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BODY COLONIZATION AND WOMEN'S OBJECTIFICATION IN THE OBSTETRIC SYSTEM

Colonização do corpo e despersonificação da mulher no sistema obstétrico

Colonizacíon corporal y despersonificación de la mujer en el sistema obstétrico colonizado

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ABSTRACT

This research aims to offer a rationale on the subjection of women to the medical-hospital authority during pregnancy and childbirth. The study analyzes the current obstetric system in Brazil from a qualitative approach, based on narratives of twenty-four women who tell stories about how they felt objectified at the time of childbirth. The analysis shows that this system has been constituted in a colonized and violent way. The relationship of these women with the obstetric system is ruled by every form of body objectification, obstetric violence, and non-attendance to the woman's wishes as the protagonist of childbirth. Professional tutelage prevails to the detriment of the body's knowledge, of sensitiveness, of what is natural. The alternative to excessive medical/hospital authority in the traditional process has been the search for humanized teams, dismantling the hegemonic procedure from the desire to live childbirth as an experience of protagonism.

Keywords: body colonization, objectification, subjection, childbirth, obstetric violence.

RESUMO

O presente trabalho tem o objetivo de construir uma inteligibilidade sobre a sujeição da mulher à autoridade médico-hospitalar nos momentos de gestação e parto. O sistema obstétrico vigente no Brasil, estudado a partir de uma abordagem qualitativa, envolvendo narrativas de 24 mulheres que contam histórias sobre como elas se sentiram despersonificadas no momento do parto, denota que este tem se constituído de modo colonizado e violento. Na relação dessas mulheres com o sistema obstétrico, impera toda forma de objetificação do corpo, de violência obstétrica e de não atendimento às vontades da mulher enquanto ser protagonista do parto. Impera a tutela profissional em detrimento da atuação do saber do corpo, do sensível, do comum. A alternativa à excessiva autoridade médica/hospitalar no processo tradicional têm sido a busca por equipes humanizadas, desarticulando o procedimento hegemônico a partir do desejo de viver o parto como uma experiência de protagonismo.

Palavras-chave: *colonização do corpo, despersonificação, sujeição, parto, violência obstétrica.*

RESUMEN

El presente trabajo tiene como objetivo construir una inteligibilidad sobre el tema de la mujer a la autoridad médico-hospitalaria en los momentos del embarazo y parto. El sistema obstétrico vigente en Brasil, estudiado desde un enfoque cualitativo, involucrando narrativas de veinticuatro mujeres que cuentan historias sobre cómo se sintieron despersoficadas en el momento del parto, denota que se ha constituido de manera colonizada y violenta. En la relación de estas mujeres con el sistema obstétrico, prevalece toda forma de objetivación del cuerpo, violencia obstétrica e incumplimiento de la voluntad de la mujer siendo protagonista del parto. La tutela profesional prevalece a costa de actuar sobre el conocimiento del cuerpo, lo sensible, lo común. La alternativa a la excesiva autoridad médico/hospitalaria en el proceso tradicional ha sido la búsqueda de equipos humanizados, desmantelando el procedimiento hegemónico del deseo de vivir el parto como una experiencia de protagonismo.

Palabras clave: *colonización corporal, despersonificación, sometimiento, parto, violencia obstétrica.*

INTRODUCTION

This study aims to offer a rationale on the subjection of women to the medical-hospital authority during pregnancy and childbirth as a process of body colonization and obstetric violence. This process implies the objectification of women within an environment operated by modern science language, in which the Brazilian obstetric system prevails.

The culture of pregnancy and childbirth medicalization is one of the first acts institutionalized by an obstetric system that fragilizes the woman as a being possessing a body that needs assistance and medical care to work appropriately. The subjection of the female body to the institutional norms of modern science is facilitated when the body is affected by imbalances out of the ordinary, becoming the object of study for health theorists when these imbalances are classified as illness (Canguilhem, 1995, p.13).

When considering pregnancy and childbirth as potentially pathological processes instead of physiological events, the women's body becomes an object of the health system, requiring institutional procedures to get back to its state of regular balance. Adopted in health institutions, this bias about the individual (body) as an object of science constitutes what Goffman (1961) calls objectification, an approach that naturalizes violent events in pregnancy, childbirth, and postpartum processes, i.e., obstetric violence.

Although there is no global consensus regarding which practices can be considered obstetric violence, Bohren et al. (2015) synthesize the mistreatment of women during childbirth – demonstrated by studies in 34 countries – and organize such practices in seven domains: physical abuse (use of force and physical restriction), sexual abuse, verbal abuse (rude language, threats, and accusation), stigma and discrimination, failure to meet professional standards of care (lack of informed consent and confidentiality, excessively painful procedures without consent or communication, negligence and abandonment), poor rapport between women and providers (ineffective communication, lack of support and autonomy), and health systems conditions and constraints (lack of resources, lack of policies, institutional culture). In Brazil, the Ministry of Health (Ministério da Saúde, 2018) recognized that obstetric violence can occur in many forms, including the submission of women to a set of norms and standardized procedures, placing childbirth as part of a standardized process of a hospital event:

> Obstetric violence happens during pregnancy, childbirth, and/or postpartum, including during miscarriages. It can be physical, psychological, verbal, symbolic, and/or sexual, in addition to negligence, discrimination, and/or extreme or needless or discouraged conduct. These practices submit women to rigid norms and routines often unnecessary that do not respect their bodies and natural rhythms and prevent them from exercising their protagonism (paragraph 3).

