Obstetric Violence as Gender Based Violence

Everyday Bioethics

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Obstetric Violence as Gender Based Violence

What it is, how it is perceived, and how it can be addressed

Edited by
Lucia Re, Irene Strazzeri and Sara Fariello

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Irene Strazzeri, Anna Maria Rizzo, Chiara Spagnolo

Obstetric Violence: Between Recognition of Rights and Trust in Transformation

Abstract: Obstetric violence denotes the mistreatment, abuse, or neglect that women may endure during childbirth, frequently perpetrated by healthcare professionals. The concepts of trust and transformation are pivotal in addressing this phenomenon and in restoring the historically rooted relationship between women, their bodies, and midwifery care. Traditionally, this bond was embedded within culturally rich frameworks, wherein childbirth knowledge and practices were transmitted orally across generations. However, the contemporary predominance of highly medicalised—and at times coercive — approaches to childbirth has significantly eroded this trust, disrupting the relational continuity between birthing individuals and their caregivers.

1 Introduction

This paper proposes to consider obstetric violence a distinct form of gender-based violence. The reflection will focus on the woman's body, which is often seen as the "object" of medical and social control even within the context of maternity.

The first part of this paper will address the processes of medicalisation (Meo 2014) that have profoundly influenced the way women's reproductive bodies are observed, perceived, and controlled. Over time, the female body has been redefined in biological terms, being regarded as a system to be monitored and corrected, with the menstrual cycle, pregnancy, childbirth, and menopause increasingly falling under the domain of medical sciences. Although for centuries childbirth was a private event, managed by women within the domestic sphere, the advancement of science and technology led to healthcare professionals gradually taking care of pregnant women and dealing with the physiology of childbirth. This shift significantly reduced the risks associated with complications from home births, while contributing to a rise in unnecessary medical interventions. Consequently, the scientific evolution of childbirth care has highlighted both the invasive nature of

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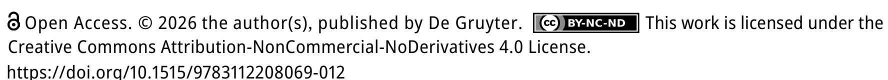
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interventions —such as induced labour, episiotomy, and caesarean section — and the resulting indirect erosion of pregnant women's decision-making power.

In the second part of this paper, a comparison will be made between different cultural practices related to childbirth (Quattrocchi 2011). On the one hand, childbirth will be shown to be a hospital-based event in Western societies. On the other hand, the importance of home birth in non-Western cultures will be highlighted, revealing how the process is characterised by strong rituals and social norms, with specialised midwives attending to the mother's psychophysical well-being and making childbirth a natural experience. Yet, despite such cultural differences, globalisation has gradually led to non-Western childbirth practices increasingly resembling the "rituals" associated with Western childbirth (Quattrocchi 2001).

Finally, the paper addresses female genital mutilation as a specific case of obstetric violence, focusing in particular on the implications that infibulation and de-infibulation may have on childbirth. By examining the physical and institutional consequences of these practices, the analysis highlights how they can deeply affect women's reproductive experiences, positioning them within a broader framework of structural and gender-based violence in obstetric care. The discussion situates them within a broader critique of the structural and gendered dimensions of reproductive healthcare.

Conventionally described as the result of unnecessary medical interventions, lack of informed consent, and dehumanising treatment, obstetric violence leads to women being deprived of their freedom before, during, and after childbirth. Therefore, obstetric violence should be denounced and recognised as a distinct form of gender-based violence.

1.1 Women's bodies between myth and medicalisation

Throughout history, female body has often been alienated from its own physicality, which has been shaped and constructed based on the pleasures of others. Women and their bodies have been associated with both motherhood and seduction, systems of meaning that have absorbed female subjectivity. Paradoxically, both aspects are most often described and narrated by men. As a result, women have been estranged from their own bodies. They have started questioning the extent to which they actually know themselves, reflecting on the nature of their desires.

Since ancient times, various social transformations have impacted the patriarchal social order, with women embarking on a journey of (re)discovery of their own desires and, more in general, their physicality. The evolution of the female body throughout history has been widely debated by feminist movements (Melandri

1993, 7). The theories they developed in the 1970s have revolutionised the concept of the body itself, placing it at the centre of public and political discourse.

By analysing the labelling of the female body over time, Alice Manfroni has shown that, particularly in Western societies, it has been considered the emblem of fertility and reproduction. While it has been regarded as a sensitive and delicate body, whose disturbances may lead to dangerous and devastating consequences (Manfroni 2022), it has also been conceptualised as strong and resilient. Michel Foucault has often highlighted such characteristics through his reflection on medical sciences. The French philosopher maintained that, since the twentieth century, the function of the body has progressively been regulated and legitimised by medical knowledge, with the understanding of the female body being increasingly grounded in essentialist and biological aspects (Foucault 1978). Such a narrative has sparked a fierce debate on rights. On 24 June 2022, the Supreme Court of the United States overturned the federal protection of abortion rights, making it clear that the female body has been — and continues to be — at the centre of a conflict between the will to control women and their self-determination (McKenzie 2024).

Anthropological studies offer crucial contributions to the dissemination of new perspectives on physicality, beginning with the recognition of the female body as a historically situated category that acquires different meanings depending on its specific cultural and social context (Marone 2003). Understood as a historical category, the female body emerges as a site where power relations and social tensions are enacted and displayed. A true political arena for identity struggles, it is seen as the political subject in which power is exercised and negotiated. Indeed, the woman-reproduction pairing pervades the Western sociocultural context and unsurprisingly underpins the concept of “women’s health,” particularly when it becomes the focus of state-sponsored prevention and protection campaigns. Repeated attempts to revoke the right to abortion clearly show how “women’s health” is ideologically linked to female genitalia and solely associated with sexual and reproductive health.

According to Manfroni, feminist movements have been fundamental to the cultural and political redefinition of the female body, as they fought to secure rights such as abortion and access to contraception. These rights have long been central to the political debate, as they entail the recognition of women’s sovereignty. In advanced modern societies, the medicalisation of the female body, through the ongoing development of assisted reproductive technologies (Meo 2014), opens up new horizons in relation to maternity and sexuality, thereby challenging traditional models. At the same time, the experiences of non-Western, non-white, non-heterosexual women prompt reflection on the need to go beyond a universal and uniform conception of the female body. This means acknowledging the experiences of non-Western, Black, and transgender women. A new perspective is needed

that accounts for the political and social conditioning impacting the female reproductive body, which should be considered in terms of a woman's experiences, transcending essentialism and purely biological factors. The use of the plural category "women's bodies" can serve as a first step towards legitimising and recognising the multiplicity of women's experiences, practices, and identities. This is a path that advances, retreats, and shifts direction, constantly seeking new ways to affirm emerging and unpredictable subjectivities.

