Reproductive Agency, Assisted Reproductive Technology & Obstetric Violence

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By way of an overview and to approach the phenomenon of women who have chosen to become mothers on their own through assisted reproductive technology (ART), I will examine the process that begins when women decide to undergo treatment with assisted reproductive techniques in private clinics (having been denied access to ART in public hospitals), how they handle the treatment, how they imagine their gestation and childbirth, their descriptions of giving birth in public hospitals and the treatment that the obstetric teams give them. All the participants declared that they had felt empowered when they took the following decisions: (a) becoming a mother; (b) choosing a private clinic to receive treatment; (c) selecting (where possible) the donor(s) of genetic material; (d) attempting to manage assisted reproduction treatment; (e) choosing a highly rated public hospital; (f) drawing up a birth plan; and (g) selecting a doula or a companion to be with them during this process and in the hospital. However, their empowerment – which the participants understand to be their capacity to control their own lives, to exercise their rights and take strategic decisions in terms of their own reproductive health – was nullified when they were in labor and the puerperium in the hospitals. They reported that their birth plans were not taken into consideration. They suffered dehumanizing treatment at the hands of the medical teams which constituted obstetric violence in not informing them about the effects of the medication administered to induce labor, compelling them to have a caesarean regardless of their explicit wish not to, and neither caring for nor accompanying the women in labor.

I am aware that there are parts of this process, such as the independent decision to become mothers using ART and donated genetic material, which are specific to these women. Nonetheless, there are other parts of the process, such as the treatment received from the obstetric teams, that can be applied to all those women who give birth in

hospitals, regardless of their age, whether they have a partner or not, or whether they used ART. Whatever the case, the sociocultural construction of mothers' age and of choosing a non-normative family with the help of ART, condition and bias the perception of this population in the legislative, medical, social and media spheres. This will be the focus of my analysis below.

Situating the study

This article is the result of a research project I am conducting entitled "Alternative families in the 21st century and social change: a cross-national and interdisciplinary study", on women who have chosen to become mothers by themselves with the use of ART in Spain and in the UK. I use ethnography to construct a holistic understanding of the complexities of politics, policy and power from an interdisciplinary perspective. Ethnography is based on the assumptions of understanding and interpretation of social events being processual, within the framework of naturalism and holism (Attia & Edge, 2017; Hesse-Bibber & Piatelli, 2012). I also take an auto ethnographic approach to my experience as I became a 'choice mother' on my own with the help of ART and anonymous genetic material at a private clinic, and gave birth in a public hospital at the age of 45 in Spain. In this sense, I am able to draw directly from my experience and to contribute an insider perspective to observation and participation that are dependent upon the ethnographer´s self. Wacquant (2004) insists that: "while ethnography must be theoretically driven, it also must prioritize the elucidation of the practical knowledge of agents. This is premised on deep immersion utilizing the body as a vector of knowledge, is a methodological and theoretical tool to analyze the hidden material and symbolic dimensions that define a particular social world and the mutual penetration of agent and world" (Hancock, 2009, p. 94). Moreover Collins and Gallinat explain that

anthropologists should incorporate personal experiences as data in their analysis: “no anthropologist can afford to omit consideration of the possibility that they may themselves be their own, intimate informants” (2010, p. 17).

One of my aims in this ethnographic study is to illuminate how becoming mothers by choice may be empowering and a site of social change for women who resist replicating "conventional" forms of motherhood. From January 2017 I have conducted a total of 40 in depth interviews, twenty of them with women in Spain, between the ages of 39 and 54 years old, heterosexual, university educated, middle class and white. From September 2018 I have interviewed 20 women in London, all of them are heterosexual except one who is bisexual, university educated and between the ages of 38 and 64 years. In London twelve participants are white British, one is a white South African, seven are “white” from European countries (Belgium, France, Italy, Poland, Spain and Sweden) who migrated to London years ago. All women considered themselves “white.” However the European participants living in London were concerned about the increase on xenophobic and racist attacks, since the Brexit vote, against all those individuals perceived as non-Anglo-Saxon and therefore non-white. Their children are between the ages of five weeks and 25 years old, and were conceived through sperm donation, and in half of the cases also with egg donation, there was only one case of embryo donation. The donation of genetic material is anonymous in Spain unlike in the UK. When the women in this study entered adulthood, they believed it would be possible to be financially independent, and to combine professions in which they would develop their full potential with egalitarian romantic relationships and also parental relationships of joint responsibility. However, none of this study’s participants found partners who were able to fulfil these criteria. As a result, for these women, the cultural and sexual revolutions combined with assisted reproductive technology converted the idea of maternity outside

of the heteronormative couple as a desirable one (Bravo-Moreno, 2019). Prior to the commencement of this study I obtained university ethical approval. The women were recruited through snowballing among different groups of acquaintances, charities, websites and associations. The participants were guaranteed confidentiality and anonymity by using pseudonyms. I conducted in-depth interviews mostly at the women's homes but also in workplaces, cafeterias, and parks. They were organised around several topics: the decision to become mothers using ART, mothering, work-life balance and public policies. Participant observation and in-depth interviews were undertaken as well as writing a fieldwork diary. My ethnographic analysis incorporated a process of reflexivity that exposed all phases of the research activity to the continuous questioning and re-evaluation of the researcher. In the next section I will contextualise reproductive politics, access to ART and the inequities participants confronted.

