

Global Maternal and Child Health:
Medical, Anthropological, and Public Health Perspectives
Series Editor: David A. Schwartz

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Robbie Davis-Floyd
Betty-Anne Daviss *Editors*

Sustainable Birth in Disruptive Times

 Springer

Global Maternal and Child Health

Medical, Anthropological, and Public Health Perspectives

Series Editor:

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Global Maternal and Child Health: Medical, Anthropological, and Public Health Perspectives is a series of books that will provide the most comprehensive and current sources of information on a wide range of topics related to global maternal and child health, written by a collection of international experts. The health of pregnant women and their children are among the most significant public health, medical, and humanitarian problems in the world today. Because in developing countries many people are poor, and young women are the poorest of the poor, persistent poverty exacerbates maternal and child morbidity and mortality and gender-based challenges to such basic human rights as education and access to health care and reproductive choices. Women and their children remain the most vulnerable members of our society and, as a result, are the most impacted individuals by many of the threats that are prevalent, and, in some cases, increasing throughout the world. These include emerging and re-emerging infectious diseases, natural and man-made disasters, armed conflict, religious and political turmoil, relocation as refugees, malnutrition, and, in some cases, starvation. The status of indigenous women and children is especially precarious in many regions because of ethnic, cultural, and language differences, resulting in stigmatization, poor obstetrical and neonatal outcomes, limitations of women's reproductive rights, and lack of access to family planning and education that restrict choices regarding their own futures. Because of the inaccessibility of women to contraception and elective pregnancy termination, unsafe abortion continues to result in maternal deaths, morbidity, and reproductive complications. Unfortunately, maternal deaths remain at unacceptably high levels in the majority of developing countries, as well as in some developed ones. Stillbirths and premature deliveries result in millions of deaths annually. Gender inequality persists globally as evidenced by the occurrence of female genital mutilation, obstetrical violence, human trafficking, and other forms of sexual discrimination directed at women. Many children are routinely exposed to physical, sexual, and psychological violence. Childhood and teen marriages remain at undesirably high levels in many developing countries.

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ISSN 2522-8382

ISSN 2522-8390 (electronic)

Global Maternal and Child Health

ISBN 978-3-030-54774-5

ISBN 978-3-030-54775-2 (eBook)

<https://doi.org/10.1007/978-3-030-54775-2>

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This Springer imprint is published by the registered company Springer Nature Switzerland AG
The registered company address is: Gewerbestrasse 11, 6330 Cham, Switzerland



The Labor & Delivery room at Sonam Norbu Memorial Hospital in Leh, Ladakh, India in 2006 (top) and 2019 (bottom). The upper image shows two tables for delivery, the stirrups that women were required to use for most deliveries, buckets for absorbing blood, and other bodily fluids during the delivery, as well as wooden tray used to measure newborns on the right-hand table. The lower image shows the brand new Labor & Delivery room that was part of an entirely new hospital construction that followed partial destruction of the hospital during the catastrophic Leh flash floods in 2010. Published with permission from © Kim Gutschow. All Rights Reserved.

From Kim Gutschow:

*This book is dedicated to the childbearers,
providers, and babies, born and unborn,
past, present, future,
for their care and compassion.*

From Robbie Davis-Floyd:

*This book is dedicated to my culture heroes
Robin Lim and Vicki Penwell, who have
developed and practiced sustainable models
of birth, saved countless lives, and brought
love, light, and joy to the thousands of people
who experienced their care, even in the most
disruptive of times.*

From Betty-Anne Daviss:

*This book is dedicated to all of our
grandchildren in the hope that they will
understand that social activism is as
important as education, regulation, and
association.*