Women's subjectivity remained at the heart of debates throughout the twentieth century, with the female body undergoing a long process of transformation from an idealised to an objectified form. As Francesca Buccini (2023) has pointed out, the depiction of the soul, the lover, and the female body is central to Aristotle's works. His concept of woman-as-matter portrays women as confined to the domestic sphere, with their perceived inferiority being justified by the anatomy of their bodies, which passively receive the vitality of male semen, the sole source of life. In this framework, man's power is exercised both materially, through the division of gender roles and labour, and symbolically, as an expression of an androcentric culture in which the subjugation of women is regarded as a natural fact (Buccini 2023, 27). The female body was so stigmatised and subjected to manipulation that women were indoctrinated to accept the roles to which they were assigned. Taking a stand on their own bodies and sexuality enabled them to become more self-aware, reject a series of paralysing and conditioning sexual models, and gain a new familiarity with their own desires (Manfroni 2022). Since the 1970s, women have developed a new self-awareness, beginning to recognise the wisdom and experience embedded in their physicality, finally seen as a source of power rather than a limitation. At the same time, the female body became an object of male envy that could cause social tension, as generative capacity can only be experienced through maternity, thus instilling fear and creating anxiety in the male world (Marone 2003).

Contemporary Western society tends to standardise the image of young, attractive and seductive women. As a result, the imposed aesthetic ideal is that of a successful woman who does not conform to the traditional role of wife or mother. Yet, the female body continues to be objectified, as such a model is not universally accessible. In this context, Michael Foucault speaks of biopower, which is exercised through self-surveillance and control over the body, particularly the female body, which has long been the site of social struggle and the target of male domination — a dynamic that continues to threaten women's freedom (Foucault 1978). Women's bodies, constantly objectified and sexualised, are subjected to a form of oppression that is also rooted in the relationship between female identity and physical appearance. This results in women being often evaluated based more on their outward appearance than their personality. The gaze through which they view themselves is a male gaze, internalised to the extent that it influences their

subjectivity. By objectifying themselves through the male gaze, women tend to compare their bodies with those of others, assessing themselves according to male standards and focusing on an ideal that values a slender figure, large breasts, full lips, and wrinkle-free skin (Ulivieri 1995, 19). This translates into women perceiving themselves as inferior, which pushes them to pursue such an assumed ideal of femininity, even to the extent of modifying their bodies surgically (Strazzeri 2013, 44–45).

This dynamic intersects significantly with the broader process of medicalisation, which increasingly frames women's bodies as objects to be monitored, corrected, and controlled. In this context, physical well-being and optimal health become central concerns, not only from a personal perspective but also within the expanding scope of the doctor-patient relationship. Medicine, rather than supporting holistic wellness, often prioritises the treatment of illness, leading to a form of encroachment on individual autonomy. Medicalisation thus encompasses the growing reliance on technologically advanced procedures, hospitalisation, pharmaceutical interventions, and other forms of medical control — practices that can reinforce normative ideals of femininity and perpetuate gendered expectations about the female body.

Foucault's socio-clinical perspective offers a horizontal reconstruction of the human body in the hospital bed, "as if it were a corpse still alive," thereby suggesting that the key to understanding modern medicine lies in a vertical conception of the body — an unprecedented form of hierarchical knowledge (Foucault 1978, 65–66). Foucault highlighted the modern mechanisms of control over the body: the patient becomes nothing more than a sick body, which can be cut open, sutured, and potentially dissected. As such, the body loses its status as a socially interactive human corpus (Foucault 1978, 66). Yet, a patient who entrusts their health and deepest experience to a physician has the right to feel safe and be acknowledged as a whole person. In this sense, medical deontology does not require compassion, but rather involvement in a patient's psychophysical health and suffering, when pain or discomfort is evident. According to the Hippocratic Oath, a physician needs to overcome personal biases, refraining from imposing their beliefs or expressing regret before a patient (Fortuna 2021). The contemporary physician has become more of a specialist who makes choices based on data, measurements, and clinical analysis. Contemporary medical practice is incomparable to that of the past, as specialist medicine has replaced generalist medicine, with diagnoses being now fully recognised even by patients themselves.

In the context of the technical transformation of medicine, the concept of health prevention emerges: medicine is no longer a science that simply cures disease, but rather one that detects, hypotheses, and prevents it. As a result, during pregnancy, medical dependence gains the strength of a moral imperative: certain

actions are forbidden or advised against, with the failure to follow guidelines causing feelings of guilt. In the United States, it has become possible for children to bring legal claims based on omissions in the care provided to their mothers during pregnancy or childbirth. Therefore, a woman may be seen as a potential "bad mother" as early as during pregnancy: anything that happens to the child while growing up may be traced back to the way the mother experienced pregnancy. Prevention takes on the characteristics of an investment in a better future. Consequently, adequate medical and psychological training becomes necessary, in order for healthcare professionals supporting pregnant women not to contribute to the physical and psychological difficulties women may already face. The issue of training — particularly for midwives — is especially sensitive, as it is currently shaped by both the integrity of the trainer and market-driven considerations. According to Chervenak and McCullough (2001), all healthcare workers should demonstrate four professional qualities: integrity, compassion, self-effacement, and self-sacrifice.

1.2 Cultural idols and stereotypes about the maternal body

In her novel *Frantumaglia*, Elena Ferrante writes that "the task of a woman writer today is not to stop at the pleasures of the pregnant body, of childbirth, of child-care, but to go with truth to the darkest depths" (Ferrante 2016, 7). In its original Italian version, this passage opens the first chapter of Adriana Cavarero's *Donne che allattano cuccioli di lupo*, a work that explores the symbolic and cultural meanings of maternity (Cavarero 2023, 4).

