MATERNAL GIFT ECONOMY FRAMEWORK FOR ADDRESSING OBSTETRIC VIOLENCE

El marc de l'economia del do matern per abordar la violència.

El marco de la economía del don materno para abordar la violencia obstétrica.

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RESUM

El present article analitza els aspectes econòmics de la cura de la maternitat, proposant la teoria de l'economia del do matern com un marc possible per abordar les causes econòmiques i estructurals de la violència obstètrica. En l'economia actual de la salut, hi ha poc espai per a l'amor. Les actituds humanes com la cura, l'amabilitat, la compassió, l'empatia i el respecte, recomanades per l'OMS i la Relatora Especial de l'ONU sobre la violència contra la dona per prevenir i erradicar la violència obstètrica, no es valoren en els sistemes de salut. Es tracta de dons que la majoria de les vegades són invisibles, explotats o condemnats a l'ostracisme. Tant les proveïdores de cura com les usuàries pateixen de falta d'humanitat quan els sistemes no valoren la seva economia del do, en particular la que està arrelada en els principis materns de la donació unilateral. Si bé donem per fet l'economia en la qual vivim i sovint ens sembla inútil o fins i tot perillós discutir els seus principis i pràctiques, no podem ignorar la influència que té l'economia en el comportament dels individus i els sistemes si volem canviar-los. Aquest article adopta la perspectiva de les mares i les usuàries dels serveis, al mateix temps que reconeix les proveïdores d'assistència sanitària. El punt de vista de la societat civil proporciona una visió més àmplia que inclou idees, visions i possibilitats que contribueixen a la millora de la cura de la maternitat i que demanen una major participació i inclusió en els sistemes sanitaris. La reflexió presentada en aquest article és el resultat de més de deu anys d'experiència de l'activisme basat en l'evidència per part de l'autora i les seves col·legues a Itàlia i internacionalment.

PARAULES CLAU: Violència obstètrica; economia del do matern; sistemes de salut; cura materna; part.

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ABSTRACT

The present article analyzes the economic aspects of maternity care, proposing the maternal gift economy theory as a possible framework for addressing the economic and structural causes of obstetric violence. In the current health economy, there is little room for love. Human attitudes such as caring, gentleness, kindness, compassion, empathy, and respect, recommended by the WHO and the UN Special Rapporteur on violence against women for preventing and eradicating obstetric violence, are given no value within health systems. They are gifts that most of the time are unseen, exploited or ostracized. Both maternity care providers and users suffer from the lack of humanity when systems do not value their gift economy, particularly the one rooted in the maternal principles of unilateral giving. While we take for granted the economy we live in and we often find it useless or even dangerous to discuss its principles and practices, we cannot ignore the influence the economy has on the behavior of individuals and systems if we want to change them. This article adopts the perspective of mothers and service users, while acknowledging the health care providers. The point of view from the civil society provides a broader picture that is inclusive of ideas, visions and possibilities contributing to the improvement of the maternity care and calling for broader participation and inclusiveness within health systems. The reflection presented in this article is the result of more than ten years' experience of evidence-based childbirth activism of the author and her colleagues in Italy and internationally.

KEY WORDS: Obstetric violence; maternal gift economy; health systems; maternity care; childbirth.

RESUMEN

El presente artículo analiza los aspectos económicos del cuidado de la maternidad, proponiendo la teoría de la economía del don materno como un marco posible para abordar las causas económicas y estructurales de la violencia obstétrica. En la actual economía de la salud, hay poco espacio para el amor. Las actitudes humanas como el cuidado, la amabilidad, la compasión, la empatía y el respeto, recomendadas por la OMS y la Relatora Especial de la ONU sobre la violencia contra la mujer para prevenir y erradicar la violencia obstétrica, no se valoran en los sistemas de salud. Se trata de dones que en la mayoría de las ocasiones son invisibles, explotados o condenados al ostracismo. Tanto las proveedoras de cuidados como las usuarias sufren de falta de humanidad cuando los sistemas no valoran su economía del don, en particular la que está arraigada en los principios maternos de la donación unilateral. Si bien damos por hecho la economía en la que vivimos y a menudo nos parece inútil o incluso peligroso discutir sus principios y prácticas, no podemos ignorar la influencia que tiene la economía en el comportamiento de los individuos y los sistemas si queremos cambiarlos. Este artículo adopta la perspectiva de las madres y las usuarias de los servicios, al mismo tiempo que reconoce a las proveedoras de asistencia sanitaria. El punto de vista de la sociedad civil proporciona una visión más amplia que incluye ideas, visiones y posibilidades que contribuyen a la mejora de la cura de la maternidad y que piden una mayor participación e inclusión en los sistemas sanitarios. La reflexión presentada en este artículo es el resultado de más de diez años de experiencia del activismo basado en la evidencia por parte de la autora y sus colegas en Italia e internacionalmente.

PALABRAS CLAVE: Violencia obstétrica; economía del don materno; sistemas de salud; cuidado materno; parto.