Natural pregnancy, age, "solo" mothers, earning power & ART

Do "solo" women aged 35 and upwards "deserve" to become mothers with the help of ART? Moreover, are they entitled to access ART with public funds under the National Health System (NHS)? Is it "natural" to become a mother after the age of 35? One of my purposes in this section is to deconstruct the idea of whether it is "natural" for women to procreate after the age of 35, and the label of "advanced age" of women in order to get pregnant. These issues are relevant in the sociocultural, medical and media perception of this population. Why is the age of women important, or their decision to become mothers on their own with ART using public funds? The perception of society, including medical teams and legislators or the media, has an influence on who gains access or not to ART in the NHS. For example, in Austria only married heterosexual couples are permitted access to ART (Präg & Mills, 2017). This perception also affects the treatment and the

type of childbirth that the obstetric teams suggest for, or impose on, these women in public hospitals in both Spain and the UK, as will be shown below.

First of all, what is "natural"? Mitchell & Singer explain: "Whether a certain practice is natural depends on one's philosophical conception of human nature. Two views can be distinguished: a) the descriptive view is that what is natural occurs in nature untouched by human intervention" (1983, p. 193). Consequently ART is unnatural and so is medicine. On the other hand, the teleological view looks to human ends. By this account, since ART and "medicine involve the exercise of human capacities, they are perfectly natural" (Mitchell & Singer, 1983, p. 193). The argument against older women's childbearing based on the perception that it goes ''against nature'' disregards the fact that nowadays in the Global North it is socially and medically acceptable to create a temporary or permanent ''against nature'' non-fertile state in women with the use of contraceptives or surgery. It is also regarded appropriate for menopausal women to confront nature by using hormone replacement therapy to defer the consequences of the menopause (Gusdal, 2006) or to vaccinate 12 year old girls against human papilloma virus to help protect them against various cancers. It is also accepted that men have vasectomies, use condoms, take Viagra and, in general, that sexually active individuals may use barrier methods to prevent venereal diseases.

Secondly, women's age is important for the NHS in the UK and in Spain. Both services discriminate against women who are 35 years and older and who want to access fertility treatment, who may face waiting lists for ART in both countries that may take up to three years. Yet, the medical fact remains that the pregnancy success rate is most strongly correlated with the age of the ova, donated or otherwise. Age becomes an issue in these women's lives: a) they do not have access to public fertility treatment if they are older than 35; b) the terms used to categorise them as pregnant women are ageist; and c)

obstetric teams take decisions regarding the type of childbirth women will have depending on their chronological age, not biological age, nor ova age, which in half of the sample reported here was donated from women in their early twenties. The terms used to refer to women's pregnancy when they are aged 35 or older are: "advanced maternal age" or "geriatric pregnancy" in English-speaking countries, and "añosa", which is employed in Spanish-speaking countries and means "aged woman". To label the gestation of these women with those expressions is ageist in both languages and denotes sociocultural constructions of pregnant women aged 35 and upwards as "old". Indeed women's use of ART has exposed age prejudices associated with women.

Petropanagos (2015) argues that pregnancy at an "advanced maternal age" may be perceived as violating social norms surrounding motherhood, where the "good" mother is construed as young, active, and self-sacrificing. However, moral criticisms of women aged 35 or older rely on a particular conception of motherhood that is, possibly, ageist and sexist, relying on restricted notions of the family. The allegation that women who become mothers in their late thirties and older might not have the energy to cope with babies and teenagers contradicts the fact that older women play, and have played historically, a key role in childrearing, including being the sole or main carer for their children and grandchildren. Moreover, ageism tends to reinforce social inequalities as it is more pronounced towards older women (Ayalon & Tesch-Römer, 2017). Intersectional identities can result in a cumulative negative impact for older women who choose to become mothers on their own as they already have a history of disrespectful treatment for other reasons: sexism, bias against single mothers, sexual orientation, racism and disability. Some reasons for rejecting an upper age limit are linked to this critique of motherhood. Furthermore, age limits are sexist because no comparable age limits exist for men. Men are not condemned for becoming fathers in their late thirties, forties, fifties

or older, which is a regular event. “It’s also hard to make an upper limit because it contradicts reproductive liberties,” says Jeffrey Kahn director of the Johns Hopkins Berman Institute of Bioethics, adding that it would be unfair to restrict women from receiving fertility treatments when men can procreate “well into their 70s” (Richards, 2015).