According to Cavarero, maternity is not celebrated through mystical or ecstatic imagery. Life as a form of creative energy is neither idealised nor represented as a complete fusion between the mother and the life process but is rather portrayed as a concrete experience. Being a mother means undergoing a profound experience marked by what Cavarero terms "the tremendous." This concept refers to the repulsion caused by the physical and carnal reality of generating another life. At the centre of the discourse lies the maternal body, the site where a new human being is formed. However, birth is considered a moment of separation, as a new life emerges — distinct and singular — from the mother's body. Childbirth is often framed in opposition to death, which is described as a return to indistinct matter. Cavarero refers to the "dark side" of motherhood when analysing the intimate and profound experience of pregnancy, during which a woman feels at one with her child and perceives another life within herself. Comparable to certain representations in the Christian tradition, such as the Madonna with Child, this idea commonly evokes only the bright and serene side of motherhood. Conversely, Cavarero aims

at highlighting that motherhood is actually conflict, fear, and self-transformation following childbirth.

In Ireland and elsewhere in Europe, sheela na gig carvings can be admired in churches or on walls. Dating back to pre-Christian times, a sheela na gig is a carving of a squatting woman displaying an exaggerated vulva, which she enlarges with her own hands. She represents the generative power of mothers. Everyone is born from a mother's body, a body that opens to give birth to another living being—another singular living being that has grown and moved in the womb before emerging through the vagina.

In Greece, the story of Baubo is widespread. It is connected with the myth of Demeter, and thus with that of Mother Earth. Portrayed as a woman who lifts her robe to show her swollen belly and genitalia, Baubo has been described by Nietzsche (2011) as the female counterpart of Dionysus. The sculptures or statuettes of women with swollen bellies and large breasts that are disproportionate to the rest of their bodies symbolise the fertility of the female body. Such sculptures depict the Mother Goddess or Mother Earth, a deity known as Rhea, Cybele, Inanna, and Ishtar in different contexts.

Childbirth can be described as a living body breaking and opening in order to create another living body. Even the postpartum period continues to reflect this process of breaking and opening. Regarding the concept of the open body, Hannah Arendt has observed that the female body is, by nature, predisposed to tearing, while the male body may be imagined as invulnerable and intact (Arendt 1958). Arendt's observation may also be read as a reference to intercourse, as the tearing of the hymen during the first-time sexual experience may signify a profound violability of the female body. Between intercourse and childbirth, a woman may be seen as unable to claim full bodily integrity.

Several statuettes and rituals celebrate the cult of the "Great Mother." Among such statuettes, those depicting the Snake Goddess stand out, the most famous examples of which were discovered in the Palace of Knossos, in Crete. Symbols of the artistic sophistication of the Minoan civilisation, the faience figures portray the goddess in a flowing ceremonial dress, with exposed breasts, and holding two small snakes in her hands.

Large breasts symbolise not only femininity, but also the vital energy provided by breastmilk and bodily strength. This representation of nurturers alludes to the maenads, groups of women who accompanied a god and honoured him with drunkenness during ritual ceremonies. The maenads owe their name to the madness that Dionysus causes in them. The same mania is described in *The Bacchae* by Euripides (Euripides 2004). Nurturers devoted to Bacchus, the Bacchae experience a powerful sense of motherhood, breastfeeding both infants and cubs with their free flowing and intoxicating breastmilk. Just like wine, milk, and honey come from the earth

and nourish all living beings, the Bacchae breastfeed human and non-human beings alike, in a spontaneous and natural way. This may be understood as a nurturing exuberance tied to a kind of motherhood that knows no boundaries — a kind of hyper-motherhood, a feeding frenzy where the body nourishes other bodies, life nourishes life. Cavarero has also highlighted how the Bacchae experience biological pleasure, due to oxytocin flowing through their veins, this being a natural opioid whose effects combine with intoxication.

Cavarero's reference to Niobe being turned into stone is also crucial (Cavarero 2023, 73). As described in a passage from the Twelfth Canto of Dante's *Purgatorio*: "O Niobe, what tears afflicted me / when, on that path, I saw your effigy / among your slaughtered children, seven and seven!" (Alighieri, XII, 70–72). According to philologist Károly Kerény (1949), the name *Niobe* originates from Asia Minor and can be associated with the figure of the Great Mother, often identified with Mother Earth, a female body that generates living beings — human beings — with a certain disturbing ambiguity. Niobe exerts her power through procreation, having borne as many as fourteen children — seven sons and seven daughters — of whom she is proud, as is evident from Ovid's *Metamorphoses* (Ovidio 6). Niobe provides another example of maternity as a life-generating force. Her mythical figure evokes a specific concept of maternity, shaped by the numerical perfection of her offspring and the exaltation of the female body as a powerful generator of lives, as flesh that tears in procreation. In Ovid's version of the myth, men play no part in this story of hyper-maternity. Only Niobe's husband, Amphion, is mentioned as a role model, as he dies of grief at the loss of his children.

2 Childbirth between tradition and modernity: a cultural comparison

The ways in which women give birth raise questions that can be said to be political, rather than a mere matter of obstetrics. Women in labour, women who undergo voluntary termination of pregnancy, women who wait for their period, and women who take hormonal contraceptives never act in complete freedom. Every decision related to childbirth is influenced by moral and social norms.

In Judaeo-Christian theology, the pain of childbirth is seen as divine punishment, a curse placed on Eve in *Genesis*: women are condemned to suffer in giving birth. In 1591, a midwife named Agnes Simpson was burned alive for attempting to ease labour pain using opium or laudanum. In the nineteenth century, the use of chloroform was introduced to render women unconscious during childbirth, so that they would awaken with no memory of the experience.

In the eighteenth century, physician Benjamin Rush investigated childbirth practices among Native American women. He observed that childbirth occurred naturally, with women receiving little to no assistance, their labour being short and not particularly painful. After giving birth, women washed with cold water, which they did autonomously in their huts. They returned to their daily routines within a matter of days (Rush 1830). The image of the Aboriginal woman giving birth without pain, medical interventions, and complications is steeped in exoticism. Aboriginal women often became mothers at a very young age, usually in their teens. They rarely suffered from pelvic malformations and seldom contracted infections, as they gave birth on their own, avoiding physical contact with strangers. In medical writings on the subject, it is pointed out that an Aboriginal midwife's main responsibilities were to care for the mother during pregnancy, assist her during childbirth, help her with the expulsion of the placenta, cut the umbilical cord, and tend to the newborn.

