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The Shift in the Childbirth Paradigm in Latin America and its Socio-Political Implications

Zmiana paradygmatu porodu w Ameryce Łacińskiej i jego społeczno-polityczne implikacje

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Abstract: The article tackles the issue of the shift in the model of childbirth taking place in Latin American countries. Based on the analysis of 2012 documentary film *Nacer* by Jorge Caballero, audiovisual material from organizations dedicated to maternity care, and selected documents and legislation it focuses on representations, discourses and practices related to childbirth, in technological and natural paradigm. I argue that a shift from the technological paradigm to the natural paradigm of childbirth may contribute to the women's empowerment and the abolition of patriarchal structures perpetuating violence.

Keywords: Latin America, childbirth, obstetric violence, humanized birth, women's empowerment.

Streszczenie: Artykuł podejmuje problematykę zmiany modelu porodu, zachodzącej w krajach Ameryki Łacińskiej. W oparciu o analizę filmu dokumentalnego *Nacer* Jorge Caballero z 2012 roku, materiałów audiowizualnych organizacji zajmujących się opieką okołoporodową oraz wybranych aktów prawnych, koncentruje się na wartościach, znaczeniach, zasadach normatywnych i relacjach władzy w technologicznym i naturalnym modelu porodu. Przejście od paradygmatu technologicznego do paradygmatu naturalnego może przyczynić się do zniesienia patriarchalnych struktur utrwalających przemoc, do upodmiotowienia kobiet i budowy społeczeństwa opartego na wartościach szacunku i miłości do istot żywych.

Słowa kluczowe: Ameryka Łacińska, poród, przemoc w położnictwie, humanizacja porodu, upełnomocnianie kobiet.

The currently dominant model of birth/childbirth described as either medicalized, technological or industrialized has been challenged by all over the world grassroots birth-activist groups, emerging particularly since the 1990s, to readdress the failure of conventional obstetric management to provide safe, effective,

humane care; the failure of government and medical profession to meet the needs of low-income women; but also because of the inhumane treatment of childbearing women (Goer, 2004: 311-312). These actions were in synergy with the progressive recognition of reproductive and sexual rights, which involved legal changes such as the jurisprudential inclusion of the category of "obstetric violence" and the publication by the World Health Organization in 1985 of a set of principles indicating practices that should be discontinued or regulated as harmful to women's psycho-physical health.

Numerous studies on perinatal care in Western culture, in the fields of sociology, feminist anthropology and gender, have pointed to the excessive medicalization of childbirth (Clesse *el al.*, 2018) as part of a more general process of society medicalization. Davis Floyd identified the dominant paradigm of childbirth as the technological or hospital model of birth, indicating that the basic tenets of this model include the Cartesian doctrine of mind-body separation and the concept of the female body as a defective machine dependent on technology for successful reproduction, concepts that have been transmitted and expressed by routines applied in obstetrical care (Davis Floyd, 1987). This author discerned humanistic and holistic model as two other paradigms that can be observed in medical practice. The dominant technological model has been questioned as shaping manifestations of violence (Magnone, 2011) and even, as iatrogenic. Drawing on Foucault's theoretical findings, researchers point out that the value placed on medical knowledge in today's societies means that the knowledge and experience of women giving birth is disqualified, they are not treated as equivalent interlocutors, and are instead subjected to a disciplining that makes it possible to control and subjugate them. The conceptualization of pregnancy and childbirth as medical events with risks legitimized medical intervention and control and in the same time deprived the woman of subjectivity in her own birth (Sadler, 2001; Arguedas, 2014; Newnham, 2014; Vallana, 2016; Magnone, 2011). This is related to the creation of the model of impotent motherhood — the mother is ignorant, passive, incompetent and has to resort to the help of experts, right from the beginning of the pregnancy. Dependency is therefore women's main feature that implicates their alienation, infantilization and loss of autonomy (Vallana, 2016: 59).