Acknowledgments

Kim Gutschow is profoundly grateful to the women and providers—midwives, obstetricians, nurses, neonatologists in the USA, India, Germany, Nepal, and elsewhere—who have participated in countless conversations on maternity care and MNCH (maternal, neonatal, and child health) over the past 16 years. She deeply thanks the doctors—Dr. Michelle Lauria, Dr. Torren Rhodes, and Dr. George Little (coauthor of Chapter 19)—who helped steward her vaginal delivery of 26-week-old breech twins who spent 77 days in the NICU at Dartmouth-Hitchcock Hospital in 2004. Subsequent conversations with these and other providers helped shape her research into the anthropology of maternal and newborn health and reproduction. She is so very grateful to Robbie and Betty-Anne for their inspirational work and wonderful friendship, cemented in 2015 on a train journey from Bad Wildbad, Germany, that helped conceive this book. Last but not least, she thanks her family—her children Tashi, Krishan, and Yeshe as well as her partner Robin Sears—for their support and many questions about how the book was coming to fruition in past years.

Robbie Davis-Floyd is deeply grateful to lead editor Kim Gutschow for her long-term dedication to seeing this book through to completion, for her international understanding of the issues surrounding sustainable birth—which enabled her to invite just the right authors for the chapters in this collection—for her outstanding editing skills, and for her ongoing friendship. She is also grateful for that train trip from Bad Wildbad—it is amazing what people can come up with when their brains are moving as fast as that fast-moving train!

Betty-Anne Daviss would like to thank her coeditors for their patience with her as they did the main work on this book while she was finishing another book, *Birthing Models on the Human Rights Frontier: Speaking Truth to Power* (BMHRF). She sees BMHRF as highly complementary to this volume, yet different in that it often takes a more iconoclastic approach and proactively calls people to action. Both styles are needed. She finds that a book focusing on sustainability is critical, given that some of the optimal birth models in BMHRF have already been threatened by the neoliberal economic values that plague healthcare funding. Betty-Anne would also like to thank a casualty of those problems, traditional midwives the

world over, whose work often goes unnoticed and disrespected at best; at worst, many are being persecuted and arrested. Finally, she would like to thank her husband, Ken Johnson, a steadfast support, who reminds her, when she engages with Kim and Robbie in trying to fix everything in the world, that Marshall Klaus said: “Opinion divides, data unites.”

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Chapter 10

Humanizing Care at the Maternity Hospital Estela de Carlotto in Buenos Aires: Providers Relearning Their Roles



Celeste Jerez

It was a sunny Saturday morning in October 2017 when our team entered the fourth workshop for pregnant people and their birth companions, called “Integral Preparation for Motherhood” (IPM). The four free IPM workshops are run by the staff of the Maternity Estela de Carlotto (MEC)—a public hospital located in the western suburbs of the Province of Buenos Aires in Argentina.¹ Pregnant women and their companions formed a circle sitting on chairs or exercise balls, as well as on handwoven mats and rugs on the floor.² During the meeting, the staff psychologist said something like: “You are sexually active women being pregnant and after giving birth, that is why you leave the MEC with a contraceptive method. In Sexual Health we do not talk about ‘patients,’ we speak about ‘users.’ The method you choose and when to use it is your decision, not ours.”

During each fourth meeting of the IPM, the social worker invited women who have given birth in the MEC to tell their birth stories, explaining how this can be empowering for others: “The testimony given by women empowers other women, because you can imagine and feel what happens in that moment.” Nina, who gave birth at the MEC, explained, “When I was in labor, accompanied by my sister, the

¹In 2017, there were four IPM meetings repeated each month of the year; their topics included (1) prenatal surveillance, danger signs, and going to the hospital; (2) national laws for respectful labor and delivery and family-centered care; (3) newborn care, health, and breastfeeding; (4) and postpartum care, contraception, and sexual and reproductive rights. Most IPM meetings began with 20 min of relaxation exercises, breathing, and stretching for all participants.

²In order to safeguard the identity of our 40 subjects, who included pregnant people, their birth companions, and the MEC staff, we have maintained their anonymity and changed names while obtaining informed consent. I use the term “pregnant people” to indicate any person with the possibility to gestate who was pregnant at the time of the research. However, I will also respect the categories used by official documents and by the people interviewed.

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midwives were there but they were not there, they were there to support me but not interrupt the moment.”

