De Facto Feminism: An Analysis of the Respectful Childbirth Movement in Hungary

by
Nora Peterson

Submitted to the Department of Gender Studies, Central European University

In partial fulfilment of the requirements for the Erasmus Mundus Master's Degree in Women's and Gender Studies

Main supervisor: Judit Sándor (Central European University)
Second supervisor: Teresa Ortiz Gómez (University of Granada)

Budapest, Hungary

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Abstract

Like many countries around the world, Hungary has adopted the western biomedical model of medicine as the primary method of providing healthcare services to its nationals. The adoption of this model of medical care has spurred a proliferation of systematic mistreatment of women during facility-based childbirth—a phenomenon known as obstetric violence and understood to be physically and/or psychologically violent acts perpetrated by healthcare personnel against pregnant women and their fetuses/infants during pregnancy and childbirth. In response to this proliferation of violence, counter movements, known as respectful childbirth movements, that promote alternative models to the technological model of birth proponed in biomedicine have developed throughout the world. These models seek to re-center women at the locus of childbirth by employing the principles fundamental to the midwifery model of care. The academic discourse surrounding respectful childbirth movements derives primarily from a rich legacy of feminist scholarship on medicalization in the 1960s and '70s in the United States. However, this legacy of scholarship does not properly account for the experiences of women who have lived under distinct material and cultural conditions, such as the women living in contemporary post-communist Hungary, where the development of women's activism has faced particular challenges and where the high profile legal cases surrounding childbirth rights in Hungary—namely, the cases brought against obstetrician/midwife Ágnes Geréb and *Ternovszky v. Hungary*—have dramatically shaped the ways in which respectful childbirth movements are framed in Hungary. The aim of this thesis is to expand the conversation surrounding respectful childbirth movements in order to include a more pluralistic understanding of what respectful childbirth movements can look like outside the hegemonic disocurse of the United States.

Resumen

Al igual que en muchos otros países del mundo, Hungría ha adoptado el modelo biomédico occidental como el método principal para prestar servicios de salud a sus nacionales. La adopción de este modelo de atención médica ha estimulado una proliferación de malos tratos sistemáticos a las mujeres durante el proceso de parto—un fenómeno reconocido como "violencia obstétrica" y entendido como actos físicos y/o psicológicamente violentos perpetrados por personal de salud contra mujeres embarazadas y sus fetos/bebés durante el embarazo y el parto. En respuesta a esta proliferación de la violencia, surgen movimientos que se oponen a la misma, conocidos como movimientos de parto respetuoso, que promueven modelos alternativos al modelo tecnológico de nacimiento propuesto en biomedicina y que se han desarrollado en todo el mundo. Estos modelos tratan de situar a las mujeres en el centro del proceso de parto y de nacimiento, empleando los principios fundamentales del modelo de cuidado de la partería. El discurso académico que rodea los movimientos de parto respetuoso deriva principalmente de un rico legado de investigación feminista sobre la medicalización en los años sesenta y setenta del siglo XX en los Estados Unidos. Sin embargo, esta tradición académica no da cuenta adecuadamente de las experiencias de las mujeres que han vivido bajo distintas condiciones materiales y culturales, como las mujeres que viven en la Hungría postcomunista contemporánea. En ese contexto, el desarrollo del activismo de las mujeres ha enfrentado desafíos particulares donde los casos legales que rodean los derechos del parto en Hungría — a saber, los casos contra la obstetra/partera Ágnes Geréb y *Ternovszky v. Hungary* — han conformado el modo en que los movimientos de parto respetuoso se enmarcan en este país. El objetivo de esta tesis es ampliar el debate en torno a los movimientos de parto respetuoso con el fin de incluir una comprensión más plural de los mismos, fuera del discurso hegemónico de los Estados Unidos.

DECLARATION OF ORIGINAL RESEARCH AND THE WORD COUNT

I hereby declare that this thesis is the result of original research; it contains no materials accepted for any other degree in any other institution and no materials previously written and/or published by another person, except where appropriate acknowledgment is made in the form of bibliographical reference.

I further declare that the following word counts for this thesis are accurate:

Body of thesis (all chapters excluding notes, references, appendices, etc.): 20,003 words
Entire manuscript: 24,250 words

Signed: Nora Elizabeth Peterson (*name typed*)

(Signature appears on the hard copy submitted to the library)

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I dedicate this work to you.

