and five days) due to a minor leak of amniotic fluid, her private doctor was not on duty. After twelve hours in labour, she finally saw him and asked him to help her because labour was not progressing, and she believed a caesarean section was necessary. In their brief encounter, he said he would do something about it, but he never returned. Raquel was in labour for thirty-six hours and continuously hoped for a caesarean section. She ultimately received an emergency caesarean section and suffered a hemorrhage that almost took her life. She believed the complications she suffered could have been prevented were a caesarean section performed earlier.

Milene's story shares some similarities with the aforementioned example. Like Raquel, Milene gave birth at the public hospital where her private obstetrician worked. Her labour was also induced: at a routine prenatal appointment at thirty-eight weeks, her obstetrician did a nonconsensual membrane sweep[6] to mechanically induce labour because she considered the baby was too big (according to her estimates, which ultimately proved wrong). The doctor said, "The baby is formed, from now on, babies are only growing fatter." Hours later, Milene was hospitalized, as her membranes had ruptured. After hours in labour, she tried to reach her obstetrician via text message; she never received an answer. Like Raquel, she felt discriminated against when faced with labour complications, she was told by a doctor it would not be possible to perform a caesarean section. A midwife updated the obstetrician on Milene's "failure to progress," saying everything pointed towards a caesarean section, but he answered: "Caesarean today? Don't even think about it. We already have too many!" Milene ended up having a vacuum extraction delivery with shoulder dystocia,[7] which left her daughter with an arm disability for life.

Both Raquel and Milene pointed out that the caesarean section overload described during their births was due to elective caesarean sections scheduled by the doctors at the public hospitals for their clients from the private sector. Complications from labour inductions, again

related to private clients, could also have been a factor. Weeks after the birth, Raquel went back to the private clinic for a postpartum appointment and asked her doctor why she did not receive a caesarean section earlier. He said, "They had probably already spent the monthly caesarean rate," referring to national directives to reduce the caesarean rate. He continued: "They had probably already spent it on cousins, friends, and it wasn't anticipated that you would receive a caesarean, because that costs a lot more money." The explanation he offered to Raquel alludes to cost-cutting efforts at public hospitals and refers to a concerted effort to reduce national caesarean-section rates from 2013 through the transmission of information and training of healthcare professionals, together with the financial penalization of hospitals exceeding stipulated acceptable rates. Although it is inaccurate to say the motivation for reducing caesarean-section rates is cost driven, since issues of public health are involved, we can question whether this system of financial penalties is effective. Teresa (OB/GYN) denied physicians generally refrain from doing caesarean sections for whatever reason: "I have worked in many places, and I never heard a colleague say, 'we're not doing a caesarean, because we've had too many.' Never. What I see is the opposite: too many caesareans." After a slight decline in national caesarean-section rates for a few years, they are again steadily on the rise. This tendency is in line with the "unprecedented and unjustified" rise in caesarean sections globally, which has been worrying specialists in recent years ("Editorial").

Making decisions in healthcare based on financial considerations—whether profits or cost reductions—has real detrimental consequences for the lives of patients. The overuse of medical interventions in childbirth is one of the clearest manifestations of obstetric violence, but underuse may also be considered a form of mistreatment (Miller et al.). For both Raquel and Milene, lack of what they considered appropriate intervention (a timely caesarean section) was the main cause of their dissatisfaction, but they also reported other problematic incidences, including inductions, forced immobility during labour, as well as other types of disrespectful treatment.

Conclusion

The organizational culture of institutions more or less governed by economic goals and technocratic imperatives accounts in great measure for the obstetric violence that prevails in both state-owned and private sectors of the Portuguese healthcare system. The intricacies between the two sectors in the particular case of healthcare provision in Portugal reflect a wider system of inequality based on material affluence. It is widely accepted that people have to pay in order to guarantee physical comfort, including privacy, and to receive dignified care, which is taken for granted in private facilities, which only a minority can afford. Clients of private services are considered powerful agents due to their affluence, which in a capitalist society equates to the possibility of choice, but their real agency in childbirth can be questioned when one considers whether their decisions regarding childbirth are fully informed. Moreover, women and couples who do not comply with the norm, which in this context is the desire for or tolerance of a high level of intervention in birth, are easily subjected to disrespectful treatment by the staff.