Informed by the above findings, in this article I provide an account of the recent shift in the model of childbirth that can be observed in Latin American countries and reflect upon its possible socio-political implications. In particular, I want to describe the reasons for which the current hegemonic paradigm has been questioned and replaced by the natural or humanistic childbirth paradigm, pointing out the socio-political dimension of this change. The analysis is qualitative

and focuses on representations, discourses and practices present in technological/hospital and natural/humanistic birth models in Latin American countries. The research material analyzed is the 2012 documentary movie *Nacer* by Jorge Caballero, material from organizations dedicated to maternity care, and selected documents and legislation. In the first section, I will present the context of installation of the hegemonic paradigm, its characteristics and its critics. In the second section, I will focus on the characteristics of the natural model. The results of the analysis will be discussed in the Conclusions.

My basic premise is that there is a reciprocal and dynamic relationship between the ways in which a culture conceptualizes, ritualize and organize birth or the coming into the world of new beings and the key values and normative principles underlying socio-political organization. I argue that a shift from the technological paradigm to the natural paradigm of childbirth, in the socio-political dimension may contribute to the women's empowerment and participation in knowledge production and to the abolition of patriarchal structures perpetuating violence.

The technological model and its critics

The establishment of a technological model of childbirth involved the installation of medicine as a profession whose practice was reserved for those with university degrees. Different authors show that in the case of Latin American countries the constitution of this model consisted on the displacement of popular medicine — in this case "female science" — by modern, masculine, scientific knowledge, such as "obstetric medicine". From the end of the 18th century Enlightenment discourse considered midwives as harmful and incompetent. The modern state authorities started to extent control over childbirth in the framework of public health institutions. This process was coupled with the goal of reducing child mortality and improving maternal health. The first hospital dedicated to maternal care in Latin America was established in Lima in 1826, followed by hospitals in Mexico (1866), Quito (1875), Santiago (1875) and Buenos Aires (1892). The legal and social recognition of medical knowledge as authorized knowledge and of medical personnel as entitled to intervene in the health/disease process as well as the establishment of a doctor-patient hierarchy, disqualified the knowledge of parturients and midwives.[1] A part of this process was transition of midwife to

[1] Vallana (2020: 92-99) shows that important for the constitution of the paradigm were, on the one hand, misogyny and the perception of a woman as an "imperfect animal", her body as deficient, incomplete, fragile, dependent, disordered, defective; on the other, reducing her to the role of a mother, whose main task is to care for and raise new citizens.

"certified midwife" and from home birth to hospital birth (Quiróz 2018, Staples 2008, Zárate 2007).

Until the middle of the 20th century, hospital births or births assisted by personnel qualified in the public system were available to a minority of women — especially to those from urban areas and well accommodated, — and were synonymous with modernity and progress. The coverage of public medical services, however, has been highly heterogeneous: in some regions of Chile, as early as at the end of the 1950s, the number of births in hospital or assisted by certified midwives exceeded 80% (e.g. 91.7% in Magallanes and 86.3% in Los Andes provinces) (Zárate, 2018: 47-49). In a large part of Latin American countries until the 1980s, traditional midwives, who acquired the knowledge from generation to generation and through practice, attended more than 80% of births (Villanueva & Freyermuth, 2018: 213). The medical services in rural and indigenous areas started to be developed since the second half of the 20th century in the context of global demographic policies aimed at reducing birth rates of indigenous population. In countries such as Mexico, Peru, Guatemala, Panama these policies contributed to the extension of control over the reproductive capacity of women and taken on an aggressive character. The medical personnel placed greater emphasis on demographic goals than on meeting women's real needs: some patients have complained against the public sector claiming that, after childbirth, they were given an IUD or sterilized without their consent. These practices deepened the lack of trust in public health institutions. Indigenous women tend to accept them in order to avoid losing their right to participate in certain social programs (Carpio, 2004: 40, Centro Legal para Derechos Reproductivos y Políticas Públicas, 1997; Quiróz, 2018: 85-87, Wądołowska, 2014: 37-42).

Facing the problem of high maternal mortality rates, international health agencies in the last two decades of the 20th century promoted universal coverage of professional childbirth care considering that qualified traditional midwives can make a valuable contribution to safe motherhood, family planning and child survival. The principle of equity and non-discrimination led to the emergence of a normative framework from which initiatives of adopting intercultural principles in maternal health care have been promoted in countries such as Peru, Guatemala, Mexico and Ecuador. Nevertheless, in the contradictory discourse of international organizations as well as in the national legislation, positions of traditional midwives vary from that of a recognized agent linking the population and the institutions, to that of a marginal agent accompanying the reproduction, depending on their subordination to the dictates of biomedicine and criteria of accrediting health institutions (Argüello & Mateo, 2014; Villanueva & Freyermuth 2018).