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List of Abbreviations

CEDAW = Convention on the Elimination of All Forms of Discrimination Against Women

ECHR = European Convention of Human Rights

ECtHR = European Court of Human Rights

NGO = Non-governmental organization

UDHR = Universal Declaration of Human Rights

WHO = World Health Organization

Introduction

"I wasn't sure if this was the type of meeting that required alcohol," joked Erzsébet, one of the women who was participating in one of my first interviews for this project. She shrugged half-apologetically as she pulled out a Tupperware container full of assorted freshly cut fruit to share with the group—"but I guess we'll have to make due with this instead" (Erzsébet, Personal Communication, March 2, 2017). The rest of us laughed as we too pulled out our own snacks that we had brought to share with the group. Between the five of us, our combined gifts of goodwill had managed to transform the sterile conference room of a Hungarian pro childbirth rights association into an intimate space, seemingly removed from all the noises of evening traffic emanating from one of the capital city's main streets running below us. We all helped ourselves to the assortment of cookies, homemade treats, fruits, and the herbal tea being served in a collection of brightly colored mugs as we settled in for our first group interview. Despite the seemingly easy-going atmosphere we had created, the mood permeating the room was still thick with apprehension. The question Erzsébet posed may have been meant to be taken in good humor but it exposed the underlying weight of the topic we were about to engage in: the appalling condition of childbirth in contemporary Hungary and the impressive efforts of the group of women sitting besides me who were trying to bring power back into the lives of Hungarian women.

What was originally intended to serve as an informative case study of a particular social movement organization has ultimately become something so much more interesting: a snapshot of a social movement in a very particular moment in its history, when non-governmental organizations are villianized in the media and when women's reproductive rights continue to be challenged all over the world as a result of a surge in conservative leadership. An analysis that focuses specifically on the

manifestation of a respectful childbirth movement in Hungary, in particular, is especially relevant given the current sociopolitical climate enveloping the country's civil society. During the period of nine months that were spent compiling the research utilized in this thesis, non-governmental organizations (NGOs) in Hungary were facing ever-increasing pressure from the government. Near the end of the research period—namely in March and April 2017—new legislation was introduced, and eventually passed later that summer, that directly targeted foreign-funded non-governmental organizations, including the pro childbirth rights NGO EMMA Hub, which was my primary contact point for accessing members of the respectful birth movement in Hungary.[1] In my analysis of EMMA Hub as an organization, I am particularly interested in the ways it situates itself as a woman-centered organization in an arguably anti-feminist context.

The first chapter provides a brief introduction to the topic, including a sociohistorical context for the development of the respectful childbirth movement in Hungary, which explores the relevant demographic, political, and social factors that led to the current manifestation of the activist movement. The second chapter explores the existing academic literature that deals with respectful childbirth movements and activism in Hungary and establishes a theoretical framework for understanding the respectful childbirth movement. The third chapter explores the methodological decisions undertaken by the researcher. The fourth and fifth chapters of this thesis serve

[1]It is significant that this newly proposed legislation is targeting foreign-funded NGOs because the majority of such organizations receive funding from the Open Society Foundation, an international grant-making network that was founded by Hungarian-American philanthropist billionaire George Soros. Soros is renowned for his support of American progressive and liberal political causes. As such, many of the organizations who receive funding from his foundation also reflect similar values in their work and inherently represent dissenting voices against the current Hungarian government's conservative political views. The Hungarian government—headed by Prime Minister Viktor Orbán of the Fidesz political party—does provide financing for some NGOs, but only to NGOs that support the government's political agenda. In effect, this division has created two competing civil society sectors. ("Hungary submits bill targeting NGOs," 2017)

as the presentation and analysis of data, respectively. Data collected from the ethnographic oral interviews is presented in chapter four in order to provide a general overview of the respectful childbirth movement in Hungary using the words of its own members. The fifth chapter features an in-depth case study of a local pro childbirth rights non-governmental organization, EMMA Hub, with the first half of the chapter detailing the organization's basic information—who, what, when, where, why, how—and culminates with a reflection on how EMMA Hub can be considered a feminist organization, using feminist as an analytic category and not as a descriptive category, despite the fact that the organization itself does not embrace that title. The intention of this reflection is not to externally apply a label to EMMA Hub that its members do not desire nor see as appropriate for its mission, but rather to extend the conversation on how de facto feminist activism can manifest in contexts outside of the western capitalist context in which it was conceived.