La cornice dell'economia del dono materno per affrontare la violenza ostetrica.

RIASSUNTO

Il presente articolo analizza gli aspetti economici dell'assistenza alla maternità, proponendo la teoria dell'economia del dono materno come cornice per affrontare le cause economiche e strutturali della violenza ostetrica. Nell'odierna economia della salute, vi è poco spazio per l'amore. I principi e le pratiche di cura, della gentilezza, della compassione, dell'empatia e del rispetto, fortemente raccomandati dall'ONU e dalla Relatrice Speciale sulla violenza contro le donne delle Nazioni Unite per prevenire e sradicare la violenza ostetrica, non hanno nessun valore all'interno dei sistemi sanitari. Si tratta di doni che molto spesso non vengono riconosciuti, ma sfruttati, oppure ostacolati. Sia i fornitori di assistenza che le donne e i bambini assistiti soffrono per la mancanza di umanità quando il sistema non da valore all'economia del dono che loro praticano, in particolare quella che si basa sul principio del dono unilaterale. Mentre oggi diamo per scontato che l'economia di mercato nella quale viviamo sia l'unica possibile, trovando non necessario e persino dannoso mettere in questione i suoi principi e le sue pratiche, non possiamo ignorare l'influenza che questa ha sul comportamento degli individui e dei sistemi se desideriamo cambiarli. Questo articolo presenta la prospettiva delle madri e utenti, riconoscendo le posizioni degli operatori sanitari. La società civile offre idee, visioni e possibilità che arricchiscono l'argomento in questione e contribuiscono ad un'ottica partecipativa e inclusiva del sistema sanitario. Le riflessioni proposte sono il risultato di decennale esperienza di attivismo basato sui dati e praticato dall'autrice e dalle sue colleghe in Italia e al livello internazionale.

PAROLE CHIAVE: Violenza ostetrica; economia del dono materno; sistemi sanitari; cure materne; parto.

> *"I endured my birth, rather than lived it.*
> *I felt hurt and powerless.*
> *In order to guarantee the safety to my son's birth*
> *I went through a nightmare.*
> *I still haven't overcome*
> *the feeling of solitude*
> *and subjection*
> *that I experienced,*
> *and the delusion of not having had*
> *a physiological birth.*
> *I didn't feel at ease,*
> *I couldn't trust.*
> *I suffered the decisions*
> *undertaken by the ones*
> *who were supposed to take care of our lives.*
> *The maternity ward was terrible.*
> *Shared bathrooms and tens of rooms.*
> *I couldn't take a shower for a week.*
> *I had to wash myself with bottles of water*
> *over the toilet*
> *and I couldn't close the door!*
> *I think I was lacking the sense of civilization.*
> *I wish I could contribute to a better experience of birth".* [1]

1. Introduction

In the present article I address the issue of obstetric violence from the perspective of a mother activist, interdisciplinary artist, and scholar[1][2]. My experience with the phenomenon starts in 2010, during the series of presentations of my book "Memoirs of a Singing Birth". I had had a positive experience of birth and I was sharing my enthusiasm during numerous presentations that involved storytelling, singing, and sharing of tears - tears of joy but also of relief and release. The audience I was talking to was traumatized. I was not prepared for this scenario, so I spent the next ten years studying birth trauma, abuse, disrespect, and mistreatment in childbirth. I could not look the other way; I had the urge to act. As an interdisciplinary artist I engaged with the issue wholeheartedly becoming an advocate for human rights in childbirth. My colleagues and I soon realized that in order to advocate for mothers and babies we needed data, since arguments and testimonies were not enough to engage in the conversation with institutions. Once we had data, we disseminated them widely[3] (Ravaldi, et al., 2018a; 2018b). Once the national data on obstetric violence in Italy became public, great controversy[4] arose making the power issues in the maternity health care system visible. I admit, as much as we were aware of the political aspects of the issue, we were naïve in thinking that mothers, as organized maternity service users, would be rightfully accepted as part of the solution, or even the conversation. As Obstetric Violence Observatory in Italy[5], a civil society initiative, we were able to impact the public discourse and introduce the term "obstetric violence" to the national audience. With our campaigns and data dissemination we reached over 24 million people. Though the campaigns were carried out in 2016 and 2017, we still receive press requests on a weekly basis, along with research proposals from national and international universities and institutions.

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[1] The testimony is translated by the author from the original anonymous Italian data set of Babies Born Better Survey and published elsewhere. (Skoko, et al., 2018a). Herein, it is rearranged and presented in the form of an I-poem, following the methodology proposed by Gemma McKenzie (2021).