The technological or hospital paradigm of childbirth remains therefore hegemonic in national policies. In the six portraits of birth documented in the film *Nacer*, directed by Jorge Caballero and recorded between 2008 and 2012 in public hospitals in Bogotá, we can observe some characteristic elements of this model.[2] The protagonists are the women who are helpless, fearful or tense, putting themselves under the care, or rather the control, of the medical staff on whom the "happy delivery" is supposed to depend. By carrying out routine questionnaires and interviews, the medical staff do not ask the women how they feel, nor do their feelings matter. – Is the baby alive? – doctor asks the nurse over the patient's head before the caesarean operation. – Her? I do not know. I know that the one in the room 4, no. A woman is spoken about in the third person in her presence, with no regard for her feelings. Patients are treated as objects and most of the people working in the hospital are indifferent and emotionally cold towards them. In some hospitals they have to dress in the same hospital uniform, and they are often called *mamá*, which deprives them of their individuality. Their role in the process of the childbirth seems to be insignificant, passive, and consists in obeying the orders of the staff: they give their consent, submit to routine examinations, and act according to instructions. This is directly related to the hierarchical organization of the hospital and the authority of the doctors. Two female patients are disciplined by the doctor during the initial interview for having another ― their fourth and fifth ― child. One of them is reprimanded for being overweight, and when she emits a moan of pain during the injection before the caesarean operation, the anesthetist admonishes her with the words: "no, it cannot be that she is so fat and so weak". Women are treated objectively and at the same time paternalistically. The perception of the body as a machine that can be improved, repaired and perfected are further elements of the technological model that we observe in the film. Women are cut, stabbed, sewn together, and the doctors' main "interlocutors" are the medical apparatuses: they silently analyse the readings of the devices and make decisions based on them. The value of technology is thus prioritized over patient interaction and experience. Relationships in the hospital are formal, anonymous. Holding the baby in their hands, the women express their gratitude to the doctors, as if the childbirth was due to them.

[2] Davis Floyd (2001) points out the following elements of the technological model: (1) mind and body separation; (2) the body as a machine; (3) the patient as object, and (4) alienation of practitioner from patient; (5) diagnosis and treatment from the outside in; (6) hierarchical organization and (7) standardization of care; (8) authority and responsibility inherent in practitioner, not patient; (9) superevaluation of science and technology; (10) aggressive intervention with emphasis on short-term results, and (11) death as defeat; (12) profit-driven system; and (13) intolerance of other modalities.

It is not clear if medical personnel consider the body as separate from the mind, which was indicated by Davis Floyd as a part of the paradigm. We have seen before that the medical staff do not consider the patient's feelings at all. In another situation, a nurse rebukes a woman who starts vomiting: – It's because you're nervous and doing it wrong. If you think "I can do it, I can do it", you will. You can't be so stressed because you won't give birth well. This demonstrates a recognition of the woman's role in childbirth, but mainly in a negative sense which contributes to her disempowerment. As Magnone (2011: 135) notes, the feeling of subjective vulnerability experienced by women during childbirth is increased; the negative messages and actions generate in her processes of disempowerment and lack of self-confidence.

The cases of two women, on the other hand, reveal the helplessness of medical staff in certain situations and their subordination to protocols. We learn that one of them had already been in hospital and had received pain relief at her own request. Now, returning after a few days, she represents an extremely ambivalent attitude: she claims to have strong contractions, she does not want to leave the hospital, but she neither wants to be hospitalized. In the second case, a woman with a high-risk pregnancy arrives from a distance, accompanied by a friend or relative; she is experiencing strong contractions too, but the admitting doctor, on the basis of the medical records, says that this is happening prematurely, and therefore labor cannot be induced pharmacologically. The woman decides to leave the hospital and states that she would give birth at home if it were not for the risk of her bleeding and the presence of infections in the place where she lives. The standardization of care and procedures does not allow women to receive the care they demand, while at the same time they refuse the doctors' proposal. These are particular moments of impasse: the staff cannot force the woman; she cannot get help and is unable to manage on her own. These cases seem emblematic, since they reveal the weakness of a model which, for the women with no knowledge or alternative model of care, is the only one available but generates in them both distrust and fear. To consent to hospitalization is equivalent to giving others authority over one's own body. A person who does not consent is left alone, without guidance or tools to help her in this situation.

