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## How Did You Do It? Shared Experiences of Birth Activism on the Issue of Obstetric Violence: Interview with Ibone Olza

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*Ibone Olza is a Spanish mother activist, psychiatrist, and author involved in childbirth advocacy and research at the national and international level. In the present interview, she talks about her experiences within Spanish mothers' movement, specifically in relation to the phenomenon and the concept of "obstetric violence"—a form of gender-based violence exercised on women within maternity healthcare. The interviewer Elena Skoko is a fellow mother activist operating in Italy. The conversation herein represents a milestone for the Italian mothers' movement because it has influenced the use of the term "obstetric violence" in Italy, which has resulted in the creation of a new public awareness and a new national movement of mothers.*

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## Introduction

Ibone Olza is mother activist and perinatal psychiatrist, and is co-founder of the associations *Apoyo Cesáreas* (Caesarean Support) and *El parto es nuestro* (The Birth Is Ours, [www.elpartoesnuestro.es](http://www.elpartoesnuestro.es)) in Spain. She is author of several books on pregnancy, childbirth, breastfeeding, and advocacy, including the latest one, *Parir (Giving Birth)*, which addresses the issue of obstetric violence. She is currently associate professor at the Faculty of Medicine of the University of Alcalá and director of the European Institute for Perinatal Mental Health. As a researcher, she explores the impact of contemporary childbirth practices on maternal and children’s mental and physical wellbeing. Her engagement in birth activism has shaped both her personal life and her professional career, as she states in the present interview, and it has affected Spanish politics and policies of maternity health care.

I met Ibone at my first meeting of the COST Action BIRTH in Lancaster (UK) in 2015, as part of this European research project where researchers, policymakers, and activists work together to produce and disseminate scientific literature on the topic of normal or physiological birth. At one of the coffee breaks, she agreed to give me an interview, and we talked about the concept and the implications of the use of the term “obstetric violence” (Sadler et al.)—the phenomenon of inappropriate and abusive healthcare practices routinely used in modern maternity care that negatively affect women’s lives. Our conversation influenced my decision to use this term in Italy for the purpose of influencing Italian maternity policies, which have not been addressing the consequences of inappropriate maternity care on women and newborns. Together with Alessandra Battisti, lawyer and mother activist, we drafted a law proposal “Norms for the Protection of the Rights of Women and Newborns in Childbirth and Regulation for the Promotion of Physiological Birth,” lodged at the Italian Parliament in March 2016, followed by a viral national campaign—“#bastatacere: le madri hanno voce” (“#breakthesilence: mothers have voice”)—and the foundation of the Italian Observatory on Obstetric Violence ([www.ovoitalia.wordpress.com](http://www.ovoitalia.wordpress.com)) (Skoko and Battisti). Our advocacy work continued with the publication of the first nationally representative data on the phenomenon in 2017, which were published in international scientific journals in 2018 (Ravaldi et al.).

Women worldwide have been reporting abusive and disrespectful care for decades, yet both high- and low-income countries have been ignoring the women’s voices on this issue (WHO). To advance the state of things, mothers activists around the world introduced the term “obstetric violence” (legally framed for the first time in 2007 in Venezuela). The use of the term in Europe started in Spain, and soon expanded to Italy, France, and other European countries—resulting in controversy with obstetricians (Villarme et al.)—and helped to build an international childbirth movement guided by mothers.

## Interview

ES: Ibone, how did you start with birth activism?

Ibone: I was in training as a psychiatrist when I had my two births; both were emergency Caesareans, traumatic. After the second one, I spent ten days in an intensive care unit. I was only allowed to touch my son after a week; I could hold him only after a week. The months following that, I became very upset with the type of care he had in the ICU, where they had been taking care of his lungs. I became very worried, very active to open the doors of the ICU. For my third birth, I was trying to have a vaginal birth after two caesareans. I read all the studies. It was like doing another PhD thesis [laughs]. But most doctors would say, “no, you’re crazy, you have the risk of the uterine rupture; you have to plan a Caesarean, and so on” ... But I had read all the literature; I knew it was safer to go for a trial of labour. I ended up having a third Caesarean, very traumatic, after I dilated at term at home with the midwife. I went into the hospital fully dilated and ready to push my daughter. They treated me really very badly; it was very violent, very traumatic for myself. After that, I joined ICAN, the International Caesarean Awareness Network, an American association dedicated to lowering Caesarean rates and to supporting women who had traumatic Caesareans. After joining the ICAN, I started the Spanish support group for women who had traumatic Caesareans (*Apoyo Cesáreas*). That was in 2001. Soon we had women who had had Caesareans, and those who had a very traumatic vaginal birth. We had to learn from them because the ones who had Caesareans, we thought we had experienced the worst. I was jealous of any woman who had a vaginal birth, but when these women came to our group, they told us their horror stories. We realized this was not a competition for the worst birth, but rather a very serious problem. So we decided to start an association. At first, we wanted to do it with people of South America because in the group, there were many Argentinians. But we realized it was difficult to work in different countries, so we started an association in Spain in 2003. It’s called *El parto es nuestro*. It all started as a need to heal myself, to understand. Rage is an important issue; you have this need to do as much as you can to avoid other women going through the same experience.