[2] The present discussion stems from the experiential knowledge acquired in over ten years of childbirth advocacy. It pertains to the critical feminist research and decolonizing framework. It is also a result of the intense "evidence-based activism" (Rabeharisoa, 2014) practiced by a network of self-defined mother-activists in Italy as well as internationally, a community based on sharing of information and strategies, mutual trust, and realization of common goals. The author wishes to thank her colleagues and friends Alessandra Battisti and Michela Cericco for endless time spent in self-analysis of our practice, and the International Feminists for the Gift Economy Network for the support and insights. This article is mainly based on literature available in English, even though many cited authors do come from other linguistic and cultural contexts, including the author. Regretfully, the richness of publications dedicated to the topic of obstetric violence published in Spanish, as well as in other languages, is not properly honored here. The author apologizes.

[3] Obstetric Violence Observatory in Italy: https://ovoitalia.wordpress.com/english-info/

[4] On the topic of controversies rising from activism around the issue of obstetric violence, see Villarmea, et al. (2015) and Skoko (2018).

[5] https://ovoitalia.wordpress.com/

Our work had positive as well as negative impact, especially on ourselves: we received legal threats from national associations of obstetricians-gynecologists and midwives[6]; personal, public, and institutional ostracism, even within the scientific community (recently a peer reviewer pressured authors to remove the citation of one of our articles) - repercussions that had a major impact on our lives and our wellbeing.

The issue of obstetric violence is complex and multifaceted. One of the aspects that is often glossed over is its economy. Within our work of advocacy one of the major forces was our capacity to self-finance our activities and initiatives. It was only when we reached a major audience, when we had a strong public voice that equaled the one of the medical establishments, that the same establishment reacted, starting what seemed more like a war than a dialogue. Our economic capacity to hire professional communication agencies and to commission data to a major national private survey company (unbiased towards the researched subject) resulted in challenging the epistemic power: apparently, the knowledge production, especially in the field of health, is not supposed to come from the civil society. All our activities were based on the gift economy: our work was *pro bono*, our initiatives were trust-based and crowdfunded, mainly by mothers and parents' non-profit associations that did not receive public funds. Our work of advocacy was not a paid job for any of us. In time, we understood that our position, though demanding and challenging, protected us from institutional (and informal) pressure (and blackmail) so common within the "non-profit industrial complex (NPIC)" (INCITE!, 2007). We saw our institutional interlocutors disengage many times after they received certain phone calls or emails. Our economic capacity was very limited compared to the economic and political capacity of the medical establishment[7], still it was crucial to make a major epistemic shift and turn the public discourse in favor of mothers, allowing the issue of obstetric violence to emerge. We have been practicing community based maternal gift economy.

The term "maternal gift economy" was coined by Genevieve Vaughan and it indicates the theory and practice of unilateral gifting, distinguished from exchange:

> "The unilateral gift economy is commonplace: its core feature is the other-directed work necessary for mothering young children successfully. Its goal is not profit but the well-being of the receiver. Unilateral giving is difficult, even dis-adaptive in the market context but rather than consider this a defect of gifting, I suggest that it is due to a deep flaw in the economy of exchange".
> (Vaughan, 2021:1).

Vaughan states that, regardless of gender, we are maternal species that should be more properly called *homo donans* instead of *homo sapiens*, however the present worldview makes this possibility invisible:

[6] https://www.aogoi.it/notiziario/archivio-news/inchiesta-doxa-violenza-ostetrica/

[7] It is worth mentioning that women and mothers contribute to a significant part of the wealth and power of the medical profession of gynecologists-obstetricians for they are the only category using and paying for their services, in Italy by 80% in a private mode during pregnancy (Lauria, et al., 2012).

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> "There is an economy that we don't see, and we don't name but from which we derive our basic sustenance and subsistence. It is as invisible as the air we breathe. I call this giving and receiving / receiving and giving a basic economic action, which satisfies fundamental material human needs." (Vaughan, 2021:2).

Maternal gift economy is a fundamental community-making economy that literally forms the bodies of people in the community and represents the first paradigm of human interaction, thus the market exchange can clearly not be considered as the primary economic interaction.

> "Under the conceptual hegemony of exchange, free gifting appears to be perhaps a failed exchange or even more commonly, a different kind of human capacity and behavior, which is understood as moral or psychological, not economic. This removes attention from the material communicative character of gifting, making it appear to depend on unusual acts of individual free will, compassion, and goodness, sometimes requiring hormonal or perhaps religious motivation". (Vaughan, 2021:4).

While acknowledging maternal gift economy as our force, as mothers and activists we became aware of the economic drivers of the health system. Our *modus operandi* was specific and innovative (as well as ancient) and we were testing it in practice and in theory. While we were functioning in maternal gift economy mode, the health system was functioning in the market (exchange) economy mode. The more we were getting to know the health system the more we realized how the market economy impacted services and providers' attitudes. We also became aware that, as service users, mothers and babies were considered first as numbers and figures and only secondarily as humans. The impact of health "performance management" (Hewko, 2016) is an interesting yet under-researched topic (Bryant, et al., 2016), despite its influence on the work and wellbeing of health care providers that seems significant, involving distress, suffering and behavioral deviations (Dean, et al., 2019). Research suggests that when working conditions of health workers prioritize healthy humane interactions, then the services improve for both providers and users (Smith, 2021).