What is ultimately at stake in obstetric violence is the integrity and autonomy of the woman, seen in the multiple dimensions that constitute her as a human being and expressed in the role she plays in childbirth. The lack of information provision remains a major problem in both the public and the private sector: The norm is that women are rarely asked for permission or fully informed about their options in childbirth. Although the physical environment—for example, the lack of privacy at some state-owned hospitals—may be related to obstetric violence, hotel-like conditions of comfort and privacy are not enough to prevent it. A major factor in obstetric violence experiences is the sense that birthing women do not manage to appropriate a space (both physical and metaphorical) that is presented to them as being the domain of hospital staff. In this negotiation between service users and health professionals, objects—those that contribute to the physical environment as well as medical devices and technologies—serve as mediators of power and emblems of authoritative knowledge.

Overuse of medical interventions in childbirth is one of the most obvious and widely discussed forms of obstetric violence, and as noted, Portugal has one of the highest rates of birth interventions in Europe. This type of obstetric violence is prevalent in both the public and

private sectors, but the statistics show it is more significant in the private sector. This can be explained by the financial and personal convenience motivations involved rather than by clinical reasons. However, users of the public sector also perceive as obstetric violence the underuse of interventions in cases when they considered them to be clinically appropriate.

Some women try to have the best of both worlds, making use of what they perceive as the personalized treatment and continuity of care exclusive to the private sector and the technological expertise that gives them a sense of clinical safety of the public sector. They engage in strategies to leverage privilege in the public sector by paying for prenatal care in the private sector with a doctor who also attends at a public hospital. However legitimate this strategy may be—in a context where women feel their rights to dignified care are not universally assured—it often proves faulty and is a source of frustration for women.

This chapter emphasizes the way obstetric violence is partly determined by aspects of material and consumer culture. It disputes the common idea that obstetric violence is exclusive to the public sector of healthcare provision, showing that acquisitive power does not always translate into obstetric violence-free experiences. Economic logics in healthcare, driven either by profit making or cost reduction, are often a cause of inappropriate care, and directly or indirectly relate to obstetric violence. Further research on how the material aspects of childbirth affect and are affected by intangible dimensions is needed to illuminate the complex interplay of factors that constitute and affect human birth.

Endnotes

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3. The healthcare system in Portugal is provided through three coexisting systems: the National Health Service (Serviço Nacional de Saúde [SNS]), health insurance schemes (subsystems) for certain professions and voluntary private insurance.
4. As of 2021, the minimum monthly wage in Portugal is 665 euros (fourteen months of payment, which include vacation and Christmas subsidies besides the regular twelve months), and the average net monthly wage of employees reached 1 022 euros in the third quarter of 2021 (INE, *Inquérito*). In the first quarter of 2019, the share of employees covered by the national minimum wage was 25,6%, whereas it attained 31% in the case of female employees.
5. A central neuraxial regional anaesthetic technique used for procedures or surgery on the lower abdomen, pelvis, and lower limbs (Martin).
6. This is a mechanical technique whereby a clinician inserts one or two fingers into the cervix and using a continuous circular sweeping motion detaches the inferior pole of the membranes from the lower uterine segment.
7. This is a difficult birth in which the anterior or, less commonly, the posterior fetal shoulder affects the maternal symphysis following delivery of the vertex (Martin).

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Anna Rita Ronzoni is a feminist and a gender-based violence expert. She has been working on women's protection and empowerment as well as women's health for the last fifteen years, particularly in the Middle East. She completed her master's on studies of sexual difference from the University of Barcelona. She is the author of different articles and researches on violence against women from a protection and an health perspective.

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