ES: At what point is the association now?

Ibone: It’s been a beautiful process. Most of us were very traumatized women; we were very upset the first years. We were going to talk to the institutions and to the newspapers asking them to bring light to this problem to make it socially known. And we succeeded at that. Finally, in 2007, the Ministry of Health of Spain listened to us and decided to launch a strategy, a national strategy to improve childbirth. At that moment, we started to collaborate a lot

with other associations and with the Ministry of Health. For a few years, things seemed to get much better, but now we have a problem with a situation that we deem to be worse. It only seems like things are different. It looks like gynaecologists, midwives, and everybody else started to be more respectful in birth, but they have just incorporated our discourse. It is make-believe; it is not true. They say they are respectful and they won't insult the woman anymore but they will play the "dead baby card" [Author's note: when healthcare providers tell the childbearing mother that her unborn baby's life is in danger even if this is not true, in order to induce here, to comply to their wishes]; they will not tell her all the science. So I'm a bit worried. Certainly, we did get a lot; things are better, yet every day in our association we still receive many women who tell us horror stories. The association is big now; we are eight hundred members. There are even midwives, doctors, and nurses, but most of us are there because we are mothers. We've done a lot of campaigns. I think a lot of good things came out of our activism. But we think there is still a lot of work to be done.

ES: What were your most successful arguments? What did trigger the change? What triggered the communication with the institutions and with the medical system?

Ibone: I don't know. I think we found receptive people at the Ministry of Health. We went with the data. We told them: "Listen, you can't be proud of the data when there is 25 percent of Caesarean rate, both in the private and public hospitals." We told them about our pain; we told them our stories. We were very good in making women's stories heard.

ES: How did you make them hear those stories? I mean, you used data, but stories are not obvious in the data.

Ibone: We wrote many stories to the newspapers, we went to the TV, and we got good people to make good documentaries on national TV. We wrote a lot, a lot of letters, to journals; every woman did it. And then we started to form a support group in each town. We did a lot of Internet campaigns. One of the first ones was about episiotomy. We translated into Spanish a French web page dedicated to the information on episiotomy. We did another campaign that was called *¡Que no los separen!* (Do not let them separate you) to inform families that they have the right to stay with their newborns, especially in the intensive care units. We made posters and we sent them to all the hospitals in the country. We created a group for professionals, where they could talk about their experiences. We also did a campaign about the Kristeller manoeuvre. We started the Observatory on Obstetric Violence because now we are really using the term of "obstetric violence" to denounce the abuse and the mistreatment of women and newborns in childbirth.

ES: What is your feeling about the concept of “obstetric violence”?

Ibone: Obstetric violence is any abuse to women and babies during childbirth. It can be anything— from doing things to the woman without informed consent, doing things that are not evidence based, and not offering the right information to the women. Venezuelan law says obstetric violence is not attending properly to obstetric emergencies, doing a Caesarean when there are ways to do a vaginal birth, separating the newborn from the mother for no good medical reason, telling a woman to give birth lying on her back, which is still used in most hospitals, even if it is totally against scientific evidence. All of this can be obstetric violence.

ES: How do you feel now about the concept? What reactions did you have? How did you use it as an activist’s tool?

Ibone: At first, we were very reluctant to use it as a term because we thought it was going to cause us trouble. To our surprise, everybody understands it. Although professionals were at first very offended, many of them totally understood what we were talking about. We thought this concept would put us into trouble, but it turned out it was the opposite. It is very easy for most people, even for professionals, to understand that doing a Caesarean for no good reason or taking away a newborn from a mother for no good reason is a form of violence. The Latin American activists have shown this to us. They have started the Venezuelan law on obstetric violence. I think it came out in 2007, so did the Argentinians and the Mexicans who also had their own laws on obstetric violence. In Spain, we thought the concept was too strong. But now we realize it is very helpful instead. People understand it.

ES: Is it producing change? When did you start using it?

Ibone: I think we started in 2014. It’s been helpful because it created a debate. At first, the professionals felt offended. They were saying: “You are not going to tell me I’m being violent!?” We were saying: “We are not telling you that you are being violent; we are telling you it is violent to take away a baby from the mother.” Or, it is violent to do a Caesarean. We asked them: “How do you feel about this? Is this something you would like to be done to you or to your daughter?” They know how it is. I think it’s helping. It also puts light on the gender issues surrounding birth. Obstetric violence is a type of gender violence that is only experienced by women or babies. Birth is a very specific and vulnerable time. It creates the potential for great damage; the impact of this violence is so important. When we talk about obstetric violence, many husbands quickly understand it as well because they have been witnessing it; they have felt it.