On May 3, 2019, the Brazilian Ministry of Health forwarded the document *Despacho/Ofício* n. 017/19 – JUR/SEC disclosing its position against the use of the term "obstetric violence," alleging an inappropriate connotation. For such positioning, both the Public Prosecutor's Office

(Ministério Público Federal, 2019), in a Public Decree (Nota Pública), and the Social Security and Family Commission of the Chamber of Deputies (Câmara dos Deputados, 2019), took a critical position on the ministries' position. This study keeps the definition of the Brazilian Ministry of Health (Ministério da Saúde, 2018), considering the process of obtaining (Sadler et al., 2016) the recognition of the term as one of the first steps to fight it as a practice.

In this context, and as a form of resistance and micropolitical action, childbirth humanization movements have gained force in the last decade, motivated by a series of factors such as access to information, the reunion of people with the same motivations to discuss objectives, paths, and alternatives to fight obstetric violence and the excessive number of cesarean sections in Brazil. The latter puts Brazil as one of the countries with the highest rates of this procedure in the world, with 58.69% of births happening via cesarean section (Portal ODS, 2017), while the World Health Organization (WHO, 2018) considers an ideal rate of cesarean sections between 10% and 15% of births.

This confluence of institutional elements that culminate in a movement of deterritorialization of the woman during childbirth (when her body is colonized by the language and launched in another territory) occurs when the woman's physiological event becomes a medical event, where she is the object of the process, and the baby is the final product.

Subjugation is easily established when the woman is shaken due to the objectification process, which happens when she takes off her clothes, when she enters a predetermined routine system, institutionally, when she, against her will, participates in symbolic activities. The mortification of the individuality, of the body, and the colonization of life are established by the institutional language (Goffman, 1961) – which we call deterritorialization, i.e., the movement by which one abandons the territory while establishing in another. In this case, the body is over coded by the circuits of obstetric language and by the layers of values and controls instituted as professional attributes (Deleuze & Guattari, 2017).

After this introduction, we started from a perspective about the subjection and objectification of women during pregnancy and childbirth as a form of body colonization by obstetric violence to build a rationale on women's subjection to medical authority. The third section presents the methodological approach, categorizing the study as qualitative research based on interviews started from an open question and submitted to content analysis. The fourth section deals with the construction of a narrative in a multitude of stories and discourses, conceiving a rationale for the central question of this work. Finally, the final considerations offer a brief discussion of the research results and contributions.

THE COLONIZATION OF THE BODY: WOMEN IN LABOR IN THE OBSTETRIC SYSTEM

Body subjectification

Deleuze and Guattari (2011) and Foucault (1979) argue that the subject is inscribed in society based on an imprisonment at the dimensions of language, culture, and moral values, since

birth, produced through so-called institutional vectors, starting with family, school, community, among others. Such institutions dislocate the subject from their becoming, from the dimension of a free body, a "body without organs," placing this body within identity outlines, ways of life, legitimizing authorities, institutions, declarations of truth and disciplinary regimes. In the public health system these structures are operated by professionals and medical-hospital services, which encompasses obstetrics.

In the midst of the "grammatical," disciplined vision, Canguilhem (1995) points out the experiences of the body between what it is denominated normal and the pathological; although the author is not sure in placing these two concepts as opposing, he explains that, when the normal enters in disharmony, it becomes pathological. Thus, the normal vital phenomena are placed almost in the opposing line of what could be considered pathological. And what would be pregnancy and childbirth processes if not a vital and normal physiological phenomenon, not only to the physiology of the woman's body, but even more to society?

The constant medicalization and pathologization of pregnancy and childbirth end up removing the vital process from the feminine body and placing it at the hands of institutions, transforming them into a medical event, not belonging to the feminine body. Analogous to this behavior, what is seen in the stories on obstetric violence is exactly the woman's feeling of not-belonging to her own body and its inherent phenomena. With this intervention, the woman feels objectified, manipulated in a production line, whose final product is the birth of the baby.