Additionally, although the average age of menopause remains around 52, life expectancy has increased dramatically over the last century, more so for women than for men. It is also a fact that women have given birth to babies naturally in their forties and fifties prior to the advent of ART services. Eijkemans et al. (2014) state that demographers use the 17th, 18th and 19th centuries to determine what happened in so-called “natural fertility” populations, which lacked access to birth control and family planning. In all these populations, the average age at last birth ranges from 39 to 42. Becoming a mother beyond 35 is not abnormal. Reproductive endocrinologists Steiner and Paulson suggest that: “There is no reason to say women in their 50s cannot be good mothers”. Their research compares women who gave birth after 50 to younger mothers in their 40s and 30s and concluded that: “our data do not support the hypothesis that mothers of advanced maternal age have reduced parenting capacity due to physical or mental ability or parenting stress” (2007, p. 1332). The data suggest that patients up to the age of 55 who are carefully selected and well managed can have safe pregnancies. Another study in Denmark of women aged between 20 and 40 states that most women labelled as of “advanced maternal age” have healthy pregnancies, especially if they begin pregnancy in good health and seek prompt prenatal care (Hatch et al., 2016). In addition, there is a difference between chronological and biological age. Chronological age refers to the number of years a person has been alive, biological age takes many lifestyle factors into consideration, including diet and nutrition, exercise and sleeping habits, stress,

mental and emotional health, exposure to environmental and other toxins, and chronic conditions, to name but a few. Biological age is a better measure of aging and how healthy a person is. However, the mechanisms underlying age-related DNA methylation changes remain mostly undiscovered (Ciccarone et al, 2018). These facts indicate that concerns about whether older women will survive long enough to care for their children are unsubstantiated.

Third, delaying childbirth substantially boosts women's earning power. Women who give birth in their late 30s and early 40s also tend to live longer, and their children score higher on tests of cognitive ability than children born to women in their twenties. Many older women report feeling more emotionally and financially prepared for parenting. Goises et al. (2017) conducted a study of three UK birth cohorts that shows the association between advanced maternal age and higher child cognitive ability. The trend all over the developed world in recent years has been more women having more children later; and whether it is a first child or a later child, more women giving birth are 35 and older, which is still classified as "advanced maternal age", and children born to the 35- to 39-year-olds did significantly better in cognitive testing than children born to the younger mothers. According to Goisis et al. (2017, p. 1221), older mothers were more likely to be educated, and socioeconomically better off. "These women tend to be advantaged", and to take better care of themselves during pregnancy.

Fourth, according to Schenker (2011), legal prohibitions or undue limitations on individuals availing themselves of ART services can be claimed to violate the rights to have a family and to reproductive health. The World Medical Association's Statement on ART, adopted by its General Assembly in October 2006, observes that "inability to become a parent without medical intervention (…) is a cause of major psychological illness and its treatment is clearly medical" (World Medical Association, 2006). ART

treatment is undoubtedly justified as medical service and medical attention assisting achievement of the goal of reproductive health. Its prohibition or undue obstruction is a human rights violation (Shencker, 2011, p. 27). Donor egg technology makes conception possible at later ages and it may contribute to a wider societal process of reconsidering women's age markers by making biological indicators such as the menopause and age less relevant as social markers (Becker, 2000). Issues raised in the debate about access to ARTs and women's age are intimately intertwined with other debates, such as those to do with feminism, women's education and earning power, reproductive agency, reproductive politics and public health policy.

"I would have done a handstand with my ears in order to get myself pregnant!"

I explain in this section how the participants experience assisted reproduction treatments to reverse the limits imposed by biology. The intense desire to get pregnant meant being aware of the need to adapt and undergo ART in the best possible way, thus freeing themselves from the biological restriction involved in the lack of sperm, their oocytes' limited number or the poor quality of their eggs. For these women, ART meant reproductive freedom in several key ways, seeking to preserve fertility against the effects of time, and having access to sperm and egg donors. The women who had chosen egg freezing felt empowered because this was a way to preserve oocytes against the threat of age, disease or early menopause. ART expanded fertility options for these women, who had invested time in their education: all of them had university degrees and some postgraduate studies. Reproductive technologies also gave them the chance to strengthen their professional careers. Therefore resorting to ART was, in all the cases, driven by their own pervasive desire for children; and by rescheduling biological motherhood to a later time, it enabled them to establish a career, and in one case to undergo cancer treatment

with less of a risk of missing out on biological motherhood. From this perspective, the desire to have a child is more important than any accompanying feeling of alienation or physical discomfort in the reproductive treatment, or private clinics' profits, taking into account that all the participants were able to afford their treatments. The cost per live birth is highest in the UK (35.647€) and lowest in Spain (21.489€) (Crawford et al., 2016).

For example, Sara, 40 years old, a Spanish economist who lives in Spain, and who got pregnant two years ago with the help of an anonymous sperm donor at a private clinic, gave birth at a public hospital and remarks about her treatment:

> Something that worried me during my treatment was preparing the medication and self-administering it... But I would have done a handstand with my ears in order to get myself pregnant! [she laughs] And thanks to ART my dream became reality.