ES: How do you sustain your activity?

Ibone: My personal or the association's?

ES: Actually, your personal and the association's.

Ibone: Personally, my activism has been causing me a lot of trouble. It was something I could not stop. It caused trouble with my family, with my colleagues, with my work. That lasted for a few years, then it became the opposite. And that kind of situation has happened to many of the women in our association. In our association, there were architects that were very traumatized by birth so they became activists. Now these architects are specialized in designing maternity hospitals. We have philosophers who were traumatized by the Caesarean, and now they are experts in the philosophy of birth. We have lawyers who are now experts in human rights in childbirth. Myself, I was a child psychiatrist but because of the activism, I ended up listening to so many women and became an expert in birth trauma. I ended up becoming a perinatal psychiatrist in my hospital. There was almost nobody doing perinatal psychiatry in Spain, except for a small group in Barcelona. It's funny for me to say this, but I'm probably one of the biggest experts on perinatal psychiatry in Spain because there was nobody else, not because I knew much. For many of us, our activism ended up also combining very well with our profession. We have teachers who also became activists, and they ended up publishing beautiful books for children and natural childbirth. Each one of us ended up getting something back professionally from the activism, which we never expected. And we never did it for that reason. We ended up getting a lot out of every word.

ES: You gained an expertise that is recognized in your community, also on the scientific level?

Ibone: Yes... this is interesting. And then there were other women who wanted to become doulas. They had not thought of being doulas; they were engineers. There was a time when many of us felt as if our activism was like a disease, like an addiction, you know. Our husbands, our parents would tell us: "Can you stop doing that?" There's a moment you can't stop; you feel you have to save all the women. I think that's a very difficult moment, but then in the long term, it all settles down. You understand many things. We say in our association that it's a feminist issue. We think our grandmothers had to battle to vote. Our figurative grandmothers, I mean. They had to battle for the women's vote, and they had to hear many of the things we hear now. Then our mothers had to battle to work, for the right to work. And now, it's our turn to battle for the right to give birth as women want, and safely. We were born in the seventies, in the eighties, and in the nineties, and now it is our time to do this.

ES: How is the association sustained?

Ibone: It's very easy. Women join us. Unfortunately, many women join us because of the bad birth experience. Basically, the association is very open. If you have any idea, we tell you: "OK, you go and do it [laughs]. We support you; you tell us what you need. If you want to start a campaign, we give you this. If you want to start a subgroup, you need to be in the association for a year, and to have a support from other members." But it's very easy; you set up a group in your town. We do most of the work through the Internet. When you join the association, you find out everything that's been done; you can choose to join the Caesarean support email list, or you can choose to support the lawyers, or you can choose to be in the scientific translation committee. There are many different groups.

ES: How does your association sustain itself economically?

Ibone: It's mostly from members' quotas. We get very little public money.

ES: Is there a core group? Is it centralized or does it work more as a network?

Ibone: It's more a network of groups, self-sustaining.

ES: As a leader of the association, is this work sustainable for you?

Ibone: There was never one leader. When we founded the association, there were twenty-one of us. I think because the way we see motherhood, we were very much against the association being associated with only one leader. We are a community. One day, one woman is the president and the next day, it's another woman. And if somebody has to go to talk on the TV, we ask: "Who wants to go?"; it's the same when somebody wants to publish a book. I think that this is the biggest treasure we have. We have a really good support network. Some of us may leave the association; some may come back. Some may be very active for two years and then forget about it. But there's never been much of a problem. The good thing now is that the association is not related to one person or two. Maybe there are five or ten people, like me, that might be a bit more known because we were there at the beginning. But even then, there are many of us. There is no person that can take the credit and say "I did this." No. It was always mothers working together. And we made sure this was clear; it was not for personal benefit or for being famous [laughs]. I think that's beautiful. It's the way mothers work. Many women were very active until they were pregnant and halfway through their pregnancy, they said: "I need to leave this." Fine.

ES: How do you make decisions in the group?

Ibone: There is an annual meeting, an assembly of the association, and it lasts for two days. In these two days, the most intense moment is a round of

presentations. We can take up to seven hours to listen to every woman; every member who is at the meeting tells us her story. We all end up crying because there are women who come to tell us about their stillbirth loss or about their successful vaginal birth after two or three Caesareans. This is very intense. Our strength is that we always listen to each other's birth stories. After that, we vote on the decisions. The president position is always held by a group of four women, sometimes there's been a man, but most of the time it's women. The four of them make the main decisions through the year, but they always communicate very well with the rest, and then there are different subgroups. The subgroups make their own decisions in communication with the presidency, but it has never been a big problem, really. Things always flew. We do vote on the main decisions at the general assembly of the year. But I don't remember a decision that was very difficult. There might have been some, but right now I can't think of any.