These overheard fragments of a conversation introduce the possibility of “sustainable birth” in the MEC and across Argentina with the following components: free contraception, free care during pregnancy, labor, delivery, and postpartum for everyone and midwives who provide respectful and unobtrusive care. The organizational culture developed by MEC staff is a turning point in the hegemonic, technocratic medical model of birth usually found in Argentina (Davis-Floyd 2001, 2018; Menéndez 1994). This new culture is a qualitative leap against abusive and invasive obstetric care and for the humanization of childbirth, and its existence provides a visible social impact in this region (Blázquez Rodríguez 2005; Fornes 2011; Jerez 2015; Jordan 1993; Sadler 2001). The MEC provides a regional scenario where care providers relearned their roles to avoid medical practices related to obstetric violence, understood as a manifestation of gender violence.³

Specifically, I understand “sustainability” in childbirth in Argentina to mean that care providers relearn their roles in a noninterventionist model of childbirth in the public healthcare system in ways that avoid obstetric violence and promote the humanization of care. My theoretical-political framework of this definition of “sustainability” is a feminist perspective on anthropology that analyzes processes of health/disease/care, that is, a focus on sex/gender inequalities in health and a non-essentialized vision of the human body (Esteban 2006). I will describe this relearning of the practitioners’ roles within the specific context of the MEC as based on four principles or sets of meaning that promoted sustainable changes over time and that illustrate a specific organizational culture of public healthcare.

10.1 Sustainable Birth Principle #1: The Importance of a Name

The MEC is a public health institution⁴ in Argentina built to reduce maternal and neonatal mortality rates and guided by the paradigm of humanized childbirth (Davis-Floyd 2001, 2018), within a framework of programs, initiatives, and national

³ Since 2017, in Buenos Aires we have been running a health research group focused on “obstetric violence in Latin America.” Our first publication describes how over the last 10 years, a new legal construct has emerged in the Latin America region that encompasses elements of quality of obstetric care and mistreatment of women during childbirth (Williams et al. 2018). Obstetric violence is understood within the framework of gender violence, through National Law 26,485 (Article 6, Paragraph e). Venezuela (2007), Bolivia (2013), Panama (2013), and Mexico (2014) also have laws prohibiting obstetric violence, though they are rarely enforced.

⁴ The healthcare system in Argentina includes three sectors: public, private, and social security. This chapter will focus on the public sector, which is under the umbrella of national and provincial health ministries and includes networks of hospitals and public health centers that provide free care to anyone who needs it.

laws that focus on guaranteeing the integral rights of cis⁵ heterosexual women and people who identify as LGTTBIQ.⁶ This public hospital symbolizes a government guarantee of healthcare as a human right and access to healthcare for all, regardless of ability to pay, assuring universal coverage of maternal healthcare services as one of the five priority actions for quality maternal care (Koblinsky et al. 2016). MEC's name refers to Argentina's famous human rights activist Estela Barnes de Carlotto, who is the actual president of *Abuelas de Plaza de Mayo*, a group of grandmothers who agitated against the violence, disappearances of thousands of people, and human rights abuses of the last Argentinian dictatorship (1976–1983) for nearly 40 years.⁷

Estela Carlotto's name is connected to the idea of respectful and sustainable birth because her life story is the story of the first women in Argentina who gave their maternity a political sense of struggle, in order to seek justice for the crimes committed by the last Argentine dictatorship.⁸ Estela's daughter, Laura Carlotto, a member of Montoneros, a Peronist group in the 1970s, was kidnapped by the last Argentinian dictatorship when she was 3 months pregnant and held in captivity in a clandestine detention center where she gave birth.⁹ Her son was given a false identity and raised by a family that illegally appropriated him with the complicity of military doctors. Estela searched tirelessly for her daughter and grandson, and since 1978 she was instrumental in forming the *Abuelas de Plaza de Mayo*, whose members began to systematically search for missing children and grandchildren and to publicly denounce these disappearances, walking around the Mayo's Square (*Plaza*

⁵The prefix “cis” is used to designate people who identify with the sex and/or gender assigned at birth, while trans people are people who do not identify with the sex and/or gender that was assigned to them when born.