The fear of doing it wrong and thinking that they might mess up the whole process means that the administering of the medication entails added stress to the assisted reproductive treatment. The women have to do it exactly as it is explained to them in the clinic, taking care not to inject an inferior dose or to do it incorrectly, reading the directions for use, preparing it calmly and checking it to avoid mistakes. Another participant is Thelma, 39 years of age, British, from London and who works for an NGO, gave birth to her baby two months ago using her own eggs and a non-anonymous sperm donor from a Danish sperm bank. She was treated at a private clinic in London and this is how she described her treatment:

> I wasn't looking forward to injecting myself every day and so I thought, 'Right, I'll make it nice. I kept the ritual of lighting a candle every evening. I found the whole process incredibly empowering and positive… I was taking control of my life.

For most of them, the treatment involved using symbolic rituals such as lighting candles before injecting the hormones or visualizing their body pregnant with the creation of

vision boards, which included photographs of bellies in an advanced stage of gestation so as to imagine and make real through images their pregnant body. This is how Rosa, a 52-year-old Spanish architect who had her child at the age of 46 in a public hospital in Madrid, having received anonymous egg and sperm donation at a private clinic in Spain, explains it:

> I so wanted to have a baby that I prepared myself mentally by projecting my vision of it: I printed pictures from the internet of the bellies of pregnant women, of newly born babies, and I stuck them on a card, and I would look at them every day, imagining that that could be my belly and that that could be my baby. Truly, ART gave me the chance to be a mother. Injecting myself and taking lots of medication every day was secondary compared to the wish to become a mother. And so I chose to create the physical possibility through medication and the mental possibility through my desire and imagination to have a baby.

The symbolic rituals, a healthy diet, taking physical exercise and visualizing their pregnancy was daily practice in the lives of these women, which fed their hope that the assisted reproductive treatment would prove to be successful. For those women who, because of their age or because the treatment did not work with their own eggs, as was the case for Eva, who had frozen her eggs when she was 39 and when 43 she used them but they failed to result in any embryo, the only option left is that of egg donation. For Eva, a doctor in biology and resident in Spain, the fact that no viable embryo was produced with her eggs meant going through what the literature in Psychology calls genetic grief (García-Lumbreras, 2019), the process of sadness that some women go through when they learn the news that they will not be able to use their eggs to conceive their baby. Nevertheless, Eva became pregnant at the first attempt with anonymous egg and sperm donation at age 44:

> I was very hopeful, thinking that as I had frozen my eggs when I was 39 years old, I had a good chance of getting pregnant with my own eggs and with the sperm of the man who was then my partner, I was 43. However, the embryos they implanted in me did not lead to a pregnancy. I was left terribly sad. Not long after I broke up with my partner and went to a clinic, where they offered me the possibility of anonymous egg and sperm donation. My desire to be a mother was so strong that I said yes. The clinic psychologist helped me to overcome both bereavements: the genetic, which I did not know that this type of grief existed but she called it that; and that of having broken up with a partner, whom, I realised, I was only with in order to create a family. When I had my baby in my arms I felt that everything that I had done had been absolutely worth it.

Thus, beyond the genetic material, according to the participants, the team of professionals working at the private assisted reproduction clinics advised focusing on the final objective, which was having a baby, the reasons for which the women wanted to undertake the journey to motherhood and all the positive feelings that the arrival of their child inspired in them. In this way, they managed to find hope again after failed attempts with their own eggs and it is then that they found themselves ready to begin with the option of egg donation. Furthermore, the private clinics informed them that recent studies demonstrated that the mother is able to genetically modify the embryo's gene expression in the first weeks of gestation, in a process explained by "epigenetics" (Huntriss, 2018; O´Neill, 2015). ART opened up the possibility of childbearing to this group of women who wanted to have children on their own and who did not have this option before. Therefore it contributed to empowering these women, granting them more control over their body, reproduction, and motherhood. The following section will deal with

participants´ plans for a natural birth in hospitals which resulted in another type of delivery marked by medical intervention.

Women's disempowerment: Confronting hospital reality, mode of delivery and its relation with "advanced maternal age" and ART.

In this section, the experiences of labor in public hospitals both in Spain and in the UK will be examined. All the interviewees except one wanted the most natural childbirth possible, that is, a vaginal birth without an induction or caesarean. Most accepted that if the pain was very intense, they would request an epidural, but this was the only intervention that they considered. Two of the participants, living in London, wished to have their baby in a pool designed for this purpose. Most of the participants resident in London had medically recommended Caesareans on the basis of their age (35-47 years), and the assisted reproductive treatment. This was despite the fact that in half of the cases, the pregnancy had been achieved using the donation of sperm and eggs from donors in their early twenties, and that only two of the interviewees, had any prior medical condition.