The technological model seems to render woman incapable of managing pregnancy and childbirth autonomously. As Camacaro points out, the very fact that she is treated as if she were sick reduces her ability to take care of herself. The hospital model of childbirth is possible by maintaining the social belief that a place dedicated to illness is suitable for the arrival of children (Camacaro, 2009). In a broader cultural context, it perpetuates an attitude of dependence on medical

knowledge, technology, pharmacology and the actions of others to achieve well-being. The pathologization of women's bodily processes interacts with the subordination of women, depriving them of agency and power over their own bodies.

An important aspect of the technological model that we see in Caballero's film is the solitude of the woman in the hospital: most women come to the hospital alone, and they are often single. This is directly related to the social reality of many Latin American countries, the prevailing machismo and the ephemerality of the father figure, as the director notes (*Entrevista con Jorge Caballero*, 2012). This fact points to the social problem of accentuating the responsibility of women in the procreation process, undervaluing the role of men and absolving them from responsibility.

Childbirth in Bogotá's hospitals is unacceptable, horrible. As one patient hears in Caballero's film: – Soon you will be able to say: the birth was terrible, but you will forget it. That's the main thing, that you forget it quickly. In another scene, we watch as two women from the medical staff bend over a lying patient making stitches to her crotch. The woman is crying in pain and despair. Earlier, we learned that while she was pregnant her relatives died — her grandmother, grandfather and her husband had been shot. The doctor gives a perfunctory answer to the question whether this could have affected the pregnancy and conducts a standard interview. During labor, another impassive doctor does not support the woman through the contractions other than by saying: "it has already passed". Now, the woman stitching her up says: – You have just given birth. We're not giving you any injections at the moment so you can cry like that. – It doesn't hurt when you give me injections, it hurts when you touch me. The doctor unconcernedly continues and then orders a disinfectant to be poured over the patient. – Put your buttocks down or you will get wet. The saddest thing is that every time you go to pee, it will be burning. The scene is reminiscent of a torture scene, it seems that the woman's pain elicits satisfaction, or at best indifference from the staff. According to Rodrigáñez "the duty to suffer in childbirth" is related to the repression of female sexuality in patriarchal society. She argues that patriarchal society demands a certain type of childbirth and birth, where pain and fear prevail, in order to hinder the chains of empowerment that could generate childbirth with pleasure (Rodrigáñez in Magnone, 2011: 131-132).

Some practices, implemented within the technological model, have been questioned as manifestations of obstetric violence. The first country to define and recognize the existence of this phenomenon was Venezuela, which in 2007 defined obstetric violence as: "The appropriation of women's bodies and reproductive processes by health personnel, which is expressed in a dehumanizing treat-

ment, in an abuse of medicalization and pathologization of natural processes, bringing with it a loss of autonomy and the capacity to decide freely about their bodies and sexuality, negatively impacting women's quality of life. (Sec. 13, Ley Orgánica Sobre el Derecho de las Mujeres a una Vida Libre de Violencia). Section 51 of this law criminalizes the following actions as manifestations of obstetric violence:

1. Failure to attend to obstetric emergencies in a timely and efficient manner.
2. Forcing the woman to give birth in the supine position and with her legs raised, when the necessary means exist to carry out a vertical birth.
3. Obstructing the early attachment of the child to the mother, without justified medical cause, by denying her the possibility of carrying and breastfeeding the child immediately after birth.
4. Altering the natural process of low-risk childbirth through the use of acceleration techniques without obtaining the woman's voluntary, express and informed consent.
5. To carry out childbirth by caesarean section, when conditions for natural childbirth exist, without obtaining the woman's voluntary, express and informed consent.