⁶In Argentina, LGTTTIQ stands for people who identify as: lesbians, gays, bisexuals, transvestites, trans, intersex, and queer. In Argentina, members of this group have promoted the drafting of several laws, including the Equal Marriage and the Gender Identity laws (laws 26,618 and 26,743 respectively) in 2010 and 2012. They have also promoted access to health and labor rights for all Argentinians who identify as LGTTTIQ.

⁷On March 24, 1976, in Argentina began the most cruel civic-ecclesiastic and military dictatorship in the country's history. A government coup was carried out by a military group made up of the commanders of the three armed forces who defeated the constitutional government of President María Estela Martínez de Perón. These atrocious actions were characterized by state terrorism, the constant violation of human rights, the disappearance of 30,000 people (the majority of whom were students, workers, union leaders, and Peronist and leftist party activists), the systematic appropriation of newborns, and other crimes against humanity. The dictatorship ended on December 10, 1983, the day of the government assumption of the elected president Raúl Alfonsín.

⁸According to the former directors of the MEC, Patricia Rosemberg and Cecilia Zerbo, “the organization's name was selected together with the staff, seeking a sense of struggle for human rights related to motherhood, even in situations of adversity. The name highlighted the need to continue the search for social justice in aspects related to our organization in the field of health. The exemplary figure of Estela de Carlotto allows a strong collective identity and also gives us the pleasure of honoring her story” (Rosemberg and Zerbo 2017: 172).

⁹In Argentina, the people who were kidnapped and disappeared were usually taken to a clandestine detention center where they were interrogated under torture for several weeks or months before being released, kept in detention, or executed extrajudicially.

de Mayo) with signs and a white handkerchief on their heads. The *Abuelas de Plaza de Mayo* spearheaded a social and political project that by 2018 had recovered the identities of 127 grandchildren including Guido, Estela's grandson, who was recovered in 2014.

Furthermore, Estela Carlotto's name is also connected to the idea of sustainable birth because it protests the cruelty of detaining young women activists (like Estela's daughter) who were subject to extended detention, torture, and violent childbirths in concentration camps before the government kidnapped their children (Calveiro 1998). By focusing on pregnant women, the dictatorship made childbirth one more step in organized violence against women, with the complicity of military and civil doctors who attended births in horrific conditions.¹⁰ Also, these doctors falsified the birth certificates as "home births," erasing this experience of terror from official narratives (Regueiro 2008).

By naming this public hospital, where humanized birth prevails, for the president of the *Abuelas de Plaza de Mayo*, MEC staff—as part of a public state institution—visibly acknowledged a political reparation for those women detained during the last dictatorship who delivered in horrific circumstances. The name becomes a principle of sustainable birth as it promotes *Abuelas Plaza de Mayo* as one of the fundamental antecedents in our country of women involved in public political activities, in this case collectively denouncing the state violence of the dictatorship.

10.2 Sustainable Birth Principle #2: Reorganizing Complex Childbirth Care

The MEC was founded in 2013 for three primary reasons: (1) to reduce the high maternal and infant mortality in the region; (2) to transform a private birth center focused on the paradigm of humanized childbirth that had operated in the 1980s into a full-fledged public hospital; and (3) to signal a concrete commitment to sexual and reproductive health that arose from municipal, provincial, and national policies. To understand reason 1, let us briefly turn to the demographics of Health Region VII,¹¹

¹⁰From December 2017 to August 2018, I conducted fieldwork on the trial for crimes against humanity concerning the Military Hospital in Buenos Aires, where women detained by the last Argentine dictatorship gave birth, their children were born in captivity, and birth records were falsified, with the complicity of both military and civil officers. As part of this investigation, I analyzed the violent and abusive maternity care provided to the kidnapped women in the Military Hospital as a gendered punishment and as a reaffirmation of childbirth as a pathological event. In addition, it was the first trial for crimes against humanity in which the Public Prosecutor's Office specifically called the medical care provided "obstetric violence." To learn more about the case, see the following note from my authorship: <https://www.pagina12.com.ar/139982-la-accion-expansiva-de-la-marea-verde> (Date of consultation: December 2019).