All of the women said that they led a healthy lifestyle and had no problems during gestation. All the participants in Spain were given epidural injections, in most cases labor was induced, and in a minority of cases a caesarean was performed. Vicky, 46 years old, a mental health nurse from Eastern Europe, who has been living in London for the past 23 years, had given birth to her baby three weeks prior to our interview. She had been treated at a private clinic in Spain using anonymous egg and sperm donors in their early twenties, and became pregnant at her first attempt. She gave birth at a public hospital in London and talks about her experience:

I really wanted a water birth at home and I hired a pool. I had a very gentle beginning but then it wasn't progressing enough. I ended up in a hospital and had an emergency caesarean. I was so shivery on the operating table, it was just such a nightmare, I've never had any operations in my life, and I never expected this. The doctors knew that I had IVF, that the baby was conceived with a double donation, with donors in their twenties. Nevertheless, they put me automatically in a high-risk category because of my age and because of IVF, but I never had any medical condition! They didn't know how to deal with it. They thought that things might get complicated. I didn't have any complications during pregnancy ... If I had been in a calm and proper state, I would have never agreed to a caesarean, I really thought that the caesarean would have been such a last resort. I thought that if I went to hospital, at least they'd give me an injection to numb my pain, and then I could continue pushing, but they wouldn't let me go into the pool at all. They had just attached the machines on my belly, they had to monitor me continuously…they told me I'd have to be in a hospital, on the labor ward. And I was, like, 'Well, I'm actually choosing home birth, you know?' I was so confident that I could trust my body, and it would happen, but it just stopped...I tried to push after they gave me synthetic oxytocin and an epidural, and I was just feeling so horrible with all this, because I really was just completely medicated when I wanted it to be so natural…

Vicky is grateful for the work of her doula, which made up for the lack of obstetric personnel who neither accompanied nor cared for her during the process. She emphasises the apparent ignorance of the obstetric team and their hostility. The medical team did not take into account that (a) she had no medical condition, (b) she had a problem-free gestation, and (c) the ovum and sperm were from young donors. The obstetrician only

focused on her chronological age and the use of ART, classifying her case as high risk, despite the fact that the research suggests that the mother's overall health (biological age) is more important than chronological age per se (Ciccarone et al., 2018; Kitzinger, 2011), and that the quality of donated eggs from women in their 20s with proven fertility are key for a successful pregnancy (American Society for Reproductive Medicine, 2012). Thus the actions of the medical team show their prejudice against the age of the participant, imposing a caesarean upon her, which caused Vicky to lose her calm and submit, to her regret, to the judgement of the specialist.

A review of 26 studies that provided data from 17 countries, involving more than 15,000 women in a wide range of settings and circumstances showed that: “Women who received continuous labor support may be more likely to give birth 'spontaneously', i.e. give birth vaginally. In addition, women may be less likely to use pain medications, and may be more likely to be satisfied and have shorter labors” (Bohren et al., 2017). On the other hand, a series of studies published in the Lancet (Boerma et al., 2018) found that the use of caesarean sections is rising rapidly worldwide with experts saying the procedure is growing at an "alarming" rate. The World Health Organization estimates that around 10 to 15% of births require a C-section due to complications and it has suggested that rates higher than that are excessive (WHO, 2015). The research found that the procedure is overused in rich countries. The global increase in its prevalence has been attributed to more women giving birth in medical institutions like hospitals where the procedure is implemented more often. According to the OECD (2017), in the UK the rate of caesareans was 27.4%, while in Spain it was 24.4%. Nevertheless the caesarean delivery rate increases in direct proportion to age in both countries: Hospital Episodes Statistics (HES) containing records of all patients admitted to NHS hospitals in England show that 35% of Caesareans were performed in women aged 30-39, and 45% in women

aged 40 and onwards (HES, 2018). And the National Institute of Statistics in Spain indicate that 30% of Caesareans were performed in women aged 35 to 39; and 39% in women aged 40 to 44, and 58% in women aged 45-49 (INE, 2015).

Fay, a 50-year-old British head of research at a private company in London, gave birth to her son at the age of 47. She had been treated at a private clinic in London with sperm donor from a US sperm bank and her sister's eggs. She describes how she ended up having a caesarean at a London public hospital:

> My pregnancy could not have been better. I wasn't sick once, it was amazing. The combination of being a first-time mother at 47 years old and IVF made me in the doctors' mind high risk, so I had a C-section.

Gabrielle, 48 years of age, a British university graduate who owns her own company and lives in London, was treated three years ago at a private clinic in Spain with anonymous egg and sperm donation, from donors in their early twenties. She explains why she had a C-section at a London public hospital:

> I was planning to give birth naturally although this hospital has a policy that every woman over 40 has to be induced. I was 45….what frustrated me was that I had a textbook pregnancy. I didn't have anything untoward, so they started the process of inducing me and it wasn't working so I had a C-section.