On the other hand, Athenian midwives were more than just midwives, as they prescribed contraceptives, gave advice on sexual problems, and performed abortions. Often accompanied by priestesses, they chanted and cast spells to relieve labour. Physicians were forbidden to induce abortions, although they were the only ones who were allowed to perform an external cephalic version, a method used to turn a breech baby into a head-down position to facilitate delivery. In Egypt, the external cephalic version was already being performed as early as 1500 B.C. by priests, rather than midwives or physicians, who intervened only when delivery became particularly difficult. In Ancient Rome, three figures assisted the mother during childbirth: the midwife, the assistant, and the priestess who prayed for a safe delivery.

It was only after the Middle Ages, as obstetrics became increasingly influenced by male roles, that doctors began striving to save the life of the woman giving birth as well. At the same time, the role of the midwife in the childbirth process started to decline. Such a shift came to be symbolised by forceps, medical instruments that represent the art of obstetrics more than any other. Forceps were a commercial device, an invention that effectively eliminated the role of the midwife, cementing the male monopoly in childbirth.

Most women have always associated childbirth with fear, physical pain, death, and numerous superstitions. Birth pains play a key role in female perception. Patriarchy has imposed suffering on women in labour, with pain being considered necessary to give birth to an extraordinary child, especially if male. Women in labour were seen as those who gave life to heads of families, heirs, and soldiers destined to fight for the tribe or nation (Rich 2024, 200–215). The fear of birth pains in both primitive and advanced societies often stems from stories, phrases, and anecdotes, being further reinforced by literature. To emphasise this point, Adrienne Rich has

made reference to the passage in Tolstoj's *War and Peace* that describes Princess Lisa giving birth:

> The cries ceased. A few seconds passed. Suddenly a terrible scream — a scream not hers, for she could not scream like that — resounded from the room. Prince Andrei ran to the door; the scream ceased, and he heard the wailing of a newborn baby. A woman came out and, seeing Prince Andrei, stopped in confusion on the threshold. He entered. She lay in the same position as before, her head thrown back, her arms extended (Tolstoj 2007, 350).

In the patriarchal order, the child's life is valued more than the mother's. Another kind of fear is experienced: the fear of change, transformation, and the unknown. Pregnancy can be perceived as the death of a former self, as it involves profound changes in a woman's life. Even those who decide to place their child for adoption shortly after birth undergo irreversible physiological and psychic changes during pregnancy.

Anthropologist Brigitte Jordan has conducted a study on the experience of childbirth across different cultures. She described hospital-based childbirth in the United States as a sequence of interventions that are medically justified in the interest of both the mother's and baby's health. Such interventions include the induction and acceleration of labour through medication, and the routine administration of sedatives and analgesics. According to Jordan, depriving the woman in labour of psychological support, performing amniotomies and routine episiotomies, using forceps, and requiring the supine birthing position show that childbirth is a culturally conditioned event even in the United States, where the same method is adopted regardless of individual needs (Jordan, Davis-Floyd 1993). Although episiotomy is useful to prevent perineal tearing, lacerations are much more frequent when the woman is forced to give birth in the supine position than when squatting, using an obstetric chair, or lying in a hammock, as it is common in Yucatán. Similarly, the use of forceps becomes more likely in the lithotomy position, where gravity cannot aid in expelling the baby. In cultures as diverse as the Swedish and Yucatecan, women are actively involved in the decision-making process regarding childbirth (Jordan 1992, 102–106). In Yucatán, midwives emphasise that each woman needs to "buscar la forma," that is, find the position that is most comfortable for her, with the midwife assisting her while respecting her decision (Jordan 1992, 105).

3 Reproductive knowledge, health policy frameworks, and forms of resistance

The anthropological investigation undertaken in the Yucatán — focusing on the practices of *parteras* and the therapeutic function of *sobada* in promoting reproductive health — constitutes only one dimension of the broader scholarly contributions of Patrizia Quattrocchi, a leading figure in the field of obstetric violence. Her work, which is extensively cited throughout this volume, is widely recognised for advancing critical understandings of the interplay between indigenous knowledge systems, public health policies, and gendered power relations in reproductive care. The ethnographic fieldwork conducted in a Mayan village between 2000 and 2006 offers nuanced insights into how traditional midwifery practices serve not only as forms of clinical intervention but also as culturally embedded strategies of resistance to biomedical hegemony. Central to this analysis are: the role of *parteras* as socially legitimised knowledge holders, the significance of intergenerational knowledge transmission, and the critique of institutional health interventions that marginalise local epistemologies. These findings have contributed substantively to contemporary academic debates on the medicalisation of childbirth and the structural forms of violence enacted upon women's bodies within clinical settings.

Patrizia Quattrocchi's work has significantly contributed to broadening knowledge of women's bodies, even from an anthropological perspective. Her book *Corpo, riproduzione e salute tra le donne maya dello Yucatán*, which is only available in its original Italian edition, presents field research conducted in the Mayan village of Kaua, located 125 km from Mérida, the capital of Yucatán. Between 2000 and 2006, Quattrocchi devoted 15 months to observing the practices of local midwives, with her work providing a detailed overview of techniques and knowledge related to the female body. She studied *sobada*, a distinctive abdominal massage with therapeutic effects. *Sobada* is not a simple massage, as it is only given by specialists, who may be either women or men. The objective of *sobada* is to reposition organs that are believed to be misaligned as a result of pregnancy, in order to prevent any physical problems that could affect the woman's well-being. Different types of *sobada* may be identified. One type of *sobada* is given by *parteras* — midwives — both during pregnancy and in the postpartum period: during pregnancy it is useful to reposition the foetus for a safer and less painful birth; in the postpartum period, it helps to reposition the woman's abdominal organs after childbirth.

Quattrocchi has also explored the history of demographic and health policies in the twentieth century, focusing on their impact on Mayan midwives who, initially having no proper medical training, were required to take training courses starting in the 1970s. Although such state measures improved the situation, poverty,

malnutrition, and poor hygienic conditions among the Mayan population in Yucatán remained the primary causes of the high mortality rates among women and children. Quattrocchi found that maternal and infant mortality was not due to the practices of *parteras*, as the highest rates occurred in hospitals. The place of delivery was crucial, and hence the choice between hospital and home birth. Based on information provided by women in Kaua, Quattrocchi understood that their choice to give birth either at home, with the help of a midwife, or in the hospital, surrounded by doctors, was influenced by their view of home birth as a natural process that does not involve the surgical violation of the woman's body. By contrast, hospital births were exclusively associated with *cortada* (caesarean section) and *picada* (episiotomy). Strong social, economic, and gender disparities within the Yucatecan population also contributed to difficulties in accessing health-care facilities.