Another country that legally challenged violence in obstetrics was Argentina, where it was defined as „violence exercised by health personnel over women's bodies and reproductive processes, expressed in a dehumanizing treatment, an abuse of medicalization and pathologization of natural processes". (Ley 26.485 de Protección Integral de las Mujeres). Mexico was the third Latin American country to question obstetric violence at the legal level, defining it in 2019 as „any action or omission by medical or administrative health personnel that physically or psychologically harms, injures, discriminates against or denigrates women during pregnancy, childbirth or puerperium" (Ley General de Acceso de la Mujeres a una Vida Libre de Violencia). In Chile, despite alarmingly high rates of obstetric violence (80% of women experience it), repeated initiatives to legally regulate the issue have not fructified so far (*Parto respetado y prevención de la violencia obstétrica: dos derechos que se quieren establecer por ley*).

As Vallana points out, obstetric violence is gendered, institutional and invisible in the sense that it is authorized, legal and constitutes a norm to the extent that many women who experience it only become aware of it after a long time, and some never dare to analyse or question the normativity imposed on their pregnancies (Vallana, 2016: 37-38). Arguedas identifies obstetric violence as a speci-

fic form of disciplinary power, linked to the gendered social structure of the patriarchal system from which this form of violence emerges as a mechanism for disciplining, controlling and producing subjectivity (Arguedas, 2014). Díaz & Fernández (2018) demonstrate, that the few countries that have established regulations that aim to directly address the phenomenon of obstetric violence have achieved little impact. These authors conclude that obstetric violence cannot be solved by regulations, as a cultural change is required.

The natural model and its defense

The critique of the technological model has led to the development of a paradigm of birth which, for the purposes of this article, I refer to as "natural", although in the literature as well as in the social practice it is also referred to as "humanized" and/or "respected"[3]. We can include here several related but different approaches, such as full demedicalization; "free births" (which are not attended by anyone at all); the humanization of childbirth, postulating a combination of the positive effects of medicalization with the containment of its iatrogenic effects or combining reasoned medicalization with a human physiological and relational approach to the parturition process, and reasserting the role of midwife support (Clesse *et al*., 2018: 163).

The concept of humanization of childbirth was defined during the International Conference on Humanization of Childbirth carried on in Fortaleza, Caerá, Brasil on November 2-4, 2000 as a: "process of communication and mutual support between people, aimed at self-transformation and understanding of the essential spirit of life". The participants of the Conference declared that humanization "seeks to develop a sense of compassion towards, and in union with: the Universe, Spirit and Nature; with other people in the family, community, country and global society; and with people who will succeed us in the future, as well as with those who have gone before us." Humanization is considered as "transcendental means of encouraging and directing the power of individuals and groups

[3] Davis Floyd (2001) distinguishes between a humanised and a holistic model. The former would include the following elements: (1) mind-body connection; (2) the body as an organism; (3) the patient as relational subject; (4) connection and caring between practitioner and patient; (5) diagnosis and healing from the outside in and from the inside out; (6) balance between the needs of the institution and the individual; (7) information, decision-making, and responsibility shared between patient nd practitioner; (8) science and technology counterbalanced with humanism; (9) focus on disease prevention; (10) death as an acceptable outcome; (11) compassion-driven care; (12) open-mindedness toward other healing modalities. The holistic model insists on the unity of body, mind and spirit and defines the body as an energy field in constant interaction with other energy fields.

towards the development of sustainable societies and the full enjoyment of life." This means can be applied not only to the labor and birth but to any aspect of human performance, such as: aging, disability, health and illness, education, environment, economics, politics, culture, and poverty. According to the Conference, labor and birth, as the starting point of life, affect the rest of human existence, hence the urgent necessity of its humanization is indicated that will be decisive and definitive for future societies (Declaración de Ceará en torno a la Humanización). During the conference, the Relacahupan (Red Latinoamericana y del Caribe para la Humanización del Nacimiento) organization was established with the aim of generate a political stance on the care of the births. With representations in the countries of the region, Relacahupan has been working on providing information on laws and safe practices, creation of national laws, strengthening of organizations, support for traditional birth attendants.

The concept of humanization of birth has been implemented in supranational organisms such as WHO and few Latin American states. Laws setting standards for perinatal care known as "humanized birth" have been adopted in Argentina (Ley 25.929 Parto humanizado) and Uruguay (Ley 18.426/2008. Defensa del derecho a la salud sexual y reproductiva). The latter, in article 3, paragraph c, states the need to "promote humanized childbirth, guaranteeing intimacy and privacy; respecting the biological and psychological time and cultural patterns of the protagonist and avoiding invasive practices or the provision of medication that are not justified".