A study published in the Canadian Medical Association Journal (Korb et al, 2019) suggests that the trade-off of risk versus convenience of scheduled C-sections for women aged 35 years and older is dramatically skewed. Researchers found that caesarean delivery is associated with a higher risk of severe acute maternal morbidity than vaginal delivery. They also found that women over 35 who had planned C-sections were at greater risk for a range of severe maternal morbidities, including: haemorrhage, stroke, blood clots in the lungs, kidney, liver and cardiac dysfunction, and admittance to the intensive

care unit. Their finding raises questions about the practices of some obstetricians who consider caesarean deliveries to be indicated by "advanced maternal age", with the idea that there will probably be no further pregnancies. Nevertheless, this practice may unnecessarily expose women older than 35 years to the excess risk of severe acute maternal morbidity. Horsager-Boehrer (2019), Head of Obstetrics and Gynecology at the University of Texas, claims that spontaneous labor is the safest route for most patients and their babies. According to WHO (2018, p. 4): "In high-income countries, the proportion of infants delivered at term following induction of labor can be as high as one in four births". Nevertheless, WHO does not recommend induction of labor for women with an uncomplicated pregnancy at gestational age less than 41 weeks, and "the potential need for induction of labor for women with a post-term pregnancy should be discussed with women in advance, so that they have an opportunity to ask questions and understand the benefits and possible risks" (WHO, 2018, p. 5).

Hospitals and obstetric violence

In this section I will analyse the experiences of participants and also my own experience of labor induction. Two of the participants in the present study epitomise the experiences of the majority of the interviewees. They comment on how, despite wishing for a natural birth, they were induced in hospitals. Induction of labor is a practice on which WHO recommends not to exceed the 10% rate. The European Perinatal Health Report states that in the case of the region of Valencia (Spain) there is a 32% of labor inductions in public hospitals, the report does not offer data for the rest of regions in Spain and in the case of England the induction of labor occurs in 21% of cases, however the report does not specify women´s age in any region (2013, p. 92).

Maya, 40 years, British, works for an NGO in London, and was treated at a private clinic in London. After two miscarriages she became pregnant with sperm from a donor and gave birth one year ago at a public hospital in London:

> I know the NHS people pressure women into induction or caesarean if they're older and they had IVF. They induced me.…they loaded me up with drugs and gave me the epidural.

Zoe, a 47-year-old South African living in London, was treated at a private clinic in Spain with an anonymous double (egg and sperm) donation, and gave birth three years ago at a public hospital in London:

> This Hospital has a policy where after the age of 40 they induce you. I didn't really want to be induced but I had no chance.

In my own case, I had my daughter on my own by choice through ART and donated genetic material at the age of 45 in a private clinic and I gave birth in a public hospital in Madrid. I chose the public hospital "12 de Octubre" because in 2011 it was the first to be awarded the accreditation for the promotion of natural birth, the health of the newborn and maternal breastfeeding. The Baby Friendly Hospital Initiative is an internationally recognised accreditation created by WHO and UNICEF to encourage hospitals to adopt practices that protect and facilitate exclusive maternal breastfeeding from birth and skin-to-skin contact in order to enable the creation of a bond between mother and child. The "12 de Octubre" Hospital stood out as one of the most respectful with the woman and her baby in childbirth. I had consciously prepared myself, researched and weighed up the pros and cons of giving birth depending on which hospital: I joined forums where they discussed which hospitals had the best obstetric services, those that respected the woman's decision to have a "natural" birth the most. When my waters broke, at six o'clock in the morning, I called the hospital and they told me I had to get

there as soon as possible. I arrived with my "Birth Plan" document and gave it to the nurse who told me that I had to wait, and that I could walk along the corridor so that the movement might cause me to start contractions and thus not have to wait long. They told me that if, twelve hours after the waters breaking, labor had not started, they would induce it. The birth plan that I had drawn up in such detail was falling apart before my eyes, without anybody commenting. I remembered a piece of data from the WHO, which asserted that it was not necessary to induce labor before 24 hours after the waters break, and I also bore in mind that a few days before, a hospital nurse had conducted a vaginal examination on me, which I believe might have caused the waters to break before time. They had not informed me of the possible consequences of performing a manual vaginal examination, such as a possible infection or causing the onset of labor (Downe et al, 2013).

And so I found myself walking up and down a corridor. They did not allow me to leave the hospital as they had to monitor me, and the twelve hours passed. The nurse told me that they had to induce labor. I did not want them to, preferring that the baby would come out when she had to come out. I asked to speak with the head of the Obstetrics department, who told me that it was necessary to follow the hospital protocol of 12 hours. When I insisted that the WHO stipulated waiting 24 hours, he accepted the negotiation and said that we would wait 24 hours but if I was not in labor by then, I would be induced. I felt hopeful, I had won a small battle. Nevertheless, after 24 hours I was still not in labor. Not allowing me to negotiate for more time, they administered prostaglandin and oxytocin. The nurse had informed me that I would sleep all night and would probably give birth in the morning. So I lay down on the bed as ordered, as they had to monitor the foetus, with many cables connecting my belly to a device. I started to feel sharp, intense cramping pains, which exploded inside me in all directions. I began to have diarrhoea, to

try to vomit with an empty stomach, my body shook so much that when I went to the bathroom I could not sit on the toilet, writhing uncontrollably. I felt intense cold, I had a fever, I felt very ill, with terrifying pains and stomach cramps. I told the nurses but they were busy. Nobody took care of what was happening to me and hours passed like this. Clearly, the hospital was not following WHO recommendations that assert: "Induction of labor should be performed with caution since the procedure carries the risk of uterine hyperstimulation and rupture, and foetal distress". Or that: "Women receiving oxytocin, misoprostol or other prostaglandins should never be left unattended" (WHO, 2011, p. 7).