For illnesses, science, and consequently medicine, should act under the principle of using the therapeutic phenomenon as an incitation to the return to the natural state, from which it strayed: "all curative resources have only one goal, to return altered vital properties to their natural state" (Bichat, 1800, as quoted in Canguilhem, 1995, p. 41). However, regarding the vital and physiological processes of childbirth, the evidence show that this principle is not followed, not only in pathological cases, when childbirth requires palliative or surgical medical procedures, like a cesarean section. The curative process is used even when childbirth follows its natural flow, in a way that medicalization is adopted as a general rule and in all situations, using artificial and/or mechanical means as a form of cure. In short, the normality, established here, is taken as pathological and submitted to a production line endowed with procedures and standardizations that "cure illnesses," regardless of their existence.

It is the pathologization of childbirth that allows its inclusion in the prevalent health systems and its subjection to medical knowledge. The expected action is medical support, monitoring the health of the mother-baby binomial during prenatal care, serving the person, respecting the woman's decisions regarding the procedures she can choose, with information and protagonism. However, pregnancy is a condition subject to pathologies, and the medical protocols act more strongly on this potential than on the natural event. As *Caderno HumanizaSUS* (Humanize SUS Journal) cites (Ministério da Saúde, 2014), the exclusion of the subjectivity of the individual was the product of a recognition process of what is science and what is health, illness being the main object of study, and health a concept constantly at risk.

Although more evident in recent years, the need for humanization is not a recent finding. This medical issue was already demonstrated in 1948. The concept of health was substituted by well-being, which is something individualized and strengthened the dimension of subjectivity (Ministério da Saúde, 2014, p. 25). However, the current obstetric system still comes close to the previous concept that deals with the objectification of the individual as a carrier of illness and the disease as an object of study.

With the Sanitary Reformation in the constitution of 1988, humanized childbirth was reviewed, considering the perspectives of universality, integrality, equity, decentralization, regionalization, and social participation. These elements should be present in a new obstetric model to produce integral health actions considering the needs of the woman and her child, childbirth necessities, safe and humanized births, and the construction and maintenance of perinatal networks. Thus, birth is considered a biopsychosocial event, recognized as a biological-anatomical event, psychological and biochemical, integrated into mental and spiritual components, that is by its very nature feminine, intuitive, sexual, and spiritual (Ministério da Saúde, 2014, p. 25). This paradigm differentiation was classified in three models, as shown in Exhibit 1, by Davis-Floyd (2001, cited in Ministério da Saúde, 2014). These models are not intended to exclude. They are synergic, and the assistance model can transit between the models according to the needs and characteristics of the individual.

Exhibit 1. Models of health assistance

Technomedical or biomedical model	Humanist model	Holistic model
1. Body-mind separation 2. The body as a machine 3. Patient as an object 4. Doctors alienation in relation to the patient 5. Diagnosis and treatment from the outside in (curing the disease, repairing a dysfunction) 6. Hierarchical organization and standardization of care 7. Authority and responsibility inherent in the doctor, not the patient 8. Overvaluation of hard science and technology 9. Aggressive interventions with an emphasis on short-term results 10. Death as defeat 11. A profit driven system 12. Intolerance to other modalities.	1. Mind-body connection 2. The body as an organism 3. The patient as a relational subject 4. Connection and affection between doctor and patient 5. Diagnosing and healing from the outside in and from the inside out 6. Balance between the desires of the institution and the individual 7. Information, decision-making, and responsibility shared between the doctor and the patient 8. Science and technology are counterbalanced with humanism 9. Focus on disease prevention 10. Death as an acceptable result 11. Compassion-driven care 12. Open mind to other modalities	1. Oneness of body-mind and spirit. 2. The body is an energy system interconnected with other energy systems3. Healing the whole person in the context of life as a whole 3. Essential unity between doctor and client 4. Diagnosis and healing from the inside out 5. Organizational structure in a network that facilitates the individualization of care 6. Authority and responsibility inherent in each individual 7. Science and technology placed at the service of the individual 8. Long-term focus on creating and maintaining health and well-being 9. Death is a process 10. Healing is the focus 11. Embraces multiple healing modalities
Underlying basic principle: separation	Underlying basic principles: balance and connection	Underlying basic principles: connection and integration.
Type of thinking: unimodal, left-brain, and linear	Type of thinking: bimodal	Type of thinking: fluid, multimodal, and right brain

Source: Ministério da Saúde (2014)

In addition to the medical care model, important structural changes that benefit the humanist or holistic model are observed. As for the obstetric assistance model, some of these changes (for example, the countries that changed their rates of cesarean sections) refer to undoing the link between childbirth and health institutions and doctor subjection, creating new spaces such as childbirth houses (as those observed in Brazil). However, there are only a few of these spaces, insufficient for the demand. With the multidisciplinary action of the obstetric nursery, therapists, doulas, and other actors, the delivery for low-risk pregnant women occurs physiologically, not pathologically, and the other cases can be transferred to a hospital, usually annexed or nearby.