¹¹Buenos Aires Province (307,571 km² of surface, representing 11.06% of the total of the country) contains 12 health regions composed of 135 municipalities, created in 2006. They are defined as a

where the Moreno municipality is located; these demographics are from 3 years before the MEC opened (Table 10.1).

Before the MEC opened, there was a dearth of hospitals in the region—with 2407 inhabitants per one labor and delivery bed—because there were only two hospitals in all of Health Region VII: the tertiary level National Hospital Prof. A. Posadas and the secondary level Provincial Hospital Mariano and Luciano de la Vega, which were responsible for the 42,000 deliveries in the region in 2010.

This absence of secondary level hospitals meant that many low-risk pregnant people without complications ultimately delivered at tertiary care centers; there was only one center focused on normal deliveries. As a result, normal, uncomplicated births were treated as high-risk deliveries requiring medical intervention, and eventually a decision was made to open the MEC specifically for normal, low-risk deliveries. Besides serving as a secondary level facility, the MEC is a maternal/neonatal hospital that focuses on childbirth attended primarily by midwives, as well as on sexual and reproductive health.¹² It is networked with the 40 primary level health-care centers within Health Region VII, including the two hospitals named above. The creation of the MEC enabled a new kind of sexual and reproductive healthcare in Moreno that also strengthened and mobilized better referral networks and improved maternal and neonatal outcomes through the entire region.

The creation of the MEC with its focus on normal, low-risk deliveries is sustainable in part because it enables pregnant people to seek their first antenatal screenings and care at primary health clinics while planning a delivery at the MEC.¹³ If complications are identified during antenatal screenings or delivery, the user is

Table 10.1 Health Region VII demographics from 2010

	Births annually	Population	Maternal mortality ratio	Infant mortality ratio
Moreno	10,000 ^a	452,505	149/100,000	5/1000
Health Region VII	42,000	2,253,772	77/100,000 ^b	13/1000
Buenos Aires Province	288,000	15,625,084	44/100,000	12/1000
Argentina	756,000	40,117,096	58/100,000	11/1000

^a70% of these 10,000 births were in the public health sector, and 30% resulted in cesareans. Trujui, the city where the MEC is located, has some of the highest numbers of pregnancies in Moreno

^bOne of the highest in the entire Buenos Aires Province

network integrated by all the provincial public health establishments that provide healthcare in its three levels of complexity—primary, secondary, and tertiary.

¹²With an area of 5600 square meters, the MEC has 40 beds, 9 offices, laboratory and blood draw services, diagnostic imaging and neonatology, a vaccination room, 3 operating rooms, 4 labor and recovery units, and a residence for people who come from afar to deliver at the MEC.

¹³The “screening” is an obstetric consultation and clinical exam of the pregnant person that evaluates the type of delivery required and risk of complications. In 2016, 72% of the potential deliveries passed through MEC screening.

referred to a tertiary care hospital via agreed-upon referral protocols. Thus, the screening serves to guarantee the humanized care that is the hallmark of the MEC by distinguishing low-risk pregnancies that will not require much, if any, technological intervention. By instituting a set of protocols that identify the complications that require referral to tertiary care, people with normal pregnancies and labor need not suffer interventions not recommended for low-risk pregnancies. The maternity care system also guarantees respectful care during labor and delivery and ensures that low-risk pregnant women can avoid interventions that have little benefit and are not recommended for routine use, such as episiotomies, inductions, etc. (Miller et al. 2016). The focus on normal and low-risk births in the MEC is ensured by the midwifery staff that attends them in the four units of labor and recovery—specially equipped rooms for respected childbirths.

In 2016, midwives represented 22% of the MEC's leased positions—the largest professional group in the MEC staff. Ensuring that childbirth care in the MEC is primarily provided by midwives constitutes a commitment to quality care and differential access according to the level of intervention needed for each delivery (Renfrew et al. 2014). In summary, the MEC care model is sustainable because it ensures low or no intervention in normal physiologic births attended by midwives. Furthermore, its existence as a second level healthcare center, along with the screening process, consolidates a model of division of care according to the complexity of childbirth, promoting better referral networks within primary, secondary, and tertiary level hospitals.