Quattrocchi also investigated the reproductive trajectories of women in Kaua. After recounting the stories and describing the profiles of the nine *parteras* with whom she established relationships, she analysed the role midwives play in the different stages of procreation — pregnancy, childbirth, and the postpartum period. Midwives provide not only practical assistance, but also emotional and cognitive support, ensuring that future mothers can benefit from a reassuring atmosphere. Since midwives tend to manage childbirth differently, some practices that were once common in the postpartum period are no longer widely adopted.

Quattrocchi's research focuses on *sobada*, in order to analyse the conception of organs, their balance and mobility as essential to women's well-being. Owing to their experience, *parteras* are considered the only ones who can restore balance to the female body. As pregnant women do not routinely undergo *sobada*, they are rarely blamed when complications arise during childbirth. This suggests that a power imbalance exists between pregnant women of childbearing age and experienced midwives. Such power dynamics are also evident within the family, between husbands and wives, fathers and daughters, brothers and sisters. These relationships shape the role of pregnant women, who can assert greater self-determination, particularly during pregnancy (Quattrocchi 2012, 291, 296). *Sobada* can be considered a form of women's discourse on the female body, an embedded practice, a means of female resistance to male power, a way for women to assert control over their own bodies, a safeguard of local knowledge from external cultural paradigms, and a defence of the midwife's role in the face of government health workers.

Their knowledge and power make *parteras* respected and admired, even in the male world. *Parteras* who provide assistance during childbirth are greatly appreciated, with such appreciation being expressed through recognition and titles. As Quattrocchi (2001, 128) explained, *parteras* believe they have a true God-given calling, without which they could not have learned anything about the trade. The

calling usually comes through a dream or vision that shows them how to act. "Soy *parteras* gracias a Dios" — I am a *partera* thanks to God — is a phrase that numerous women interviewed by Quattrocchi have used at various times and on different occasions. *Parteras* begin putting their knowledge into practice much later than when they start learning. They acquire knowledge of medicinal plants and massage techniques when they are twelve or thirteen years old, although they begin assisting during childbirth only when they are around twenty-five. Mature age, experience, and, in many cases, the fact of already being a mother are considered undisputed indicators of reliability.

Regardless of a young girl's reasons for approaching this job, in most cases, training is formalised through participation in one or more courses, called *capacitaciones*. It was in the 1950s that the Honduran Ministry of Public Health officially recognised the important role of *parteras* and began to take an interest in their work. This resulted in the first courses in health education, hygiene, nutrition, and childbirth assistance, which, however, soon proved to be a failure. The reason for that lies in the fact that giving a mere technical and obstetrical significance to the relationship between a *partera* and a pregnant woman does not take into account the broader role that *parteras* play within the community and the social life of a pregnant woman. The *partera* is the first to diagnose that conception has taken place, relying on fundamental symptoms such as nausea, poor appetite, cravings for particular foods, headaches, and other typical indicators of pregnancy. Only after being visited by a *partera* does a woman go to a health centre, often accompanied by the midwife herself, to receive confirmation of her pregnancy. During pregnancy, the midwife sees the pregnant woman once a month, to check that everything is progressing well, with the greatest concern being the position of the baby, which should be upright. If, by touching the pregnant woman's belly, the *partera* understands that the baby is in an incorrect position, she gives her a special three-minute massage, *sobada*, which repositions the baby. During pregnancy, the *partera* advises her patients on what to eat and wear. In the last month of pregnancy, the *partera* sees her patients more frequently.

It was not until the late 1980s that a new methodology for delivering *capacitaciones* was developed. In addition to *capacitadas*, an untold number of non-*capacitadas parteras*, who reject any form of external interference in their work, have become active in communities. Quattrocchi pointed out that *sobada* is not given in hospitals, which illustrates the perceived epistemological superiority of local knowledge systems over Western obstetrics. Similarly, in the treatment of certain illnesses, it has been repeatedly observed that biomedical practitioners often fail to comprehend the clinical manifestations at hand, while *parteras* demonstrate an intuitive and culturally embedded understanding of the condition (Quattrocchi 2001, 131).

These divergences between traditional and biomedical knowledge systems acquire an additional layer of complexity within migratory contexts, where cultural dissonances and systemic inequalities often influence healthcare access and outcomes.

3.1 Culture, health, and immigration

National culture, familial trajectories, educational background, religious orientation, migratory experiences, personal attributes, health status, economic position, social capital, and degree of societal inclusion or marginalisation intersect in unique configurations within each individual. These multifaceted and interwoven dimensions pose significant challenges in the interface between migrant populations — or populations of migrant origin — and the host society, specifically within the Italian context. Such complexity becomes particularly salient in the organisation and delivery of healthcare services. Ensuring the health of foreign populations constitutes a critical and non-negotiable public health obligation, to be upheld through coherent and inclusive socio-health policies, grounded in the recognition of health as a fundamental and inalienable right.

Therefore, the way healthcare services are organised and provided is crucial, as it can either result in mechanisms perpetrating inequality and disease or contribute to addressing both.

Focusing on Italy, where access to care for the immigrant population is protected by one of the most inclusive legislative frameworks in both the European and global context, we can highlight that the national healthcare service is founded on the key principles — universality, comprehensiveness, and equity — which should always underpin the realisation of the right to health protection, enshrined in Article 32 of the Italian Constitution. Furthermore, healthcare planning should always be guided by the organisational principles established at the national level — centrality of the person, public responsibility for health protection through the guarantee of essential levels of care, collaboration between the various branches of the national healthcare service, integration of social and healthcare services, and valorisation of the professional skills of healthcare workers. Despite this, the interpretation and implementation of legislation concerning access to healthcare for foreigners remains highly uneven across the country, as well as within regions and autonomous provinces.

Although the right to health is universal, several obstacles continue to hinder immigrants' access to healthcare services. Such obstacles include language and cultural barriers, limited knowledge of the rules and functioning of the national healthcare service, distrust of a healthcare system that immigrants do not recognise

as their own, and difficulties and misunderstandings in interactions with healthcare professionals. Characterised by complexity and dynamism, the protection of immigrants' health requires multidisciplinary and integrated tools that draw on the theoretical frameworks of social determinants of health promotion (Cardano and Costa 1998; Sarti 2006; Terraneo 2018).