ES: How did your profession as a psychiatrist influence your activism as a mother? How did the profession combine with the motherhood and issues about birth?

Ibone: I learned a lot from this process. I gave so many talks. I learned how to deal better with health professionals. You asked me how my profession affected me as a mother?

ES: How is this connection working? How is it balancing?

Ibone: I have a lot of problems ... with medicine. I love medicine. At the same time, I'm very upset by the way medicine is these days. This created a lot of conflict within myself, both as a mother and as a psychiatrist. It created a lot of tension. The more I learned from other mothers, whether it was about breastfeeding or about birth, the less I liked medicine. I went through a personal process of trying to get to the roots. I like medicine. I believe in evidence-based medicine. But at the same time, I think there are many problems with modern medicine. The biggest one, I think, is that medicine has to now listen to mothers. I don't know how to say this. It's very difficult; it's a strong tension. Then, as a psychiatrist, when I had a serious posttraumatic stress disorder (PTSD) after my last Caesarean, nobody diagnosed it, not even myself. It took me years to understand what I had gone through. I have to say this in Spanish: "*En casa del herrero, cuchillo de palo*" ("The shoemaker's son always goes barefoot"). The fact that I was a psychiatrist made it much more difficult for me to get help for my own PTSD, or even to understand what was happening. Now I teach many students, but I'm very critical about medicine. Yet, I love medicine. It's very contradictory.



ES: You can probably improve medicine this way.

Ibone: I hope I can humanize medicine. Our association *El Parto Es Nuestro* is a fabulous support network for me and for many of us. I have a very good support network from women, from different professionals whom I totally trust, and who can give me the best advice in various situations. Many members of the association say this is one of the most valuable things, belonging to this association, the fact that we have this network. If someone needs help in Barcelona or in Canary Islands, they can always find help. It can be help for a mother; it can be help for a divorce, what diet to have, how to manage your money or how to focus your professional goals. You get support for things that are not related to birth because of this big network of activism; it's a big network of women helping other women with a common trust. That's a gift coming from the activism.

ES: Did you ever have to choose the role you wanted to assume to give authority to your words, acting at times as a mother, at times as a psychiatrist?

Ibone: At first, it helped. Because I was a psychiatrist, I had the opportunity to make doctors, psychiatrists, or others listen to women's experiences of childbirth. I did that a lot. But many times, I would be rejected. The more I healed my own traumas, the better I was able to do that. Now that I feel I have healed, I can talk to doctors, and I can make them listen to women's experiences without getting upset anymore. I think that before they could feel my rage [laughs]. I feel I'm lucky to have the opportunity, because of my degree, to make them listen to me. I wish they could listen to me, and that they could listen to mothers, but this is the world. Now, I have this platform to talk to them, so I take it.

## Conclusion

The experience of childbirth affects women in many ways, resulting in a radical change in women's life; women realize that becoming a mother means reorganizing their own identity and its relation to society. As Andrea O'Reilly puts it, "motherhood is the unfinished business of feminism", and many women realize that statement's truth the moment they give birth to their first child. The conversation between Ibone Olza and me reveals the struggles women face when they realize feminism has left them behind as mothers and has handed them over to an oppressive patriarchal system—disguised as medical and technological advancement—that completely devalues them as women and as human beings (Cohen Shabot and Korem). For some women, this awareness triggers a desire for action, and they invest energy and personal resources to change the state of things for other women. These acts of empowered motherhood, in O'Reilly's words, are powerful agents of change,

which may result in shifting of social paradigms, in community building, and in new careers for women who practice them. Yet they also come with consequences, such as exhaustion, post-traumatic stress disorders and others (Barry and Djordjevic).

Current practices of empowered motherhood focused on childbirth are using what has been called “evidence-based activism” (Rabeharisoa et al.); scientific knowledge and data are used together with experiential and embodied knowledge to make the desired changes within the system, rather than acting outside of it. In case of obstetric violence, this approach shall be considered as a successful one, even if the outcomes are debates and controversies. At least now, there is a reaction, whereas for decades, there was complete indifference. Marketing strategies, such as media campaigns and the press, are additional tools that the motherhood movement has learned to apply for major social and political impact.

Though criticized for “sensationalizing the data” (as expressed by an executive of the Italian Ministry of Health in a personal conversation), mothers activists are financially investing in the production and dissemination of scientific data related to the issues that concern them, and they demand accountability to the system financed by citizen contributions. It is only by showing their financial and political (socially influential) strength that mothers’ voices are heard and acknowledged by the system; they can challenge stagnating relations of power, such as the power of obstetricians in the domain of maternity healthcare.

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