Still, while clinical work has a set of monetary values, the value of social and emotional skills needed for the humanization of health care is still to be determined. Generally, these skills are considered to be the personal talent of each individual, basically a free gift. While compassionate care is indeed a gift that comes from the heart, it does not mean it should be invisible, valueless – or without a theoretical framework. Instead, I argue that it is part of the maternal gift economy made invisible inside the market-based (patriarchal) paradigm we live in. The qualities of the respectful, gentle, humane care we envision as a solution for the obstetric violence very much resemble the maternal care, practiced by mothers (and other family members) with their children. Any care that resembles maternal care faces the same cliché of spontaneity, naturalness, or even instinctivity (all terms used as pejoratives) that prevent it from being accepted as a purposeful and reasonable strategy producing desired outcomes. This invisibility and negative stereotyping of maternal care is damaging to the health system, health practitioners and especially to mothers and babies, and it is one of the causes of obstetric violence.

2. THE EXCHANGE ECONOMY OF HEALTH SYSTEMS AND ITS RELATION TO OBSTETRIC VIOLENCE

Obstetric violence is defined in the first national law that addresses the issue in 2007 *(Ley Orgánica sobre el Derecho de las Mujeres a una Vida Libre de Violencia, Venezuela)* as "the appropriation of women's body and reproductive processes by health personnel, which is expressed by a dehumanizing treatment, an abuse of medicalization and patologization of natural processes, resulting in a loss of autonomy and ability to decide freely about their bodies and sexuality, negatively impacting their quality of life." (Sadler, et al., 2016). I wish to focus the attention on the word "appropriation", since it appears to be crucial: the question of the ownership of the body of a person entering a medical facility - in our case one person entering and at least two persons leaving (in the majority of cases). The appropriation of a human body is not a lawful procedure, unless it is done by the State in specific legally determined circumstances - maternity is not among them. It appears that a woman's pregnant body belongs to her until she enters a medical facility which, from that moment on, becomes the temporary owner of it and its "products". Yet, the rightful owner of the pregnant body is a pregnant woman. Even if she wants to, she is legally not entitled to give away the property of her body to anyone: the right to her body is inalienable, even by herself[8]. She might or might not consent to medical procedures offered in a medical facility, but she remains always the rightful owner of her bodily integrity. The medical facility is not entitled to the appropriation of the personal freedoms of pregnant women in any legal system. However, when a parturient woman enters the hospital to give birth it is as if she gives away her rights to personal freedom, autonomy, and integrity, as if by personal choice. On the other side, hospital personnel acquire actual legal medical responsibility over the body of a patient, a responsibility that in Italy is individual (as a single provider) and administrative (as a facility). The doctrine of medical necessity applies, and it is very difficult to prove in court that a medical intervention was not necessary, especially if the damages are minor (Šimonović, 2019). In the case of parturient women even though there is a long list of unnecessary procedures, confirmed as such in the scientific literature and international guidelines for decades (Wagner, 1994), they are still not seen as damaging by the courts. The stereotype of childbirth as a pathology instead of a normal physiological process, an integral part of a woman's reproductive life, is deeply rooted in modern maternity care practices that justifies the over-medicalization of care. Consequentially, for the law, the boundaries of bodily integrity in the case of a pregnant woman may be fuzzy (Pickles, 2020).

While the issues of bio-medical power within medicolegal systems have been well addressed since the fundamental work of Michel Foucault[9], the underlying economic aspects and their

[8] The market of surrogacy is not discussed here, however, even in that case, the woman is contracting the services provided by her body, not its ownership. The object of the economic transaction is the child, traded as a commodity. See more in Danna (2016).

[9] Michel Foucault (1926-1984) was a French philosopher whose research, lectures and publications have contributed to the meticulous analyzes of the role of medicine within the formation of modern States and identities. His *opus* is vast and popular, and its bibliography too broad to be cited in the present work.

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influence on the outcomes of health care, maternity care in particular (Diaz-Tello, 2015), still remain under-researched. The process of dehumanization and obstetric violence starts with the apparent transfer of ownership of a pregnant body of a woman from herself to the medical authority. Though not openly stated, this apparent transfer of ownership involves a transfer of real money. Maternity care in Italy is freely available to each pregnant woman, regardless of her citizenship. Even though maternity care is free of charge for users within a universal health coverage, the health economy still applies, for each childbearing person and baby the facility receives from the State a compensation that is calculated according to the type of birth (vaginal or cesarean), the time spent and additional costs. The more women chose to give birth within a certain facility the more money this facility receives from the State[10]. When a woman chooses not to give birth in a hospital, the economy of the health system is affected, since births are a source of regular income for the hospitals.