The intent of this thesis is not to dismiss western biomedicine as irrelevant or to villainize the individual medical professionals who provide care to pregnant women; rather, the aim of this thesis is to challenge of system of violence and oppression that underlies the very structure of western biomedicine as we know it and to call attention to the failures of that system in hopes of embracing a more supportive model of care. Nor is the purpose of this thesis to justify home birth as a valid and safe option for women. There is a wealth of resources that explore the safety and value of home births, but this is not one them.

Finally, I recognize that despite my best intentions this essay is far from comprehensive; as such, this thesis concludes with a collection of reflections on the implications of this research and explores some suggestions for further investigation in the future. It is the task of scholars to raise more questions than answers. I hope that this

work provides some insights, but even more, I hope that it inspires more questions, more research, and more action in conjunction with the respectful childbirth movement in Hungary and around the world.

Chapter 1. Contextualizing the Respectful Childbirth Movement in Hungary

In the last century alone, Hungary has undergone many profound transformations as a country. Politically, it has gone from a constitutional monarchy to a Soviet-occupied territory to now a rights-based representative democratic republic. Economically, the country has undergone a market transition, in which socialist redistribution has been transformed into a capitalist market-based economy. Culturally, the country has undergone equally profound changes as Hungary, once a glorious kingdom in its own right, is now a fully incorporated member of the European Union and one of the world's "middle powers" at the beginning of the twenty-first century (Bollobás, 1993)(Koulish, 2005). In order to better situate Hungary's respectful childbirth movement in its own particular context, this chapter will provide a concise analysis of the most relevant social, cultural, and political factors that have contributed to the development of the current manifestation of the movement in contemporary Hungary.

1.1 Demographic Concerns

It has been well documented in the academic literature that Hungary has experienced demographic concerns since the beginning of the twentieth century, when the country lost half of its geographic territories and upwards of three to four million ethnic Hungarians[2] (approximately 33% of the country's population at the time) to its bordering countries as a result of the two World Wars (Bollobás, 1993)(Sándor, 2013). In the case of Hungary, demographic concerns have presented themselves as a preoccupation over a decreasing population. In the aftermath of World War II, Hungary became the first country in Europe to have a declining fertility rate below the simple

[2] In this context, ethnic Hungarian is defined as

level of replacement for the population and the country currently maintains one of the lowest fertility rates in Europe.[3] In an effort to combat the phenomenon of a declining population, pronatalism—i.e. the policy of encouraging reproduction—has featured prominently in Hungary's political agenda and healthcare policy for decades (Sándor, 2013).

However, this pronatalist sentiment does not apply to all Hungarians equally. Deeply entrenched with the preoccupation with the country's decreasing population is a grave concern regarding ethnic purity. Specifically, there is concern in the rate of decrease in ethnic Hungarians and the rate in increase of the Roma ethnic minority population. The Roma[4]—a traditionally nomadic ethnic group whose heritage originates in regions of modern-day northern India—are the largest minority group in both Hungary and in Europe in general (Jaroslav, 2014). In Hungary, the Roma represent five to ten percent of the country's population. However, unlike the general population in Hungary that is seeing a decrease in population growth, the Roma community is seeing an increase in population (Koulish, 2005). A deeper analysis of the situation of the Roma in Hungary is unfortunately beyond the scope of this thesis.

Analyzing these demographic concerns through a feminist lens, it becomes apparent that women bear additional burdens in relation to preoccupations over a decreasing population. As reproduction is still conceptualized as a primarily female matter, women are held accountable for "not making up for the country's tragic historical loss" that the country has suffered as a result of two World Wars and a series of revolutions (Sándor, 2013, p.118). As birth becomes a matter of great significance

[3] As of 2016, the actual net change in population per 1,000 inhabitants in Hungary was -3.2, a record low in terms of population change and a significant difference from the figure of -2.5 in 2015 (Hungarian Central Statistical Office, 2017).