The intertwining of an immigrant's culture and religion tends to persist and be passed down from generation to generation. Even when situations change, identity, adherence to traditions, and social cohesion continue to play a significant role in an immigrant's life. If the concepts of health and disease may vary across different cultures, this is even more true when it comes to gender.

3.2 Immigrant women with female genital mutilation between tradition and change

The migration process introduces new subjects and cultural aspects that may produce a shared community project, which is often hindered by oppositional dialectical dynamics. The interaction of multiple cultures may lead to cultural uncertainty, conflict, and disorientation that result in cultural distress (UNICEF n.d.). This is caused by a clash between two realities: on the one hand, immigrants need to adjust their expectations and cultural perceptions to the host country; on the other hand, the host country holds a generic, concise, and homogeneous idea of the immigrant (Weny et al. 2020).

The increase in foreign users requires a redefinition of the national healthcare service. Immigrant women coming from countries in the Global South may have experienced violations of basic human rights, having faced poverty, hunger, disease, excessive workload, tyranny, repression, and war. Numerous foreign women who reach Italy bear wounds that cannot be healed, as they are the result of ancient excisional practices. One of these is Female Genital Mutilation (FGM), a phrase label that encompasses several traditional ritual practices. Migration has contributed to the spread of FGM to industrialised countries, such as the United States, Canada, Australia, and several European nations (UNFPA n.d.). Female genital mutilation holds significant value in African cultures, as it is an initiation rite that marks group membership, a rite of passage for the construction of identity. These values are not shared by host societies, which results in immigrant women living within communities that regard everything they valued — and that contributed to their womanhood — as violent, inhuman, and illogical.

The practice of FGM is based on socio-cultural, aesthetic, hygienic, spiritual, religious, psychological, and sexual reasons. While participating in a study conducted in Lecce, in southern Italy, in 1999, some young immigrant women coming from

countries with an excisional tradition talked about the two main types of cuts used in excisional practices. They explained that in some cases only a small cut is made, which is better than when "everything" is removed. A woman mentioned being "as smooth as a hand" and stated that if she had a daughter she would opt for a small cut (Rizzo 1999, 153). In another study, also carried in southern Italy with immigrant women, thorugh more than a decade later, a Somali mother who wanted to ensure the best for her daughter said that eliminating "that junk" was the only way for her girl to have a future, as she would otherwise never find a husband, with her fate being life on the street (Morrone and Sannella 2010). Findings from research carried out in 2022 confirm that the situation in Europe remains unchanged (Thomas et al. 2022). The latest data, collected by the UK Immigration Centre in January 2025, even report a 30% increase in FGM over the past 10 years. Paradoxically, the practice of FGM is supported and performed by women, as it is seen as being vital to the maintenance of fundamental social structures, such as the patrilineal system, family honour, and social standing. Performing FGM is believed to be in the best interests of girls, so as to ensure them a happy future as wives and mothers. Not practising FGM is therefore tantamount to exposing a young woman to enormous risk.

The construction of female identity is a process that includes complex dynamics, such as the introjection of female figures, cultural and social influences, and any relationship that may lead a child to become a woman. A key role is also played by culture, religion, values, and traditions. Self-representation is shaped not only by the reality of the body, but also by the gaze of others, particularly the way the child perceives her parents' gaze. This process becomes even more complex when migration is involved, as women who have developed a certain self-image based on their own culture and beliefs have to face a new reality where those values and beliefs are not recognised. Following migration, a woman's self-representation may conflict with her new reality, which does not often accept it and may even reject it. This can lead to a loss of identity and significant psychological distress. Adopting an unbiased view of women from different cultures becomes crucial, even when they hold values and beliefs that involve practices such as female genital mutilation.

According to the classification of the World Health Organization (WHO 2023), four types of FGM can be identified: Type 1 is the partial or complete removal of the clitoral glans; Type 2 is the partial or complete removal of the clitoral glans and labia minora; Type 3, also called infibulation, is the narrowing of the vaginal opening through the creation of a covering seal, sometimes through stitching; and Type 4 includes all the other harmful procedures to female genitalia performed for nontherapeutic purposes.

As these practices pose a high risk to a woman's health, they should receive particular attention from health professionals. Not only should the cultural background

and prevalent diseases in migrant women's countries of origin be taken into account, but it should also be considered that healthcare professionals in the host country may be unprepared to face such situations. These aspects are essential in maternal and child care, and hence should be emphasised when developing intervention strategies for obstetric and paediatric care. Failing to assess cultural and gender determinants may further jeopardise adherence to care and reduce the therapeutic efficacy of health interventions. Discrimination may occur when healthcare professionals strictly follow treatment protocols, having little to no awareness of differences in terms of cultural aspects, medical practices, experiences, and beliefs. This may result in immigrant women choosing not to benefit from the national healthcare service. A number of immigrant women have reported experiencing double victimisation during gynaecological examinations, due to harsh comments being made about their body.

It seems necessary to integrate a culturally adapted, gender-sensitive approach into the organisation of healthcare services, in order to ensure adequate responses to the health needs of the immigrant population, improve access to care, and protect immigrant women and their families. As the World Health Organization has pointed out, the assessment of gender-sensitive roles and relationships is a crucial health determinant that may help to protect beneficiaries' well-being and perceptions, promote mental and physical health, prevent the onset of illness, facilitate adherence to treatment protocols, and improve their effectiveness. As the literature has shown and healthcare professionals have reported (UNFPA n.d.; Farouki et al. 2022), foreign women undergo fewer pregnancy screenings and ultrasound examinations than Italian women. Additionally, foreign women tend to have their first medical check-up later in pregnancy than Italian women, with 11.5% of foreign women having their first visit after the twelfth week of pregnancy, compared to 2.65% of Italian women. This delay may hinder early diagnosis and the monitoring of clinical conditions that may help to identify pre-existing physical or social problems.

3.3 Main aspects of deinfibulation

Deinfibulation is a relatively simple surgical procedure performed to reopen the vaginal introitus of women with Type 3 FGM. Deinfibulation surgery can partially or fully repair the physical effects of FGM, although it may not be sufficient to reduce psychological distress, which makes it essential to provide sensitive and culturally oriented support to women undergoing it. Deinfibulation cannot be viewed as a mere "anatomical reopening," as it is characterised by deep, shifting, and sometimes conflicting symbolic and social meanings. Deciding to undergo this surgery

means confronting one's past and the painful implications tied to it, which may lead to a break with tradition and, in some cases, conflict with one's community of origin (AMSI; UMEM). On the other hand, deinfibulation surgery also represents a choice for improved physical, reproductive, psychological, and sexual health, with women securing a better future for both themselves and their daughters.