The holistic and humanist models propose practices constructed based on feeling, aware of the needs of the body, not exclusive to the technical rationality. The authority and the power built within the relationship between the woman, the doctor, and the hospital (or health) services are horizontal. The woman starts to occupy a different place, dislocating herself from the dimension of the passive patient. According to Deleuze and Guattari (2011), making the body without organs by leaving behind the references of medical authority and language means to surpass the capture and the truths spread by the modern and transcendent machine of *sócius*. Starting from the stripping of the hegemonic discourse (cultural and referential grid) and accessing the desire in the dimension of the will of power (and not due to the lack of medical knowledge), the woman asserts her differences while producing through the *affections*, in the relationship with the medical-hospital knowledge that also starts to differ (becoming) (Deleuze & Guattari, 2011; Rolnik, 2018).

Subjection of the individual

Before discussing the issue of subjection, it is essential to address the theme of power and its entanglements in social actions since social control over the individuals does not start from ideology or awareness, but in the body and with the body (Foucault, 1979, p. 80). Both the capitalist scheme and medicine use the body, and consequently its subjection, as a biopolitical strategy. It is in the control of the body, of the forms of experience, in the subjection of the body to a system or social machine (Deleuze & Guattari, 2011) that power spreads and develops.

Subjection begins with the power disciplining bodies – which are systematized, categorized, placed in order and pattern, wishing self-repression. Discipline is the first form of destitution of the bodies themselves. The docile bodies are conceived in a passive dimension, inscribed in the language (referential grade), objectified, legitimizing the authority of the medicalization (Foucault, 1979), when the discipline places them at the disposal of institutional rules and truths (moral-scientific circuit, for example), subject to the medical authority, obedient to surveillance and continuous monitoring. In this context, "the individual emerges as an object of medical knowledge and practice" (Foucault, 1979, p. 111, our translation).

According to Foucault, the constitution of the subject as an object of knowledge to themself is the core of what we could call subjectivity. It is how the subject makes a relationship experience with the self (Foucault, 1984, p. 230). Still, the subjectivation process is the recognition of oneself simultaneously as subject and out of the subject (coextensive dimension), a movement where

the subject is in a relationship with the external world and with its inner world, through thoughts and the constitution of itself in a circuit of *affections* that summons it to the 'strangely familiar' dimension. In this network of relationships, the subject feels if the subjectivity installed in its body over codes it in constant subjection or if it deterritorializes the individual as a continuous process of subjectivation without a subject, as a potential to be, an active micropolitical becoming (Deleuze & Guattari, 2011, 2017; Rolnik, 2018). However, as a subject, the woman sees herself following institutional norms, accepting the culture, or including herself in the form of being that society imposes on her.

In this study, the standardized form of subjection is in the patient-medical institution relationship, where power is constituted for the one who holds the procedures and technical knowledge, an authority already established by a set of power practices that do not necessarily need to act upon the other, but upon the actions of the other (Foucault, 1984). The word patient itself says a lot. Of Latin origin, "patient" means the one that resists. The word already denotes passivity, the subjection to another, i.e., objectification.

Objectification of the woman during childbirth

Goffman (1961) describes the forms of objectification in total institutions, i.e., those where individuals find themselves subjected to conducting their daily activities for a certain period, with enclosure traits (without contact with external life), such as monasteries, asylums, and prisons. In these organizations, the first violation of privacy occurs, according to Goffman (1961, p. 31), at the time of admission to the institutions, even if the admission is voluntary. When a person enters a hospital, they have to register and offer personal information to meet the requirement of bureaucratic control and subsidize the service provided by the medical and administrative personnel. For the author, at that moment, the border between the individual and the organization is already invaded by the latter. From these records, the individual-subject (the woman), when having to dress in the institution's clothes and when assigned to a ward, expose her nudity and physiological needs to the institution's knowledge, have her visits and accompaniments monitored, carry out exams where "both the examiner and the examination penetrate the individual's intimacy and violate the territory of the self" (Goffman, 1961, p. 35), as in the case of an internal exam, for example, and when subjected to a relationship of scientific power-knowledge inherent to the medical-hospital team, objectification takes place.

Although there are no high walls, closed doors, or a mechanism of physical containment, the majority of women in these institutions obey a "hospital discharge" mechanism so that they can leave. Other points in common between Goffman's closed institutions and maternity hospitals are: 1) constant supervision; 2) the authority of those who hold power, which is established through technical knowledge (also described by Foucault, 1987); 3) the social distance between the social strata of those who are interns and those who supervise them, such as the medical and nursing staff; 4) standardization of procedures and meeting demands; and 5) subjecting the patients to the institution's routines and ways of life, such as schedules that must be obeyed.

METHODOLOGY

This study adopted a social constructionist approach (Gergen, 2009) that involved immersion in the theme-field (Spink, 2003) of pregnancy and childbirth, exploring the relationship of women with the traditional/hegemonic medical language and the humanized alternative language.

The narrative (language) is a way to produce meaning to build reality. Therefore, the research was conducted based on the social construction of realities, considering the different narratives from different voices and registers, voices that tell specific and small stories, which construct the main story that answers the proposed research problem (Borges, 2013). It consists of qualitative research using the social constructionist approach to offer a rationale about women's subjection to medical and hospital authority during childbirth, based on narratives from 24 women (23 were written and one was recorded).