The humanist perspective privileges midwifery for normal or low-risk childbirth, referring to the gynecologist when a pathological complication arises. This perspective can be considered a "recovered" or "recreated" one, drawing on tradition of women's experience, on knowledge of evidence-based maternity care and the physiology of childbirth as a normal biological process. The adoption of this perspective is linked to resurgence of urban midwifery, the resilience of rural, indigenous and afro midwifery, and their claims of a field from which they had been excluded. There are also numerous women's associations and groups with a strong activism around childbirth, articulated with the broader demands of the feminist movement (González *et al.* 2017) and in convergence with the new type of spirituality (Felliti & Abdala, 2018: 104-110).

The uprising paradigm requires recognition of birth as a natural or normal event. At the same time, birth is considered the most sacred ritual of welcoming a new being into the world, so it is a special moment, a feast that should be celebrated in the family, in the community. Childbirth can be treated as spiritual work; as one midwife from the ASUPARUPA (Asociación de Parteras Unidas del Pacífico) notes: "childbirth is unconditional love". It is also compared to a dance, as

another midwife from ARUPARUPA says: "when a woman has contractions, feels pain, we tell her, remember how you dance the reggaeton".

The main element of the natural model that distinguishes it from the technological model is the promotion of the empowerment of parturients (Clesse *et al*., 2018: 163) As a student midwife interviewed by Magnone (2011: 111-112) observes:

> It is very dangerous for the dominant and patriarchal system that all women know what they want and are connected to what is happening to them at that moment, that is, the moment of birth is a moment of contact with your sexuality, as I want it to be experienced. And in reality you can live it on your own, if you are informed and aware, you don't depend so much on what they tell you or what they come to do to you. The danger is that women can do it that way, without the system, that's the danger that they don't depend, that they have more power. A controlled woman means that you tell her something and she doesn't say anything, she accepts all the interventions you make. An uncontrolled woman may not. The power of childbirth.

María Cristina Galante, midwife and co-founder of Nueve Lunas, organization headquartered in Oaxaca, Mexico[4], explained that "the idea is that every woman, every man, every family should find their strength, their power, and especially that a pregnant woman should recognize her inner power, her physical power with which she can give life" (*Madrinas del ombligo*). In the natural childbirth model, the woman giving birth is placed at the center, her needs and decisions are the most important.

The role of the midwife is to support the woman, accompany her, sometimes guide her and create the most appropriate environment for the labor/birth process to take place. The profession is seen as a service to the community and is carried out with love. In some communities, a person becomes a midwife after experiencing a dream, which is like a vocation. In their approach, feelings are present and matter, the personal relationship with the woman and the child is important, and this is established already during pregnancy. As recent research shows, the context in which childbirth occurs is crucial to the perception of the experience of childbirth. The most important satisfaction factors are the relationship with professionals, continuity in support, a caring and empathic attitude of caregivers and a strong and confident relationship (Clesse *et al*., 2018: 164).

The midwives from Nueve Lunas consider themselves as guardians of life, of the four elements, depositaries of ancient knowledge; their work is based on values such as ethics, impeccability, humility, generosity, neutrality, intuition and patience. They recognize hierarchy and its limitations (*Madrinas de ombligo*). Sabrina Speich, midwife and co-founder of the organization IAP Osa Mayor and

[4] In May 2021 Nueve Lunas announced the end of its activities. In an official letter posted in Facebook, the founders stated that after 16 years, the cycle of their collaboration had come to an end and they would continue their activities individually.

the birth home Cueva de la Partera, located in Tulum, Mexico, says that "midwifery is much more than care during childbirth. Midwifery for me is all about being a woman." (*Entrevista con Sabrina Speich*).

As Saletti (2009) notes, in feminist discourses on motherhood, together with approaches that deconstruct motherhood in a patriarchal model, other perspectives reconstruct motherhood by understanding it as a source of pleasure, cognition and power typically feminine. Some feminist scholars have criticized the essentialist construction of femininity associated with natural childbirth movements. However, as Santos *et al.* (2019) indicated in their study of home births in Portugal, "essentialist perspectives, which conceive birth as an opportunity to reconnect with women's oppressed femininity, coexist with non-binary conceptions of gender, where masculinity and femininity are regarded as fluid forms of energy that everyone has in different degrees, and where men are potentially welcomed in the birth setting, either as fathers or as professionals". According to these authors, the essentialism present in the natural model is constructed as a form of resistance, against the dominance of the androcentric perspective in obstetrics.