An operative protocol of therapeutic deinfibulation has been devised that involves preparation for surgery and postoperative support. Such a protocol consists of three phases during which the patient undergoing surgery meets the team that will support her throughout the entire process. In the first phase, preparatory information about deinfibulation surgery is provided, with a linguistic-cultural mediator being present, if necessary. Anaesthetic options are discussed, and the patient is given a clear and comprehensive explanation of the surgical procedure, in terms of the steps involved, the professionals present in the operating room, surgery and recovery times, and postoperative care. In the second phase, deinfibulation surgery is performed, with the patient having the opportunity to be supported by a psychologist and a cultural mediator during the procedure. The third phase involves postoperative follow-up, treatment, and support. The patient is seen by a gynaecologist, and her emotional state is monitored through psychological follow-up, with appointments scheduled based on her needs and preferences.

The procedure can be performed either *antepartum* or *intrapartum* (Purchase et al. 2013). Any health-related initiative, including training on the possible health consequences of the procedure, should be mindful of the context to which the woman and her family are connected, as well as the complex set of beliefs that underpins it.

When women choose to refuse FGM in a community in which it is a widespread practice, they are breaking with the traditions of their group of origin, risking ostracism and being seen as victims of external factors. FGM is regarded as a normal stage in a woman's life, an expected step in a girl's path towards adulthood, embedded in the experience of womanhood. As FGM is a tradition that is reinforced by the social pressures that hold a community together, any girl who decides not to conform and rejects FGM may face stigmatisation. Therefore, holistic, woman-centred care should be ensured, through a multidisciplinary approach that may effectively help to support women with FGM. Obstetric counselling and continuity of care, provided by informed health care professionals throughout the journey to childbirth, are even more vital in improving the well-being of mothers, their newborns, and their families, while also contributing to preventing FGM in future generations. Healthcare professionals should be adequately trained to correctly identify FGM and develop appropriate management strategies.

4 Conclusions

The analysis carried out in this paper has highlighted how medical practices and cultural norms have redefined the female body, reshaping the way it is perceived. In the Western world, the modern development of certain medical practices has gradually reduced the central role once played by women during childbirth. By contrast, in various non-Western cultures, childbirth continues to be regarded as a sacred event that, experienced by the community as a whole, cannot be fully medicalised.

Consequently, at least two societal views of childbirth may be identified. On the one hand, a rigid model aims to prevent medical complications during childbirth, despite risking dehumanising the process. On the other hand, community-supported childbirth is prioritised, which humanises the experience, even at the cost of potential health risks.

In the postpartum period, women often face a series of challenges. Mainly caused by a woman's physical, psychological, and emotional transformation, they are also the result of childbirth being considered not only a biological process, but also a cultural event.

Therefore, it seems necessary to both improve birth care, by ensuring respect for pregnant women's physical integrity and moral dignity, and contribute to the self-determination of the female body. Obstetric violence may be more easily prevented if it is acknowledged that it stems from a culture that fails to recognise women's freedom.

References

Alighieri, Dante. 2003. *Purgatorio*. Translated by Robert Hollander and Jean Hollander. Anchor Books.

Arendt, Hannah. 1958. *The Human Condition*. University of Chicago Press.

Associazione Medici di Origine Straniera in Italia (AMSI), Comunità del Mondo Arabo in Italia (CO-MAI), Unione Medica Euro Mediterranea (UMEM), and Accademia Internazionale per lo Sviluppo Economico e Sociale (AISC). 2025. *Statistiche AMSI-CO-MAI-UMEM-AISC*. https://www.immigrazione.com/review/article/10499 (last accessed February 4, 2025).

Beard, McKenzie. 2024. "The Unique Toll of Stress and Depression on Women's Hearts." *The Washington Post*, June 11.

Bills No. 179-183/2019, known as the Born Alive Infant Protection Act. https://www.biodiritto.org/Biolaw-pedia/Normativa/Wisconsin-Stati-Uniti-Bloccati-i-progetti-di-legge-n-179-180-181-182-183-2019-Born-Alive-Infant-Protection-Act (last accessed January 13, 2020).

Buccini, Francesca. 2023. *Genere e Stem: Una prospettiva bioeducativa.* Pensa Multimedia.

Cardano, Mario, and Giuseppe Costa. 1998. "Classi sociali e salute. Le diseguaglianze di mortalità a Torino." *Quaderni di Sociologia* 17: 86–122.

Cavarero, Adriana. 2023. *Donne che allattano cuccioli di lupo: Icone dell'ipermaterno*. Castelvecchi.

Chervenak, Frank. A., and Laurence. B. McCullough. 2001. "The moral foundation of medical leadership: the professional virtues of the physician as fiduciary of the patient." *American Journal of Obstetrics and Gynecology* 184 (5): 875–880.

"Cos'è la violenza ostetrica." n.d. Nurse24.it. https://www.nurse24.it/ostetrica/professione-ostetrica/cos-e-violenza-ostetrica.html (last accessed February 16, 2025).

"Depressione post partum: sintomi, cosa fare e come si cura". *MyPersonalTrainer.it.* https://www.my-personaltrainer.it/salute/depressione-post-parto.html (last accessed February 2, 2023).

De Sanctis, Davide, Sara Fariello, and Irene Strazzeri. 2019. *Sociologia della maternità.* Mimesis Edizioni.

Farouki, Leen, El-Dirani Zeinab, Abdulrahim Sawsan, et al. 2022. "The global prevalence of female genital mutilation/cutting: A systematic review and meta-analysis of national, regional, facility, and school- based studies." *PLoS Med.* 19 (9). https://doi.org/10.1371/journal.pmed.1004061.

Ferrante, Elena. 2016. *Frantumaglia: A Writer's Journey*. Translated by Ann Goldstein. Europa Editions.

Fortuna, Stefania. 2021. *Ippocrate. Il dovere della cura. Giuramento di Ippocrate.* Garzanti.

Foucault, Michel. 2010. *The birth of biopolitics: lectures at the Collège de France*, 1978-1979. Picador.

Foucault, Michel. 1978. *The History of Sexuality: Volume 1. An introduction*. Translated by Robert Hurley. Pantheon Books.