The health economics is guided by the money-based exchange paradigm where apparent scarcity (austerity) is used as a lever for reducing human resources while contemporarily investing in the medical industry. Maternity care is organized within this paradigm as well, where diagnostics, which requires the use of expensive and up-to-date medical equipment, is favored over the time and attentions dedicated to the service user. The administrators and head clinicians are required to have managerial skills and run the clinic according to market economy criteria (performance management). The value of an obstetrician-gynecologist often depends on the number of childbearing women he or she can "bring inside" the hospital where he or she is employed. In Italy, each doctor working in the public facility can exercise private practice within the same medical facility (it is called *intramoenia*, "inside the walls", legally determined since 1992) or outside (*extramoenia*). Despite the fact that within the national health system maternity care is free of charge for the final user, each childbearing woman can pay "a little extra" (according to the quotation of each hospital) within this legal framework, if she wants to use the private services of the same doctor employed by the public hospital without going through the national health service, or if she wants a private room and the ability to choose health providers among the hospital staff during childbirth. The price of the *intramoenia* varies if the birth was vaginal or cesarean, something that often can be determined only after birth. Practically, if a woman does not pay the agreed amount, she and/or her baby will not be allowed to leave the hospital. Since this option regards mainly families that can afford it, it is not seen as an issue. However, many middle-class women struggle to be able to afford the *intramoenia* because they believe that by paying something extra, they will receive more humane care. Yet, finding 10.000 Euros (for an unwanted cesarean) instead of the agreed 5.000 (for a spontaneous birth) before leaving the hospital can be a problem[11]. Outside the hospitals, the national health system extends into the "territory", providing the rest of the health services that are not based inside the facilities. There is no notion of "community" within the Italian national health system and there are no systemic post-partum maternity services. The

[10] In health systems that do not have universal health coverage, the economic transactions involve the medical facility and the insurance companies.

[11] The example is based on an actual court case followed and concluded by Alessandra Battisti, lawyer, and co-founder of the Obstetric Violence Observatory in Italy.

existing ones are based on the gift economy practiced by family members and civil society (peer-to-peer mothers for breastfeeding support, for example) (Skoko, 2020) or they are left to the free market of maternity and post-partum services.

Generally, within medical facilities, health providers work under stressful conditions having to juggle among economic and bureaucratic requirements of their jobs, clinical practice, and the human aspects of their work. Stressed, underpaid, and overworked health providers cannot deliver optimal care, one of the conditions to be addressed in order to prevent obstetric violence, as stated by the UN Special Rapporteur on violence against women, its causes and consequences. The Special Rapporteur Dubravka Šimonović in her report to the UN General Assembly "A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence" (2019), points out that while poor working conditions of health care providers do not justify abusive practices and neglect, they contribute to creating an abusive environment for which health systems and States should be accountable. In relation to the economic aspects of maternity care,

> "States should address: (a) structural problems and underlying factors within reproductive health-care systems that reflect discriminatory socioeconomic structures ingrained in societies; (b) the lack of proper education and training on women's human rights for all health professionals; (c) the lack of qualified staff and the resultant heavy workloads in health-care facilities; and (d) budgetary constraints." (Šimonović, 2019: 21).

The dehumanization of current maternity care practices is negatively impacted by the dehumanization of health workers as well as service users, the economy playing an important role in the problem. In order to remedy this long-lasting issue, she recommends that

> "states should establish constructive cooperation between health institutions and professional associations with women's non-governmental organizations, women's movements and independent human rights institutions dealing with reproductive and obstetric care" (Šimonović, 2019: 21)[12].

While it is true that health practitioners, particularly midwives and nurses, are often not adequately paid, especially within national health systems, research shows that the quality of interrelations among colleagues and medical teams is valued as crucial for better working conditions as well as for better service provision (Downe, et al., 2010; Lazzerini, et al., 2019; Liberati, et al., 2021). Another type of economy appears to be the driving force of a humane health care environment.

The World Health Organization (WHO) lists several hospital practices that can be considered abusive and disrespectful in childbirth, such as:

> "Outright physical abuse, profound humiliation, and verbal abuse, coercive or unconsented medical procedures (including sterilization), lack of confidentiality, failure to get fully informed consent, refusal to give pain medication, gross violations of privacy, refusal of admission to health facilities, neglecting women during childbirth to suffer life-threatening, avoidable complications, and detention of women and their newborns in facilities after childbirth due to an inability to pay". (WHO, 2015:1).

[12] It is noteworthy to say that the institution of the Special Rapporteur within the UN is an unpaid position, it is not a job but an honorary role – a gift at its highest political level. The role is purposefully devoid of monetary implications in order to guarantee the impartiality of the reports, which represent legal obligations for the Member States.

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According to the WHO the ability to pay shall not influence the quality of care, also the right to health does not comprise the right of health providers to appropriate personal freedoms or exercise clinical expertise in an arbitrary manner, resulting in obstetric violence. The degree of mistreatment that women face worldwide when giving birth within facilities is significant and it happens in all countries, regardless of their economic status (Šimonović, 2019). Part of this abuse is structural, and it has economic roots.