Nobody had informed me of the consequences of taking prostaglandin and oxytocin, of their effects on my body. Not one healthcare professional accompanied me at any time. After hours of intense pain, stomach cramps, shaking, diarrhoea and vomiting (caused by complications associated with the use of oxytocin and prostaglandin), they transferred me to the ward next to the delivery room. I had wrapped myself in a blanket because I felt very cold, I was shaking and could not manage to sit down on the bed. A nurse watched me from the doorway and ordered me to sit down on the bed, to take off the blanket, that these were hospital rules, as though I were purposefully disobeying her orders. Not once did she help me, she only gave me orders. I felt utterly sick. I stared at her and asked her: Do you know what empathy is? Can't you see the state I'm in? In response, she told me that the rules were that I sit on the bed and take off the blanket, and she left the room.

She did not help me, she did nothing other than speak to me of rules while my body was beset by side effects from the hormones, about which nobody had bothered to inform me. Hence the nurse hid behind hospital rules, transferring her responsibility and her negligence to the institution, reaffirming the normative relations of power and repressing behaviour that threatened the established hospital protocols. I tried to lie down

on the bed, shaking, cold from head to foot. I had far surpassed my pain threshold, so they gave me an epidural, which only had an effect on the left side of my body, which felt dead. The right side was absolutely trembling with pain. When I asked the nurses to correct the unequal result of the epidural on my body, they told me that the anaesthetist was very busy. Thirty-two hours after my waters broke, I gave birth. One of the midwives who assisted in my labor told me knowingly that I had been lucky: "you got an obstetrician who favours a humane delivery, if you had got another they would have cut you up". In other words, they would have performed an episiotomy on me. They had placed my daughter in my lap and I felt relieved and overcome with joy, in spite of that statement.

The very morning that I gave birth I was visited by a nurse, when I commented to her that I was producing no breast milk, she suddenly squeezed my nipple roughly, without a word of warning, as if my breast were a cow's udder to milk. After 32 hours of trying to give birth, of the adverse effects of the labor induction hormones, that this nurse should cause me even more pain horrified me. She did not speak to me, she did not ask for permission, she did not warn me of what she was going to do; she treated me as if I were an inanimate object. She probably did not know that "synthetic oxytocin given during labor can negatively affect breastfeeding" (Gomes et al., 2018, p. 748). I wrote two letters of complaint concerning the treatment I received during my time in the hospital, but never received a reply.

Both neglect of care of the nurse during labor and the omission or concealment of information by the medical team concerning the possible adverse effects of labor induction or of a caesarean, interfere in the decision-making capacity of the woman and constitute ´obstetric violence´ (Tribunal de Justicia, 2006). This affects women's experiences of childbirth and puerperium in hospitals, resulting in feelings of

powerlessness and anxiety. Negative interpersonal relations between caregivers and women in labor have been found to be features of traumatic birth experiences (Elmir et al., 2010). Laws on obstetric violence originate from Venezuela and Argentina, but they are an exception despite the predominance of obstetric violence worldwide. In 2006, Venezuela became the first country to legally define obstetric violence and to classify it as a crime: "the appropriation of the body and reproductive processes of women by health professionals, which is expressed in dehumanizing treatment, in an abuse of medicalization and pathologization of natural processes, resulting in loss of autonomy and ability to freely decide on their bodies and sexuality, negatively impacting the quality of life of women" (Tribunal de Justicia, 2006, p. 30). Regarding obstetric violence in the UK, drawing on wide-ranging evidence and in consultation with women and their families, as well as an ample variety of stakeholders including NHS staff and independent experts, the NHS England commissioned a review chaired by Baroness Julia Cumberlege, who argues:

> We heard that many women are not being offered real choice in the services they can access, and are too often being told what to do, rather than being given information to make their own decisions. We found almost total unanimity from mothers that they want their midwife to be with them from the start, through pregnancy, birth and then after birth. Time and again mothers said that they hardly ever saw the same professional twice. That is unacceptable, inefficient and must change. We spend £560 million each year on compensating families for negligence during maternity care. And when things do go wrong, the fear of litigation can prevent staff from being open about their mistakes and learning from them. All these factors contribute to the UK having poorer outcomes on some

measures than our peers in Europe, which is unacceptable (Cumberlege, 2016, p. 3).