In 2016, after 3 years of existence, the MEC showed very promising quality indicators, even though it still only deals with a very low percentage of deliveries in Health Region VII (Table 10.2):

10.3 Sustainable Birth Principle #3: Providers as Protagonists of the Paradigm Shift

The MEC model of care is part of a broader attempt by the Ministry of Health to humanize childbirth through the “Safe and Family-Centered Maternities” (*Maternidades Seguras y Centradas en la Familia*) (MSCF) program founded in

Table 10.2 MEC health quality indicators, 2016

	MEC	Argentinian Health System (2016)
Number of deliveries	1633	728,035
Accompaniment chosen by the pregnant person during labor, delivery, postpartum	96%	36%
Use of oxytocin	1.5%	Not found
Cesarean rate	13.4%	32%
Episiotomies performed in primiparous women	14.2%	61%
Babies admitted to the NICU	3.1%	6%
Neonatal deaths	0	4716

2010. Endorsed by the Pan American Health Organization (PAHO) and UNICEF, the MSCF initiative has promoted improved outcomes by favoring the minimum interventions necessary in pregnancy, labor, delivery, and the postpartum period, through ten implementation strategies (Larguía et al. 2011):

1. Recognize the MSCF policy within the institution
2. Provide prenatal support and care for women and their families
3. Respect the decisions of pregnant women and their families in labor and delivery
4. Prioritize joint healthy mother and newborn care with postpartum participation of the family
5. Facilitate the inclusion of mother, father, and any family in the neonatal intensive care units (NICU)
6. Allow mothers to stay or sleep near their newborns while they are in the NICU
7. Have hospital volunteer staff
8. Organize postpartum care for healthy newborns and at-risk newborns that prioritize family inclusion
9. Actively work to promote breastfeeding
10. Receive and provide cooperation with other institutions that relate to sexual and reproductive health

These strategies center the pregnant woman as the protagonist of the entire maternity care process and focus on quality of care, cost-effectiveness, and sustainability and replicability. The report on the impact of the MSCF initiative in 14 hospitals made by UNICEF Argentina, 4 years after it was launched in the country (2010–2014), shows that 60% progress was made toward the general objectives of the initiative.

MEC's paradigm of humanized birth was instituted in workshops conducted over the first 4 months of 2013 (January–April) before the MEC opened its doors to the public. Because the MEC practitioners came from other hospitals where the technocratic model of birth had prevailed, the objective was to retrain these staff members to work within the humanistic model of birth. As Andrés, who managed this initial training at the MEC, noted, "The first months here, we started a process of training about the importance of respectful care and we designed the services ourselves. That took a lot of work, a lot of months of working body-to-body with providers."

During this initial training in 2013, all MEC practitioners were exposed, without hierarchical distinctions, to academics from national universities and the national Ministry of Health, activists who had worked on gender and sexual identity, and community members who could explain the evidence-based practices that improve outcomes for pregnant people and newborns. There were also sessions on the difficulties of changing clinical practices and the psychology of resistance within groups to the challenges of promoting a new care paradigm. MEC practitioners themselves were involved in developing and illustrating their interdisciplinary protocols of care and in planning the services they would provide. The staff discussed how they could best promote and provide humanized care in this new setting, connected with primary and tertiary level health clinics in Health Region VI, developing the valuable

skill of identifying and receiving the uneventful pregnancies and referring the complicated ones (Campbell et al. 2016).