There is no clear and unanimous definition of a health system, even within the WHO. Although "health systems are responsible for delivering services that improve, maintain or restore the health of individuals and their communities"[13], for the WHO hospitals are at the center of care. In order to strengthen the health systems, precise requirements are seen as a priority: "a well-functioning health system working in harmony is built on having trained and motivated health workers, a well-maintained infrastructure, and a reliable supply of medicines and technologies, backed by adequate funding, strong health plans and evidence-based policies"[14]. Apart from the wishful "harmony" and "motivation" for the system itself and its workers, humane aspects do not appear as a priority. When defining appropriate and respectful maternity care, the WHO states that "greater action is needed to support changes in provider behavior, clinical environments, and health systems to ensure that all women have access to respectful, competent, and caring maternity health care services. […] The focus on safe, high-quality, people-centered care as part of universal health coverage can also help inform action" (WHO, 2015:2). It is very unlikely that providers and facilities will focus on respectful, caring and people-centered services if this is not a priority for a health system, deeply conditioned by its own economy.

Market based economy is present within health systems at every level. Health systems are part of the job market. Health care jobs are hierarchically structured according to power relations based on the economic values of each job. Midwives are at the bottom of the scale. Medical education and training reflect this structure and prepares each role for its own place in the medical job market. The political and negotiation power of each professional category in this field reflects its economic status. The only motivational tool a health system takes into consideration is monetary and it requires a hard bargain at every level. Since the 1980-90s, public health care facilities are considered as enterprises ("health trusts" in UK, *"aziende sanitarie"* in Italy), and they are managed as such (Neri, 2009; Tousijn & Giorgino., 2009). Though it sounds harsh, in the actual health systems patients (including parturient women and babies) are considered as a commodity, even if they are called "users" or "consumers". Each patient is given a money value and an economic transaction takes place when a person enters a hospital. Furthermore, healthcare systems are part of the medical industry where technology and pharmaceutical development are a priority. Health providers are undervalued resources and considered a mere cost to the system, therefore the "investment in human resources" is generally scarce. Health insurance companies are part of the medical financial market, playing a crucial role in laws, policies, and litigations. As for the infrastructures, health care facilities

[13] https://www.euro.who.int/en/health-topics/Health-systems

[14] https://www.who.int/data/gho/data/themes/topics/health-systems-strengthening

are real estate commodities that are part of the large-scale construction business involving private as well as State economy. Making the facilities anew is favored over maintaining them on regular basis. The management of medical waste is a highly profitable activity. The legal system is tuned into the economics of the health market: the only redress a person with iatrogenic damage (including damage derived from obstetric violence, a category yet to be recognized in the legal practice) can aspire to is of monetary nature, again not without a hard bargain and considerable economic investment in long-lasting legal procedures.

In the health economy there is little room for love. Human attitudes such as caring, gentleness, kindness, compassion, empathy, and respect are given no value, they are gifts that most of the time are unseen and exploited. Both providers and users suffer from the lack of humanity when systems do not value their gift economy, particularly the one rooted in the maternal principles of unilateral giving (Vaughan, 2021). While we take for granted the economy we live in and we often find it useless or even dangerous to discuss its principles and practices, we cannot ignore the influence the economy has on the behavior of individuals and systems if we want to change them.

3. THE MATERNAL GIFT ECONOMY

When addressing the topic of the gift economy within the academic context the first association that arises is related to the school of thought initiated in 1920s by the anthropologist Marcel Mauss (1923), where the gift is intrinsically defined by its reciprocity or exchange. Contemporary scholars challenge this authority (Kuokakkanen, 2007; Vaughan, 1997; 2015). When we talk about the gift economy, it is often interpreted as a sort of a bargain, an agreement between parties settling what each shall give and take or perform and receive in a transaction. However, a gift is not a bargain or an exchange. Mandatory reciprocity excludes *per se* the idea of a gift. By its definition a gift is unilateral, there is a giver and a receiver that may or may not take turns. While there is a genealogy of scholars that insist on the inexistence of the unilateral gift, the author of the present article takes a stand[15] and adopts the theory of the maternal gift economy as proposed by the American semiotician, independent scholar, and feminist Genevieve Vaughan, from the perspective of mothers and the practice of motherhood.

Vaughan starts developing her theory of the maternal gift economy inside the Italian milieu of semiotic scholars influenced by historical materialism and within the feminist movement of the 1970s. Her theory is informed by the experiential and embodied knowledge of maternal practice that she progressively incorporates into her analysis. While publishing and disseminating her work internationally, she puts theory into practice and develops her philanthropic activity[16].

According to Vaughan (2015), human society is based on the gift economy that starts with the action of mothering, representing the fundamental paradigm of social interaction. This

[15] For the use of the standpoint theory see Harding (2004).