[4] In many countries, the Roma are colloquially referred to by the exonym "gypsy." This term has become unfavorable within academia due to its derogative tone.

within the political rhetoric, women's autonomy in matters relating to birth becomes increasingly compromised. This phenomenon can be seen in increasingly restricted access to abortion, elective female sterilization, and in the increasingly controlled business of birth, in which every healthy birth counts towards maintaining the population (Sándor, 2013). This last topic will be expounded upon later in the thesis.

1.2 Post-Communist Legacy

Among the most evident distinguishing characteristics of the respectful childbirth movement in contemporary Hungary from the hegemonic discourse regarding respectful childbirth movements in western capitalist countries is the lingering influence of communism. Hungary was liberated from communism in 1989 but the post-communist legacy looms large in almost all aspects of contemporary Hungarian society, but it is especially palpable in the way that gender roles and human rights are prescribed and understood within the general population (Bollobás, 1993)(Funk, 1993).

1.2.1 Sex Equality

According to socialist rhetoric, women's equality was "achieved under socialism" (Funk, 1993, pg.1), citing the inclusion of women into the workforce and the public sphere as demonstrative of that fact. Feminist scholarship has demonstrated that this myth of women obtaining liberation under communism is in fact false. While women were in fact incorporated into the workforce, men were not equally incorporated into the private sector, in essence doubling the responsibilities of women under socialism. This myth of achieved equality, in addition to being invoked by the communist party itself as a part of its formal propaganda, has also been perpetuated within the academic discourse by women from external contexts—largely from western, capitalist societies—who applied western conceptualizations of liberation to idealized realities of other women's lived experiences (Bollobás, 1993).

1.2.2 Social Welfare Rights

The post-Soviet legacy has also left significant marks in how social welfare rights, as a subset of human rights, are understood. In stark contrast to the struggles faced by women in the United States and other western countries in their fight to obtain access to adequate maternity care, and healthcare more generally, social welfare rights—including universal healthcare—have already been recognized in Hungary since the implementation of communist policy when healthcare was socialized. In a post-communist context, where social welfare rights—such as access to healthcare—are actively recognized by the State, it is difficult to feel entitled to demand more rights.

In analyzing the recognition of social welfare rights under communism through a feminist lens, however, it becomes apparent that while increasing access to State-funded obstetric care did improve the maternal and infant mortality rate in Hungary, it also represented an additional layer of control over women's bodily autonomy (Sándor, 2013).

1.3 Hungarian Feminism

It is well recognized that when feminist movements develop outside of the cultural contexts where the hegemonic discourse regarding feminism originates—i.e. in western capitalist countries—they often develop in response to the existing feminist discourse. Such is the case in Hungary, where western feminism was vilified as a bourgeois philosophy before an authentic and native feminist movement could develop on its own. Because of this hegemonic anti-feminism existing in Hungary since the time of Soviet-occupation, some scholars have even gone so far as to characterize Hungary as "anti-feminist" (Funk, 1993).

In actually, the existence of a Hungarian feminist movement remains quite controversial. Some sources say that it has never existed; others say that this is a lie perpetrated by the male media to cover up the true Hungarian feminist movement. Regardless of whether a fully developed movement has existed or not, some explicitly feminist organizations have existed in Hungary. The two main organizations were the Feministák Egysülete ("Hungarian Feminists' Association) and the Hungarian Women Worker's Association, which represented bourgeois women and working class women, respectively. These two organizations were often at odds with each other as class conflict became their focus. They were also poorly received by the general public, and were attacked by the socialists for being western and bourgeois and by the nationalists for taking women away from their proper role in the home. Ultimately, their own internal conflicts over class stratification kept them from ever truly coming together and they were never able to overcome the rampant antifeminist sentiment that had come to define Hungary (Arpad & Marinovich, 1995). This lack of unity continues on until present day, as the few self-proclaimed Hungarian feminist organizations still create spaces of exclusion rather than inclusion, as we will explore in more depth in chapter 4.

1.3.1 Gender Activism in Post-Communist Contexts

One of the biggest obstacles in garnering public support for a matter that could be construed as a feminist matter is the myth of sex equality obtained under communism. As was discussed earlier in this chapter, within the communist regime, equality between the sexes was an essential part of the discourse and therefore negates the necessity for any sort of feminist organizing, on the rhetorical level. Considering the lack of a strong Hungarian feminist movement, it is not surprising that there is also a lack of gender activism in the country (Arpad & Marinovich, 1995). This lack of collective social movement, however, is not necessarily inherent in post-communist

countries as other countries, such as Poland, do exhibit strong social movements. It is not simply due to the lack of a centralized feminist movement that such activism does not exist in Hungary.