By asking the MEC care providers to unlearn and abandon the technocratic model that they had initially been trained in to begin to practice in a humanistic fashion, the MEC directors guaranteed that their efforts would be sustainable and persist into the future. By asking staff to recognize that they now had a new role in a new model of care, they allowed staff to feel themselves to be the protagonists of the learning process, rather than being “schooled” or criticized for practices they had learned under the traditional technocratic model of care. By allowing staff to have power and experience transformation rather than imposing a new type of care in a top-down manner, they enabled a transition that was empowered by the staff themselves rather than forced upon them. The self-affirming nature of this process of change percolated through all levels of the staff, thereby ensuring its success and sustainability. One of the MEC neonatologists described how challenging it was to modify her interventionist practices: “When there is a birth in the ‘respectful labor and delivery rooms,’ I watch, I do not need to go in and intervene, but I just approach, observe, and wait. I have learned that waiting is a valuable part of my work.” This neonatologist and all other MEC practitioners now understand that waiting and not intervening can be more valuable than jumping to intervene.

10.4 Sustainable Birth Principle #4: Childbirth in a Sexual and Reproductive Healthcare Setting

The MEC opening in 2013 came 3 years after the founding of MSCF. The MSCF initiative described above resulted from a political shift toward promotion of greater sexual and reproductive rights in Argentina between 2002 and 2015, including laws that protect and promote the rights of cis heterosexual women and LGTTBIQ communities.¹⁴ In this sense, MEC practitioners were trained to be protagonists in their own transformation based on a sexual and reproductive rights paradigm, including practices against gender and obstetric violence, and an inclusion of all gender identities and of sexual diversity.

One of the main objectives of the MEC was to generate an organizational culture focused on rights, especially sexual and reproductive rights. In concrete practice, this guarantee of social rights means not only the right to reject the invasive treatments that form part of what Davis-Floyd (1993, 2001, 2018) has called “the technocratic model of birth” but also the right to information and access to a variety of

¹⁴Sexual Health and Responsible Procreation Law (Law 25.673, of 2002); Respected Birth, Rights of Parents and Children during the Birth Process (Law 25,929, of 2004); Integral Sexual Education (Law 26,150, of 2006); Integral Protection to Prevent, Punish and Eradicate Violence against Women (Law 26,485, of 2009); Equal Marriage (Law 26,618 of 2010); and Gender Identity (Law 26.743 of 2012. In 2015 Article 11 was regulated; it requires access to integral health for trans people through active training for health professionals), among others.

contraceptive methods, as the first person quoted in this chapter reflected, in which anyone who has given birth in the MEC leaves with a contraceptive method. This guarantee of social rights includes legal abortions¹⁵ and a range of sexual health services that promote rights based on gender equity and sexual diversity in the same setting.¹⁶ In relation to these objectives, the members of the Interdisciplinary Sexual Health Team, composed of 15 practitioners (as of 2017), function as counselors in pre- and post-abortion. A member of this team told me:

Today we wonder why we call the institution “Maternity” when in fact we do tasks that are specifically linked to sexual and non-reproductive health ... Maybe we can change our name so that it is consistent with the tasks we do and stop emphasizing only maternity—that is not the only thing we work on. In addition, it would seem that we propose motherhood as a destination, and it is not so.

MEC staff spoke about humanizing childbirth while avoiding thinking of maternity as a destination and proposing a model of sexual and nonreproductive care. I understand that the MEC includes a nondeterministic, non-essentialized vision of the body, promoting the rights of cis women and LGTTBIQ communities by guaranteeing safe obstetric practices for all parents, regardless of their sexual orientation, and promoting medical practices related to nonreproductive rights, gender identity, and sexual diversity (Jerez 2015). They attempt to guarantee contraception and abortion, avoid reproducing the mandate of compulsory maternity, and offer vasectomies to cis heterosexual men and trans people.

Maria, a trans woman who had worked on behalf of LGTTBIQ rights in Moreno, asked for a vasectomy in 2016. In her case, MEC respectful care included using the name and gender pronouns she had chosen as well as fostering discussions about cis-heteronormative bias in clinical histories through MEC providers. Further, lesbian women who came to the MEC for colposcopies—a procedure used after an abnormal pap smear to examine the cervix—have been able to share their sexual identity with MEC practitioners, integrating it into the comprehensive sexual health medical practice. During a MEC workshop called “We Want to Live: International Day of NO Violence against Women, Transvestites and Trans People,” a trans activist gave a presentation called “Institutional Violence towards the Trans Community.” Her presentation generated a discussion among MEC staff, who expressed a wish to be trained in trans issues and in setting up a sexual diversity office at the MEC. One