[16] http://www.genevievevaughan.org/

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paradigm involves a "motherer" (generally a mother, but it can be any close relative or other person taking care of the child) and a child that from the start develops an interrelation based on unilateral giving - with the "motherer" on the giving side and a child on the receiving side. The unilaterality of maternal giving is practiced without pay or any monetary exchange between the mother and the child, yet it develops an economy involving production, reproduction, management skills, thriving and abundance as well as time and energy consumption. It is an economy that creates benefits without profit, and it is essential for human survival. Within maternal care, the child develops its full biological as well as social potential by learning to receive and to give. Maternal education influences its linguistic capacity that reflects the gift paradigm, forming the basics of future communicational capabilities, that Vaughan considers as mutual satisfaction of communicational needs. The maternal gift economy is necessary for the satisfaction of basic needs, and it is essential in the development of human beings. However, the maternal gift economy theory is far from being essentialist.

Vaughan argues that mothering is a cultural universal required by the biology of infants, not of adults:

> "To each different culture, mothering must appear simply part of the nature of things but, for the mothers, the need to nurture is social and its accomplishment is intentional. Women's ability to give milk is a biological advantage that makes caretaking more convenient, but they must do the caretaking in a cultural context within social parameters. In mothering, there is an intentional transfer of goods and services from adult to child, from giver to receiver" (1997:22).

In other words, mothering is a rational and socially determined activity.

The exchange paradigm Vaughan talks about is the market economy that is modelled on a social construct of non-maternal men elevated as unique representatives of humankind, or its most exemplary specimen:

> "The view of all women as having a maternal 'essence' is only the appearance of an alternative economy seen through the filter of the hegemonic exchange paradigm, narrowed down to a common quality of women in binary heterosexual gender opposition to non-maternal masculated men" (Vaughan, 2015:298).

By the age of six, a child – especially male – is required to reject the gifting paradigm that he has in common with the mother and assume the exchange paradigm that dismisses motherly values, making a male child Other compared to the mother. According to this artificial economic gender model, men - promoted to the representatives of all humans - are self-oriented calculating beings that respond only to monetary *stimuli* and regulate their interactions based on profits and losses, an activity considered as rational even if it produces damage on a small and big scale. On the contrary, female children are required to remain in the gifting paradigm, socialized as intrinsic care givers that are not as elevated or capable of behaving in "manly" ways (non-maternally, that is) but are useful to the reproduction of the society and the maintenance of men's wellbeing. If women wish to be considered as "real men" they too must behave non-maternally. A modern general amnesia takes place by which whatever system comes before the exchange economy is considered as inexistent, even if life depends on it.

In the maternal gift economy theory mothering is a universal, each one of us has been mothered and this initial imprint guides our lives, whether male, female, or in-between and

beyond, enabling us to survive and thrive. Mothering is part of our biology as well as a social construct and a successful economic practice, and it is generalized. The exchange economy comes after, it profits upon the gift economy, manifesting itself in the (explicit or implicit) exploitation of women, men, peoples, and entire eco-systems, for the benefit of few. To consider the exchange paradigm as a universal and unique guiding force of human interactions equals living under a spell (Pignarre & Stengers, 2005). Making mothering invisible makes the magic work.

A woman giving birth is laboring in every way, including economic. Her labor is work done purposefully even if she is not paid for it; it belongs to the sphere of the maternal gift economy not to irrationality. She is "giving birth". Her labor is a gift. The baby is a product of her labor. There is no wage for her work and considering a "bundle of joy" as a compensation is cynical and deceptive. The love produced by the process of undisturbed birth is a biological advantage that benefits both the mother and the newborn, it is also a socially valued sentiment that only a distorted mind can consider as a payment. But, the stereotype of motherly love as a payment for the gift economy the mother and other caregivers practice is in fact part of the distorted vision promoted by the generalized exchange economy paradigm.

A woman entering a hospital to give birth, expecting to be honored (yes, even spiritually) (Olza, et al., 2018) and to receive the care she needs, instead becomes a number, her birthing processes a protocol, her body a parcel, and her child a "product of the birth canal" (as defined by obstetricians-gynecologists' university manuals). She envisioned something else for her maternity care, she hoped for a positive birth experience, as recommended by the WHO (2018) and the most recent evidence-based literature (Downe, et at., 2018), she expected "personalized professional maternal care" (Skoko, et al., 2018). Women value "gentleness" and "warmness" within maternity care as part of providers' "professionality" (Skoko, et al., 2018; Lazzerini et al., 2020), on the contrary, obstetricians consider "coldness" to be one of the major factors in defining their professional behavior (Morano, et al., 2018). Nobody explains to the parturient woman that her expectations do not match the inner economic structure and ruling mindset of the hospital and its staff. The maternal gift economy she lives in and the one she expects from her caretakers is not recognized within the facility. The trauma deriving from this incomprehension affects her body, her inner self, and her "sense of civilization" (as in the testimony from the opening citation). The economic burden of this trauma is on her alone, since she has to provide for the reparation of damages derived from obstetric violence. Despite their trauma and the consequences of personal and systemic mistreatment, most women who share their testimonies and engage in social campaigns and academic research surveys wish to contribute to the improvement of maternity care making it better for other women, in a maternal gift economy mode.