Giarelli, Guido. 2008. "Il contesto della mediazione. La sfida dell'interculturalità nella società multietnica." In *Immigrazione, mediazione culturale, salute*, edited by Claudio Baraldi, Valentina Barbieri, and Giudo Giarelli. FrancoAngeli.

Horsch Antje, Susan Garthus-Niegel, Susan Ayers, et al. 2024. "Childbirth-related Posttraumatic Stress Disorder: Definition, Risk Factors, Pathophysiology, Diagnosis, Prevention, and Treatment." *American Journal of Obstetrics and Gynecology*.doi: 10.101610.1016/j.ajog.2023.09.089.

Jäger, Fabienne, and Schulze Sylvie. 2002. "Female Genital Mutilation in Switzerland: A Survey among Gynaecologists." *Swiss Med Wkly* 132 (19-20): 259–264. https://doi.org/10.4414/smw.2002.09912.

Jordan, Brigitte, and Robbie Davis-Floyd. 1993. *Birth in Four Cultures: A Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden, and the United States*. 4th ed. Waveland Press.

Kerény, Karoly. 1949. *Niobe: Neue Studien über Antike Religion und Humanität*. Rhein-Verlag.

Maffi, Irene. 2012. "Recensione di Patrizia Quattrocchi, *Corpo, riproduzione e salute tra le donne maya dello Yucatan (Messico)*, Pacini Editore, 2011." *Confluenze: Rivista di Studi Iberoamericani* 4 (1): 291–296. https://confluenze.unibo.it/article/view/3264.

Manfroni, Alice. 2022. "Il corpo della donna: ripensare una categoria plurale." *La Rivista Culturale*. https://larivistaculturale.com/2022/07/29/antropologia-culturale-teoria-corpo-analisi-donna-attualita/ (last accessed February 14, 2025).

Marone, Francesca. 2003. *Narrare la differenza: Genesi, saperi e processi formativi nel Novecento.* Unicopli.

Melandri, Lea. 1993. *Il corpo: Una geografia di confine*. Lapis.

Meo, Milena. 2014. "La medicalizzazione del corpo femminile." In *Ripensare il corpo. Rappresentazioni, medicalizzazioni, decolonizzazioni*, edited by Milena Meo. Aracne.

Morrone, Aldo, and Alessandra Sannella. 2010. *Sessualità e culture. Mutilazioni genitali femminili: risultati di una ricerca in contesti socio-sanitari.* FrancoAngeli.

Morrone, Aldo, and Gioia Di Cristofaro Longo. 1995. *Cultura, salute, immigrazione. Una analisi interculturale*. Armando Editore.

Morrone, Aldo, and Pietro Vulpiani. 2004. *Corpi e simboli. Immigrazione, sessualità e mutilazioni genitali femminili in Europa*. Armando Editore.

Nietzsche, Friedrich. 1889. *Dionysos-Dithyramben*. Zeitschrift für Germanistik 2025, 35 (3): 563-57.

Quattrocchi, Patrizia. 2001. "Parteras gracias a Dios. Il sistema di nascita lenca (Honduras) fra tradizione e modernità." *La Ricerca Folklorica* 44: 127–138.

Quattrocchi, Patrizia. 2011. *Corpo, riproduzione e salute tra le donne maya dello Yucatan (Messico)*. Pacini Editore.

Purchase, Thomas C.D., Maya Lamoudi, Sarah Colman, et al. 2013 "A survey on knowledge of female genital mutilation guidelines." *Acta Obstet Gynecol Scand* 92 (7): 858–861. https://doi.org/10.1111/aogs.12144.

"Quale impatto ha avuto la campagna #bastatacere?". 2019. *Osservatorio sulla Violenza Ostetrica Italia (OVOItalia)*. https://ovoitalia.wordpress.com/2019/04 (last accessed February 16, 2025).

Rich, Adrienne. 1976. *Of Woman Born: Motherhood as Experience and Institution*. W. W. Norton & Company.

Rizzo, A. Maria. 1999. "Storie di donne." *Palaver: Culture dell'Africa e della Diaspora* 11/12: 141-156.

Rush, Benjamin. 1830. *Medical Inquiries and Observations Upon the Diseases of the Mind*. 4th ed. Grigg.

Sarti, Simone. 2006. "La classe sociale in buona salute." *Polis* 20 (3): 317–346.

"Servizi dedicati alle MGF — Mutilazioni Genitali Femminili". 2023. *SaperiDoc.it*, Direzione Generale Cura della Persona, Salute e Welfare. https://www.saperidoc.it/flex/cm/pages/ServeBLOB.php/L/IT/IDPagina/864 (last accessed March 2025).

Smith Helen, and Karin Stein. 2017. "Surgical or medical interventions for female genital mutilation." *International Journal of Gynecology & Obstetrics* 36 (S1): 43–46. https://doi.org/10.1002/ijgo.12053.

Strazzeri, Irene. 2014. Post-patriarcato. L'agonia di un ordine simbolico. Roma.Terraneo, Marco. 2018. *Salute negata: Le sfide dell'equità in prospettiva sociologica*. FrancoAngeli.

Tolstoj, Leo. 2007. *War and Peace*. Translated by Richard Pevear and Larissa Volokhonsky. Vintage Classics.

Thomas, Hannah S., Nnenaya A. Mmonu, Gregory Amend, et al. 2022. "Awareness, Clinical Experience and Knowledge of Female Genital Mutilation/Cutting Among Female Pelvic Medicine and Reconstructive Surgeons in the United States." *Urology*. doi: 10.1016/j.urology.2021.10.023. Epub 2021 Nov 7.

Ulivieri, Simonetta. 1995. *Educare al femminile*. Edizioni ETS.

UNFPA. n.d. "Female Genital Mutilation." https://www.unfpa.org/female-genital-mutilation (last accessed February 15, 2024).

UNICEF. n.d. "What is Female Genital Mutilation?" https://www.unicef.org/protection/female-genital-mutilation (last accessed February 15, 2024).

Weny, Kathrin, Romesh Silva, Rachel Snow, et al. 2020. "Towards the elimination of FGM by 2030: A statistical assessment." *PLoS One* 15 (10): e0238782. https://doi.org/10.1371/journal.pone.0238782.

World Health Organization (WHO). 2023. "Female Genital Mutilation." https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation (last accessed February 15, 2025).