One of the biggest obstacles in generating a large-scale women's movement in Hungary is the lack of collectivity present in contemporary Hungarian culture. Scholars have identified Hungary as a very "atomized society", in which citizens identify more readily as private individuals than as members of a unified organism, or community. The key to connecting the individuals to the larger society in which they are a part is civil society, a key component in establishing and maintaining democracy and equality. The civil society that had existed before the Soviet-occupation was destroyed when communist ruling elite attempted to gain control over Hungarian society, ultimately leading to demobilization of the general population (Arpad & Marinovich, 1995)

What has since ensued is a deep-seeded distrust for the public world. For decades the Hungarian people had been fed propaganda claiming that they were living a better life under socialism that they knew were lies. Some scholars have identified this phenomenon as "split consciousness" due to the dual nature that people take on to cope when their public and private realities differ so significantly. In addition to perpetuating a deeper divide between the private and public as people grew more cynical of public life, this phenomenon of "split consciousness" also deterred people from becoming engaged in civil society after the fall of socialism because that had already been disillusioned from the years living under fallacious socialist rhetoric. Another result of this split consciousness was that the home and the family—and with it conservative gender roles—became a refuge from the distrustful public world, making family life more sacred and therefore less accessible for transformation on the part of social movements (Arpad & Marinovich, 1995).

Furthermore, in a context such as Hungary, where the notion of feminism has been demonized, as has been explored in an earlier section of this chapter, matters that might otherwise be conceptualized as belonging to a feminist agenda—such as respectful childbirth practices—are often subsumed within another discourse. In the case of respectful childbirth practices in Hungary, that discourse is universal human rights, as we shall see in the next chapter.

Chapter 2. Theoretical Framework: Conceiving of Respectful Childbirth Practices as a Feminist Issue

"The first assumption made in medicalized birth is that our bodies are inherently flawed. They are likely to break down, so those managing them must be alert to forestall malfunction by obstetric interventions to make childbirth conform to a norm" – Sheila Kitzinger, anthropologist and natural birth activist (Kitzinger, 2006, p.33)

As I familiarized myself with the existing academic literature on respectful childbirth movements, especially in attempting to find literature that would be directly pertinent to the movement in Hungary, it quickly became apparent to me that this thesis would be a trailblazer of sorts. While there has been some research done on obstetric violence—although admittedly there is still a lot more work to be done on that subject—there is fundamentally nothing in the academic literature on respectful childbirth movements. As a topic, the respectful childbirth movement in Hungary is disadvantaged within academia on two distinct axes. Firstly, it deals with childbirth, a subject that has been remarkably absent from mainstream feminist academic literature since the 1960s and 1970s. And secondly, the topic it physically situated in a context—namely, Hungary—that is very underrepresented in the academic literature, especially in terms of ethnographic research. Additionally, in contrast to other respectful childbirth movements—such as the alternative birth movement in the United States— the respectful childbirth movement in Hungary has largely been framed by the human rights discourse as opposed to an explicitly feminist discourse. As such, in presenting the theoretical framework for conceptualizing the respectful childbirth movement in Hungary as a feminist issue requires a great deal of interdisciplinary research.

2.1 Movement for Respectful Childbirth as a Response to Obstetric Violence

Fundamental to any understanding of the notion of respectful childbirth is a reflection on the phenomenon in reaction to which this concept has been created—namely, obstetric violence.

2.1.1 Medicalization of Birth

Biomedicine is a system that is founded on scientific principles, carried out by technology, and performed in healthcare institutions that are themselves based on ethics of patriarchy and supremacy (Davis-Floyd, 1987). Medicalization, and especially the impact it has had on women, has been the subject of a great deal of feminist scholarship. Conceived of as the process through which human conditions and problems pertaining to health and illness become defined as medical conditions and become the site of intervention.