As pointed out by Stella Villarmea in her "birth philosophy": "the lived experiences of women and their situated knowledge challenge widely-held assumptions about rationality" (Villarmea, 2021:1). In the modern Western philosophical worldview, it is assumed that biology imposes more restrictions on women's rationality than on men's. This presumed biological disadvantage of women becomes more evident in childbirth and in the related field of obstetrics, where an

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allegedly unbridgeable chasm between the spheres of birth and reason manifests itself with all the deriving consequences. A woman in labor is considered out of her mind to the point of negation of her capacity to hold the complete spectrum of her civil rights. Her behavior during labor and birth is considered irrational even though it accompanies the birthing process in a positive way and leads to favorable outcomes. Her embodied knowledge is neglected, dismissed, and overruled by other authoritative knowledges on the ground of their presumed superiority.

The idea of presumed rationality permeates the economy, including the economy of health systems, where exploitation of workers and service users is seen as favorable while free gifting is considered irrational or even dangerous. The mistrust (and persecution) towards lay midwives and folk medicine men and women in the past had far more to do with the gift economy they practiced than with their alleged unskillfulness (Federici, 2004). Health providers (of whom the majority are women, especially among nurses and midwives) that meet the emotional and physical needs of a birthing woman, doing more than professionally required or investing more time than considered necessary by common practice, are not positively valued among peers and by the system, even though their gratuitous efforts produce good outcomes and a more positive experience for the woman and the baby. They are not rewarded for the work done within the gift economy. Again, the flow of love is considered to be a compensation, not a pleasurable result of a gifting practice, even for health workers. For the system, meeting emotional needs of childbearing women equals irrationality and economic loss. Providers attending to those needs are deemed inconsiderate and wasteful by their peers and their superiors. Their gift is unilateral, no one expects the mother to "give back" the same amount of attention she received from the midwife or a doctor. Still, a deep emotional bond, based on trust and gratitude often develops between the health care user, her providers, and the place where she gave birth.

We can affirm that the gift economy many health workers practice, based on the maternal (kinship) model, is purposeful, helpful and it produces good results in line with the essence of health care work, that is the pursuit of "complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1946:1). Acknowledging the maternal gift economy within the medical setting, in theory as well as in practice, may help to address the systemic causes of obstetric violence and contribute to developing the ground for the practice of respectful maternity care.

4. Conclusions

> "Although the increasing calls for women to 'wake up' and 'take their power' may appear to be only an exhortation towards individual improvement, actually they imply this need for women and especially mothers to lead the movement for radical change. They/we have to come forward as relevant, to make the gift relevant and generalize it" (Vaughan, 2015:345).

Within the science of childbirth, we can fairly claim that the "master's tools will never dismantle the master's house", using the inspiring phrase by Audre Lorde (1983). We can aspire to change the practices only if we first "change the conversation", as suggested by Soo Downe (Villarmea, 2021). Much work has been done within the rising field of academic midwifery, whose scholars have contributed to the creation of new scientific evidence and discussions that have been taking into consideration women's and midwives' perspectives, informing international clinical guidelines and national policies in global maternity care. A great portion of this work is done in the unacknowledged gift economy mode, so customary in academia (Coin, 2018) and, generally, in the advancement of the human knowledge[17]. Academic midwifery is a growing field slowly gaining affirmation and funds for its development. Though midwifery widely precedes medical science, its scientific reputation and authority is only at its beginning; we can say that we are living in the avant-garde of the science of midwifery. In the current era of scientific development, knowing that we still do not understand very well how babies are born and we do not seem to care, sounds at least unsettling. Within the humanities, the "philosophy of birth" is a new field promising to restore epistemic dignity to mothers and childbirth. There is a burgeoning academic scholarship around "maternal theory", published under the Canadian editor Demeter Press[18]. The "maternal gift economy" theory has the potential to offer a theoretical background for an innovative economic framework that can contribute to a "maternal science" that is now appearing on the horizon. From the perspective of mothers, the maternal gift economy restores the visibility of care and reproductive work done mostly by women but practiced by all, and it offers clues for new, more humane, maternity care devoid of obstetric violence.

The audience who will most likely read the present text belongs to the community of mother-activists, midwives, and women academics. I wholeheartedly invite us to challenge the current episteme within academia as well as in real life by taking the courage to speak up for ourselves, to make our economy visible and affirm our own theories that are based on lived experiences, mutual respect, and free critical thinking, and not on stereotypes. Embracing the maternal gift economy theoretical framework is as challenging as giving birth – there is a moment when you think you will explode and disintegrate, the very next moment you are holding a brand-new creature you made yourself. It is empowering[19].

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[17] The author takes the opportunity to thank the editors and peer reviewers of the present publication that participate in the academic gift economy.

[18] https://demeterpress.org/

[19] Warning: Endorsing the maternal gift economy theory can challenge your academic credibility and your career. So can motherhood.

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