The question that guided the research was: "At what point in your pregnancy/delivery/postpartum did you feel treated as an object of the system without autonomy of your body?" Data were collected in January 2019, sending an electronic link to participants, leading to a form where they could send data through video, photos, and reports. The form displayed a phone number so respondents could contact researchers to complement the data collection process. After researchers were immersed in the theme-field, it was necessary to move away to disassociate the feelings evidenced from the exposure to the collected data. The answers came from several regions of Brazil and one from Portugal. Labor experiences in hospitals, both public and private, and domiciliary childbirths were reported. Demographic data were not collected since it was not the focus of the study to categorize the respondents in any way, thus respecting their protagonism and particularities. The names were suppressed for confidentiality, adopting "Interviewee I(number)."

Of the 24 received stories, only one was discarded for not addressing the research question. Based on content analysis (Bardin, 1977), the reports were transcribed and organized into a single document, which contributed to recognizing the situations of body colonization, objectification, and the emergence of concepts such as obstetric violence.

The different narratives form a multiple and unison voice, expressing something that women want to tell about the violence of subjection when experiencing pregnancy and childbirth. This is a fundamental micropolitical action in the struggle of the displacement of the objectification of women during pregnancy and childbirth, i.e., a decolonial cry, which deterritorializes women from records conceived in their relationship of subjection to language and medical-hospital knowledge.

DATA ANALYSIS AND RESULTS: A RATIONALE ON THE SUBJECTION OF PREGNANT WOMEN TO MEDICAL AUTHORITY

The narratives of different women who have experienced pregnancy and childbirth express pain, anguish, fear, or abuse, a state of institutionalized objectification. It is a state produced by the obstetric specialty operating system hegemonic in Brazilian culture.

Pregnant women enter a moral and authoritarian constraining circuit legitimized and produced by scientific and professional rationality. It is a constraint marked by the body, colonized and over-coded by disciplinary vectors, institutionalized by norms and procedures built by a knowledge that deauthorizes the person, transforming them into a docile subject, devoid of freedom and protagonism in the relationship with the professional.

However, it is precisely from the anguish and discomfort that women subjected to the medical codes find the motivation to re-tell their experiences and speak about the violence suffered. It is a development of thinking based on the body, based on a wound difficult to elaborate. However, it is a wound that demands confrontation, only to promote the effectuation of mental health and the necessary micropolitical action.

Through reading the 24 reports, full of emotion, struggles, and mourning, some important rationales emerged that evidence objectification during childbirth, namely:

1. The use of medical power-knowledge to disregard the pregnant woman's wishes for a type of delivery;
2. Blaming or placing the responsibility on women in a process where they, without realizing it, find themselves victims of violence in a technocratic system (Technomedical Model, Exhibit 1);
3. The objectification of women, disregarding their subjectivities, emotions, and psychic desires;
4. Objectification.

Obstetric violence, which is a large umbrella involving all the above subjection modes, occurs implicitly or explicitly, physically, morally, emotionally, or psychically causing many women to suffer as victims of an obstetric system that still disregards human subjectivity in medical practices, treating patients in an objectified, alienated, dysfunctional, standardized way and with the other characteristics of the technomedical or biomedical model.

The lack of knowledge of the real causes of medical indication for cesarean sections is present in many reports, including when the doctor disregards the pregnant woman's wishes during prenatal care, claiming that she will not be able to have a vaginal delivery, because: "I broke my arm during pregnancy" (Interviewee I4), "the baby is very big" (Interviewee I13), "you can only go to 39 weeks" (Interviewee I16), "you are overweight" (Interviewee I21); showing that:

> Medical power finds its guarantees and justifications in the privileges of knowledge. The doctor is competent; the doctor knows the diseases and the patients, they have the same kind of scientific knowledge as the chemist and the biologist, which allows their intervention and decision. (Foucault, 1979, p. 70, our translation)

The indications for cesarean section mentioned above do not reflect real medical recommendations. Instead, they denounce a lack of desire on the part of the medical team to accompany a delivery. During such a delicate moment, the woman or the family are hardly willing to challenge the medical position, and the subjection prevails. For Interviewee I22:

"when the doctor said 'it has to be a cesarean section,' I had to accept what he said. For me he was in charge. They didn't call my husband to the delivery room and they didn't put the baby on my chest" (Interviewee I22).

Pregnant women who were not well-informed during pregnancy about childbirth and its processes – and mainly because of the pathologies that may arise leading to a cesarean section – do not have the resources to decide when faced with a medical allegation changing the procedure previously agreed (as in the case of pregnant women who opt for vaginal delivery and end up being directed to a cesarean section).