¹⁵In Argentina, in 2012 there was a trial called “F.A.L.” (the initials of a 15-year-old pregnant girl) that clarifies the interpretation of Article 86 of the penal code regarding the non-punishability of abortions through two causes: in all types of rape and if life is at risk or the health of the pregnant person. Based on this fact, in 2012, the National Health Ministry established a protocol for the care of legal abortions, called “Protocol for the integral care of people with the right to legal termination of pregnancy” (2015 MINSAL), which points out two reasons why it is legal to practice abortions in public health centers: the health reason and the rape reason.

¹⁶According to the difficult political panorama of adjustment of public policies carried out by President Mauricio Macri and the governor of the Buenos Aires Province, María Eugenia Vidal (2015–2019), the Ministry of Health (MOH) reduced contraceptives overall, eliminated injectables, and stopped subsidizing vasectomies without a scalpel. This was a clear sign of the progress of conservative policies in the Latin American region.

psychologist noted, “Trans men approach us, and yet we often do not have the tools to understand their surgical reassignment.” Juan, a liaison management coordinator, supported having trans activists train the MEC staff.

MEC promotes sustainable birth by creating an institutional framework that guarantees sexual and reproductive rights for all people, including contraceptive methods, and regardless of gender identity or sexual orientation. This framework includes guaranteeing the rights of lesbians to have gynecological consults; assuring legal abortions and contraceptive methods; offering training for all MEC staff to improve their care for trans people; and guaranteeing respectful delivery for all pregnant people, regardless of sexual orientation and gender identity. In the same setting, these practices create an organizational culture that integrates sexual and reproductive rights with parental rights around respectful childbirth care.

10.5 Conclusion: A Humanized Model to Deepen and Expand

The case of the MEC as a public health institution illustrates how practices related to the guarantee of humanized delivery prevent the reproduction of obstetric violence (Jerez 2015). Through a feminist perspective in anthropology, I have shown that the MEC achieves its goals to promote the sexual and reproductive rights of cis heterosexual women and LGTTBIQ people because it consolidated its model of care through a careful and sustained process of definitions that can be summarized as follows:

1. The MEC built a political-social identity based on the collective memory of Estela de Carlotto and her role in the human rights movement of Argentina.
2. It made a commitment to reduce maternal and infant mortality in the region by including the MEC in a system of transfer and referral among primary care centers and secondary and tertiary care hospitals, focusing on the care of low-risk deliveries by midwives in rooms especially designed for low or no intervention.
3. It retrained medical staff in a humanized model of care by making providers protagonists in their own transformations.
4. It guaranteed the rights of cis heterosexual women and LGTTBIQ people by offering integrated sexual and reproductive rights across the entire institution.

These four principles or sets of meaning promoted sustainable changes in MEC practitioners, who relearn their roles in a noninterventionist, humanistic model of childbirth in the public healthcare system that avoids obstetric violence. These sustainable changes can be exported to other institutions and regions in the country. The MEC is already training other medical staff at other public hospitals in Argentina, with help from the Argentinian Ministry of Health and UNICEF, to replicate the successes that have been achieved.

Acknowledgments This chapter is the result of 9 months of fieldwork at the MEC (May 2017–January 2018) and was part of my doctorate in social anthropology, which includes a feminist and intersectional analysis. This fieldwork was also part of the ninth UBANEX project at the University of Buenos Aires, an annually subsidized research action program, directed by Monica Tarducci PhD. Our team included students and the following feminist researchers: Claudia Cernadas Fonsalías, Valeria Fornes, Marlene Russo, Mayra Valcárcel, and myself, all anthropologists from the University of Buenos Aires (UBA) belonging to the *Colectiva de Antropólogas Feministas* (CAF). I would like to thank the MEC staff and the directors. I also deeply thank Robbie Davis-Floyd for inviting me to write this chapter and for her careful edits.

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