In 2014, the WHO strongly criticised the disrespectful and abusive treatment that women suffer while giving birth in hospital. In August 2019, Dubravka Šimonović, United Nations Special Rapporteur on violence against women, submitted a report entitled, "A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence" to the UN General Assembly. In October 2019, a motion by the Parliamentary Assembly of the Council of Europe called on all member states, including the UK, to address obstetric and gynaecological violence, which the motion asserts is a reflection of a patriarchal culture that is still dominant in society, including in the medical field. The motion declares that obstetric and gynaecological violence is a form of gender violence that has long been hidden and is still too often ignored. In the privacy of a medical consultation or childbirth, women are victims of practices that are violent or that can be perceived as such. These include inappropriate or non-consensual acts, such as episiotomies and vaginal palpation conducted without consent or painful interventions without anaesthetic as well as sexist behaviour in the course of medical consultations, which has also been reported (Parliamentary Assembly of the Council of Europe, 2019).

Discussion

Historically, women have continued bearing children until the end of their reproductive age. What is different nowadays is that there is an increase in the age at which women give birth to their first child. The global fertility rate has fallen rapidly due to several major reasons: the empowerment of women, their growing access to education and increasing labor market participation, their opportunities for family planning,

technological, sociocultural and economic changes, as well as a rising cost of bringing up children, to which the decline of child labor contributed. We also need to take into account the impact of ART and the fact that women live longer as part of the changing field of motherhood. The fact is that women are having their first baby later in life, and social and media debates tend to be played out through a discussion of the clinical problems about older women's ability to carry a pregnancy in their late thirties and forties and give birth to a healthy child. This tends to simplify and distort the science around fertility. Researchers with the British Pregnancy Advisory Service (BPAS, 2015) shows there is disproportionate concern among women about their fertility, and a tendency to overestimate the difficulties that may be encountered conceiving at the age of 35 or older.

The prevalent paradigm of medicalization in the institutionalized care of childbirth sees the woman who gives birth as an object of intervention and not as a subject of law, removing or detracting from their active role during the experience of pregnancy, childbirth and the puerperium. Obstetric knowledge obtains greater legitimacy using a discourse aimed at showing medical intervention as the most effective way of decreasing maternal and infant mortality during childbirth. The institutionalisation of the reproductive processes supplants the leading role of women in their own pregnancy, birth and puerperium with the authority occupied by professional knowledge, thus bringing to fruition the asymmetry between obstetric professionals and patient. Foucault coined the term “medical gaze” to denote the dehumanizing medical separation of the patient’s body from the patient’s person (Foucault, 1963). Furthermore, the dehumanization of the delivery entails the naturalization of violence. The practices and instrumentation of obstetric treatment are exerted on women who are conceived merely as objects or bodies subject to intervention, and denied, implicitly, their human nature and their rights inherent to such.

All the participants in this study belong to the national racialized majorities of their respective countries, have university education, are economically independent and have read and researched profusely about their assisted reproduction treatment and the type of delivery they wanted. All of them felt empowered by the use of ART and think it contributed to granting them more control over their body, reproduction and motherhood. All except two were free of pre-existing medical conditions, led healthy lifestyles and had no problems during their gestation. Nevertheless, none of those advantages protected them as laboring women at the hands of health professionals in public hospitals. Davis (2019) talks about obstetric racism which best describes Black women's reproductive care in the US.

The obstetric teams in this study, according to the women interviewed, did not follow the recommendations of the WHO that women with an uncomplicated pregnancy at gestational age less than 41 weeks should not have an induction. If health professionals consider induction of labor to be necessary, they should discuss this option with women in advance, so that they understand the benefits and possible risks. In addition, if it is to be performed, women should be accompanied by health professionals at all times. Furthermore, the health professionals involved did not take into account the fact that none of the participants wanted a caesarean section.

The medical world is not exempt from the ageist and sexist attitudes prevalent in our patriarchal societies, e.g. to be labelled "high risk" because the pregnant woman is over 35, the constant warnings of the potential risks associated with pregnancy after 35; the tendency to perform a caesarean section on women over 35, despite having an uneventful pregnancy and being healthy. Moreover, ageism might aggravate the negative impact of other forms of discrimination, including sexism. Women who choose to become mothers on their own with the help of ART in their late 30s and onwards have decided to

take control of their reproduction and choose when they want to become mothers. These women's life choices intensify moral judgements socially, in the media, and in the field of reproductive health, penalising them for not complying with the norm of the heterosexual nuclear family, or procreating after the age of 35, or demanding their right to be informed regarding medical interventions on their bodies as well as their right to be treated humanely, with dignity and respect by health professionals.

Above all, these women wanted a successful birth. Thus they submitted themselves to what obstetric specialists told them, having no other option. They had no room for manoeuvre other than accepting what was imposed or recommended. These women were not complicit in the appropriation that obstetric professionals made of their bodies. They were resigned to accepting medical decisions, trusting that at the end of it all they could hold a healthy baby. For the women in this study, the coveted "natural" birth proved a difficult goal to achieve.

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