The reports also show a constant blaming and accountability of women, so that they are gradually weakening and subjecting themselves to avoid blame:

1. We saw three pediatricians during those hours until the last one told me that it was my fault because my daughter hadn't spent enough time in the sunlight and was jaundiced (Interviewee I3);
2. If I moved, I could contaminate the area (Interviewee I10);
3. (When I opted for vaginal delivery) my doctor already scared me, saying that a uterine rupture was very dangerous, that there was no way to know if it would happen, and then the baby and I would die (Interviewee I13);
4. I would be responsible for something that went wrong (Interviewee I16);
5. I was humiliated for being overweight, hearing a "you got pregnant because you wanted to, you took the risk" (Interviewee I21).

This evidences a lack of support. The woman needs to be integrated into the decisions and informed of the potential risks that actually exist in each decision, not to blame her for the risk (item 3 above), but to act as protagonists in the decision-making process.

Blame attribution is not justified when the woman is really integrated, taking the leading role in childbirth and occupying a position as part of an entire context. The previously mentioned arguments are still strongly related to the verbal, psychological, and emotional obstetric violence suffered by these women. In addition, these arguments evidenced a feeling of guilt and were categorized as such, explicitly indicating one of the constituent elements of objectification (Goffman, 1961) and obstetric violence.

During hospitalizations, some women reported what made them feel like objects, deprived of their own subjectivity. They felt particularly objectified when neglected, differently from the evidence provided by Goffman (1961), who pointed out objectification due to institutional norms and the daily life of hospitalizations. Perhaps objectification is perceived in a very subjective and unconscious way from the moment of hospitalization, but it culminates in real perception, precisely in moments of helplessness, as the following reports indicate:

1. So they left me alone in the room with my legs slightly bent, my husband accompanied our baby and I stayed there... Feeling like a "baby-removing machine"... It was as if they had already taken what mattered from me and at that moment I was not even a whole body. (Interviewee I4);

2. When they left me in the hallway for almost two hours, waiting for the health plan to be released and my daughter stayed in the nursery. (Interviewee I9);
3. I started asking the nurse how long the anesthesia lasted and why I felt so cold. She responded and asked me to stop asking so many questions. That's when I started to feel that I didn't have any autonomy... When I left the delivery room, the nurses picked me up, took me to the room and put me to bed in a rough way, I felt like an object because in addition, nobody talked to me (Interviewee I11);
4. I realized that the nurses had brought the wrong dose of medication. I complained and they just wouldn't listen. I started to feel pain throughout the day, and at the next dose of the medicine, I complained again. They pretended that they had heard and would confirm it in the chart. I spoke to the obstetrician, she confirmed that I was right and she needed to intervene so that the medication was given in the correct dose... I was reduced to a chart that was not even read correctly (Interviewee I15).

In the reports, it is evident that the woman does not act in the birth process. After the birth of the baby – "final product" – the woman, as a non-protagonist of childbirth, is not legitimized as an individual with subjectivities, but mainly acts as a means (subjected body) that enables birth, which is seen in a discard position (stories 1, 2, and 3 above). In the postpartum period, interviewee I15 (item 4 above) shows how she felt reduced to a medical record when on several occasions, she reported the error when administered medication, and she felt disregarded by the nursing team.

Goffman's (1961) objectification mechanisms are evidenced in the reports, where the institution imposes subjection to the woman's institutional routine. As much as it may seem like an organization of an institution routine, authors such as Foucault (1979), Deleuze and Guattari (2011, 2017), and Goffman (1961) show how these structural mechanisms (language operators) act to discipline the individual and make them docile, as a form of power or, in other words, how the subject is captured and over coded by the moral regime, of values (medical, professional knowledge), from a binary rationality, to the detriment of knowledge of the body, of the living plane.

As the disciplinary regime to regulations is one of the first forms of the individual's subjection (by making them obedient, putting them into routines, clothes, processes, and medical procedures), the patient is a newcomer who must adapt to the institution, which works and exists independently of the particularities of the individuals who come and go. It is not exactly this institutional organization that is questioned, but the force of action as a structure of power, of language, capable of not legitimizing the individual subjectivities, by framing them in an objectified way, by reducing them to the reactive subject (Deleuze & Guattari, 2011, 2017; Rolnik, 2018). The reports that follow exemplify the forms of subjection to the structure through which women's bodies are inscribed in a loss of subjectivity:

1. Upon arriving at the hospital, on the scheduled date and time, I was instructed to take a shower (I had already taken a shower, but this orientation did not give me a choice and I took another), I put on the hospital gown... my son was born, so they showed my son and he was taken to the pediatrician for standard procedures (Interviewee I4);

2. During labor I asked for a glass of water, and they did not allow me a drink (Interviewee I8);
3. I was deprived of food. Deprived of giving birth in the most comfortable position. I had my legs held while the doctor tried to pull Vincent out with his fingers while I screamed in terror. I had my belly pushed in a prohibited maneuver, outside the expulsive period and without being fully dilated. I lost stability, they put me on oxygen, and I heard my son's heartbeat disappearing with the sonar. It was terrifying (Interviewee I21).