On the other hand, Johnson (2009) suggests that arguments about the negative impact of medical intervention in the lives of women seem to resonate only among privileged populations than in disadvantaged ones, when the latter are much more vulnerable to dominant institutions, like medicine. This author considers that in poor communities or under-serviced areas, medical care is a necessity, upon which exercise of agency and autonomy is contingent. The refusal of pharmaceuticals and clinical care among well accommodated women and their reverence for the natural and the traditional (or at the very least a demand of the restoration of a focus on caring) would be, according to Johnson, a political resistance and an assertion of identity, that is likely connected to the sharpness of the division between their public and private spheres of identity and existence.

In view of the above observations, I am inclined to consider the implementation of the natural childbirth model as aimed at recovering women's subjectivity and autonomy, as well as control over their own reproductive power, participation in the process of producing and transmitting knowledge, in accordance with the assumptions indicated by O'Brien (2008: 49-58), that experiences related to the process of reproduction influence the framework of reproductive consciousness, which differentiates current male and female consciousness.

At the same time, the implementation of the natural childbirth model should be considered as aspiration, aware of the socio-political implications of the conditions and ways of giving birth: birth in closeness and love, with respect of the dignity of women in their reproductive process, free from manifestations of violence — these are the fundamental prerequisites for building of a peaceful society.

Conclusions

The establishment of a dominant, technological paradigm of childbirth involved the exclusion of women from the process of production and transmission of knowledge, alienation of women from their reproductive power and depriving them of their subjectivity and autonomy in this area. As shown in the documentary *Nacer*, the technological model of childbirth in Latin America today, supported by the concepts that pathologize normal biological processes, generates manifestations of obstetric violence, making hospital birth a frightening and even traumatic experience for many women. This model may produce distrust and fear of parturients who are reluctant to give others authority over their own body. Although medicalization allows to cope with lethal situations, as Newnham (2014: 258) observes, "hospital <<safety>> is firmly entrenched into birth discourse, and this is the discourse into which women are born and raised in the West. The contingency of hospital based birthing practices, and their hinging on the aspirations of one professional group over another is not a part of our cultural knowledge." We should therefore be aware that the way we understand childbirth is culturally conditioned and has implications for the shape of the socio-political order. In symbolic and material level, the technological paradigm perpetuates relations of subordination, structures that generate violence, attitudes of insensitivity to the suffering of others, confirms the exclusion and dependence of women by weakening their agency. Moreover, it perpetuates dependence on technology, medicine and pharmacology to achieve personal well-being and personal goals.

The deprivation of women's subjectivity and autonomy in childbirth and the obstetric violence are the main reasons for challenging the technological paradigm. So far, few Latin American countries (Venezuela, Argentina, Mexico) have recognized the category of obstetric violence in their legislation by prohibiting inhumane practices or have adopted laws promoting a new model of childbirth (Argentina, Uruguay).

The natural childbirth model is promoted by a growing number of women's organizations, including midwives' organizations. It is based on the concept of humanization, understood as communication and mutual support between people, aimed at self-transformation and understanding of the essential spirit of life. It considers birth as a natural or normal event but simultaneously, as the starting point of life that affect the rest of human existence, which therefore must be treated as the most sacred ritual of welcoming a new being into the world. The woman giving birth is the main protagonist of an event that is potentially transformative, empowering, positive. The midwife is the person who accompanies her in this process, supporting and guiding her, according to the needs of the parturient. In this model feelings and a personal relationship based on trust are important.

Although the socio-political dimension of the shift in the model of birth require a broader study, it can be interpreted as liberation from and abolition of oppressive, material and symbolic, structures. The implementation of the natural model of birth undermines the hegemony of the technological model and carries important implications: women's recovery of subjectivity and autonomy during childbirth process, control over their own reproductive power, participation in the process of producing and transmitting knowledge. It is a qualitative shift from a stance supported by fear and subordination/dependence to courage and autonomy/agency. This shift is a fundamental prerequisite for a society free of violence.

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