The silencing of subjectivity stems from the strong evidence of subjection and disregard of the living condition to which Interviewee I21 was subjected. All these forms of subjection and objectification culminate more explicitly in obstetric violence:

1. At the time of performing the internal exam, six people felt my dilation. I felt embarrassed, even though the "HU" is a University Hospital, there are many people touching you without even asking if this is ok (Interviewee I1);
2. With my first child, at age 21... I got tired of hearing about vaginal delivery, something like "Ahhh, she's young, she can handle having the baby delivered naturally, it was easy to do". (Interviewee I2);
3. I asked them not to cut me (episiotomy) and they did it anyway (Interviewee I8);
4. During labor, they tied my legs even though I asked not to do it, they did an episiotomy even though I didn't want to, the nurse climbed up and pushed my belly (Interviewee I9);
5. Mine was a vaginal delivery, I asked them not to do the episiotomy and the doctor laughed, did it [the episiotomy], and used forceps. Then the anesthesiologist climbed on me to push the baby, I couldn't move so I wouldn't contaminate the area and a nurse complained all the time because her son kept calling asking why she wasn't home (Interviewee I10);
6. In the first pregnancy, at 37 weeks, the obstetrician performed an internal exam, which was actually forcing dilation for vaginal delivery (Interviewee I12);
7. They broke two ribs in a cesarean section. (Interviewee I20);
8. I was humiliated for being overweight, hearing a "you got pregnant because you wanted to, you took the risk" while crying in fear of losing Vincent. But it wasn't my body's fault. Being fat or thin doesn't stop the body from doing its job. The fault was the doctor's haste to make me give birth..." C-section only as a last resort, it will all be open and infected." Hearing this at the most fragile moment of my existence tore me apart. When I went up to the room after the emergency C-section, I just cried, repeating that I would get infected, and the head nurse had to come to reassure me. The worst happened and I really was all open and infected for a month. Humiliation was not the only violence I suffered (Interviewee I21);

9. An ultrasound doctor asked if this pregnancy was from the same father as my first child and said that I should be hospitalized because I have two children at age 24. I, as I am going through an acceptance problem with the pregnancy, suffered a lot from the comment (Interviewee I17);
10. You're not in enough pain to scream like that (Interviewee I18).

Obstetric violence can occur verbally (evident in items 2, 5, 8, 9, and 10 above), physically, psychologically, and emotionally. It harms women's dignity and occurs during pregnancy, childbirth, and postpartum. Any form of verbal depreciation, laughter, disregard, or appropriation of something as subjective as pain (item 10) is part of what is considered obstetric violence. The internal exam is a procedure that can be used in labor to assess the progression of dilation; it is a procedure that helps but is not mandatory; if done painfully, excessively, or without consent, it can be considered obstetric violence (Ministério da Saúde, 2014).

Procedures performed during vaginal delivery are rarely performed in isolation, for example, the use of synthetic oxytocin greatly increases the intensity of pain due to the force of contractions, and the side effects range from the request for analgesia to an intrapartum cesarean section. This is due to changes in the baby's heartbeat and, in the case of analgesia, they can culminate in a lack of control in the expulsive period, which is usually associated with the use of other procedures considered violence, such as the Kristeller maneuver (items 4 and 5 above), a maneuver in which the mother's belly is pushed in order to expel the baby, and episiotomy (items 3, 4, and 5 above), a cut made in the perineum with the aim of increasing the amplitude of vaginal passage. Since 1980, there has been sufficient scientific evidence to advise against its use. However, episiotomy is still routinely performed in vaginal deliveries. Its recommended use should be limited to a maximum of 15% to 30% of cases and with justifications of fetal or maternal distress (Diniz & Chacham, 2006, p. 85).

Disallowing the women to wander around, move (item 5 above), or forcing them into a lithotomy position (items 4 and 5) are also very common forms of obstetric violence. The Ministry of Health (Ministério da Saúde, 2014), in the *Caderno HumanizaSUS*, has some recommendations for respectful care for the mother, so that there is, mainly, a change from the hospital-centered scenario to humanized care:

> It implies, above all, a change in the attitude of the teams and professionals so that the physiology of childbirth is respected, unnecessary interventions are avoided (such as ultrasounds without clinical indication, routine episiotomy, elective cesarean section without clinical indication and/or under false pretenses, internal exams before labor without clear indication, membrane detachment before weeks of pregnancy, early hospitalization, fasting, shaving and enema, restriction of freedom of movement, routine use of oxytocin, routine aspiration of the newborn's airways born, among others) (Ministério da Saúde, 2014, pp. 239-240, our translation).

To "escape" the current obstetric system, women usually seek alternative procedures through doulas or humanized teams. Interviewee I13 reports that she managed to have a humanized delivery, with the respect and autonomy she was looking for, after two cesarean sections in which she says that the system did not allow her to experience the delivery. After two pregnancies in which her search and desires were not met or even considered, she delivered her third child with a team that listened to her and legitimized her as a woman with autonomy over her own body and the lives present at that moment:

> My innermost needs were taken care of, my body's needs were taken care of, my baby's needs were taken care of, my older children's needs were taken care of... and I really felt powerful, strong, warrior, embellished in love and care from a team that made me believe in myself and was with me until the end (Interviewee I13).

The childbirth in the dimension of a responsive encounter allows the relationship of listening and welcoming, in which these women learn and elaborate on their experience, on what could have happened or not, so it is not about looking for blame for the suffering but mainly to remove from themselves all the guilt they carry for having allowed themselves to feel discomfort in a moment so sacred. The reports mention that they feel coerced not to report that they did not like something in the delivery because, after all, the most important thing happened, the baby was born well and healthy. But what about the mother?

> People angrily accused me and questioned why I was like this (crying), that there can be no reason to be like this, it was ungrateful on my part to cry, because the baby doesn't deserve a mother like me, who isn't happy and happy to see her own baby (Interviewee I12).

Within this elaboration process, some women even go to maternity hospitals to get the medical records to check if everything the medical team did was reported in the documents; such behavior is part of a process that begins with the intention of healing and ends, in many cases, with a desire to inform and help other women, whether groups of friends or in support groups, so that the violence suffered does not recur with others. The vast majority want and fight for a change in the obstetric system:

> In addition to not submitting to institutionalization, the new type of activism does not restrict the focus of its struggle to an expansion of equal rights – macropolitical insurgency – as it expands it micropolitically to the affirmation of another right that encompasses all others: the right to exist or, more precisely, the right to life in its essence of creative power. Its target is the reappropriation of vital force in the face of its expropriation by the colonial-capitalist regime (Rolnik, 2018, p. 24, our translation).

Many reports came full of encouragement and thanks with words that refer to the fight, the voices that must not be silenced, and the claims to the leading role that was taken away from them at that moment. This movement acts in a very important micropolitical way, whether in small group performances or in what seems to be simple, the recognition of themselves after experiencing these moments and the elaboration of what was lived in a way that can be used for themselves and to help other women, to help what is called activism but which can be understood as sisterhood.

FINAL CONSIDERATIONS

This study goes beyond the informative and explanatory nature of the forms of objectification that women suffer within institutions, during pregnancy, childbirth, and postpartum. It refers to micropolitics and resistance to the impositions arising from the medical and hospital authorities, of professional categories. It is essential to increasingly adopt mechanisms that work in favor of deconstructing women's passivity as subject to a system that, in most cases, still occurs in a technocratic and mechanical way and disallows women from protagonism regarding the activation of their own bodies.

Objectification occurs with the colonization of this biopsychosocial event. With the emergence of cities and modern life, the industrial way of life, health began to be assisted within this social model developed through techniques, procedures, standardizations, and childbirth progressively became part of the institutional model, and less and less to ancestral knowledge. Technology and advances in medicine have made it possible to cure several pathologies, including those developed during pregnancy or linked to childbirth. However, over coding was evident; childbirth no longer belonged to women, nor did their bodies and desires. The technomedical model trained the view of its professionals for the objectification of bodies and individuals, and, as much as there are attempts at humanization and attention to the holistic model, the reports still offer strong evidence of the validity of the technomedical model as a disciplinary regime and hegemonic language. .

The humanization of childbirth symbolizes a return of practices oppressed by the hegemonic language constructed as a project of modernity of capitalist society. The proposals for action and resistance, through active micropolitics, occur when these women meet with their experiences so that they can elaborate in a "personal-sensory-sentimental-cognitive" way (Rolnik, 2018) their experiences and the recognition of repressed subjectivities, with the aim of healing and social action, so that other women benefit from an experience of autonomy and freedom in childbirth, living this moment in the maximum.

In the macro-political field, it is possible to see that actions go back three decades on the humanization of childbirth. However, the latest reports and many studies show that obstetric violence, in all its faces, still occurs in institutional environments. From the latest figures that place Brazil as one of the leaders in the number of cesarean sections, it is clear that these policies need more action and greater reach, as many women still arrive at the maternity hospital with

little or no knowledge about the physiology of childbirth and how to handle the procedures. The reports show that subjection still occurs and often culminates in obstetric violence and women objectification, depriving them of being protagonists of their own bodies.

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AUTHOR'S CONTRIBUTION

Francielli Martins Borges Ladeira and William Antonio Borges worked on the conceptualization and theoretical-methodological approach. The theoretical review was conducted by Francielli Martins Borges Ladeira and William Antonio Borges . Data collection was coordinated by Francielli Martins Borges Ladeira and William Antonio Borges . Data analysis included Francielli Martins Borges Ladeira and William Antonio Borges . All authors worked together in the writing and final revision of the manuscript.