When understood as a pathology requiring intervention as opposed to a normal physiological process prone to complications, pregnancy and childbirth both become prone to unnecessary intervention. Furthermore, intervention is viewed not only as the solution to existing problems but also as the preemptive measure to prevent problems from occurring. Ergo, within this conceptualization negligence is framed is now framed as the failure to intervene but not as the act of intervening unnecessarily, which is understood as being proactive and alert. As renowned natural childbirth activist Sheila Kitzinger describes it,

> "the first assumption made in medicalized birth is that our bodies are inherently flawed. They are likely to break down, so those managing them must be alert to forestall malfunction by obstetric interventions to make childbirth conform to a norm." (Kitzinger, 2006, p.29)

This conceptualization of necessary medical intervention as a means of preventing future problems leads to a vicious cycle in which the first medical intervention often creates a consequential problem that can only be solved by further medical intervention

and so on and so forth. A clear example of the complications that arise from using unnecessary medical interventions is the now commonplace use of fetal monitoring during labor. Initially this technology was designed to monitor the fetus' heartbeat during risky labor, but it has become standard practice to use this technology during early stages of most deliveries regardless of risk factor, effectively limiting the laboring woman's ability to manage her own body's processes as they are flattened to numbered readings on a screen. Furthermore, the actual equipment utilized to monitor the fetus's heartbeat limits the woman's ability to move freely as she is now connected to a machine, confining her to her hospital bed and impairing her from laboring in positions other than the supine, which is the most convenient position for obstetricians (Kitzinger, 2006).

Many scholars trace the beginning of the medicalization of birth to the introduction of pain-killing drugs into labor in the nineteenth century. The administration of this substances required trained professionals, making the hospital a more desirable option for giving birth. The use of these drugs—such as ether, nitrious oxide, and anesthesia—did help remove pain, but they also created passive bodies of women in labor, who were now left at the hands of a physician, who was most often a man. In essence, they were separating the woman from the labor. Scholar Adrienne Rich titled this phenomenon "alienated childbirth" and characterized it as "the lonelines, the sense of abandonment, of being imprisoned, powerless and depersonalized" (1995, pg. 176).

2.1.1a "Biopower" and "Authoritative Knowledge" within Childbirth

The discourse of biomedicine posits that its knowledge is objective and timeless, an argument that has made biomedicine—and in a more general sense science as a

whole—a reining authority in contemporary western society. The language of science is understood to be the ultimate discourse of truth. With the subsumption of birth into biomedicine, through the process of medicalization, birth is not subject to this ultimate discourse of truth. As the holders of this precious truth—this precious knowledge—physicians wield an enormous amount of authority—in the form of authoritative knowledge—over their patients (Foucault, 1975).

Foucault, and many other scholars, challenge this notion of timeless truth in science and argue that science, just as all other meaning making systems, is subject to its own historical context. Nonetheless, Foucault recognizes the very real power that such discourses carry. Trying to capture the power contained in this discourse, Foucault formulated the concept of biopower—a subtle mechanism through which the masses can be controlled, even in matters of literally life and death. This notion of biopower replaces the previous conceptualization of power, in the sense of a sovereign individual who has the capacity to order life or death. In the context of biomedicine, biopower is wielded in the form of medical authority. It is through this new, subtle manipulation of power that judgments of life, death, and health are delivered (Foucault, 1975). In the case of obstetrics, it is almost always a male obstetrician wielding this power and this authority over a female patient.

2.1.1b "Technological Model of Birth"

In her seminal text, "The Technological Model of Birth", medical anthropologist Robbie Davis-Floyd explores the paradigm through which childbirth is conceptualized in the western biomedical model of medicine. Directly contrasting what she coins as the "technological model of birth" with the "natural birth" model championed in the midwifery model of care—which is founded on the principles of providing woman-centered and community-based care in a partnership that takes into account the

individual wishes of each woman and her family—Davis-Floyd identifies a conceptual model that views women as essentially a machine that needs to be managed by a physician (Davis-Floyd, 1987). Now it is the physician, not the woman, who holds the ultimate authority in matters of birth. The woman is no longer the master of her own body—it is the obstetrician. Within this model, as the body is viewed a machine liable of breaking, childbirth is construed as an active matter that requires active involvement. According to this logic, the conceptualization of negligence expands to include the failure to intervene. However, the converse—interfering unnecessarily—is not construed as negligence, making unnecessary interventions in labor more and more common (Kitzinger, 2006).

2.1.2. Defining Obstetric Violence

As both a concept and a term, "obstetric violence" remains controversial, despite the fact that the prevalence of systematic violence being perpetrated against women during facility-based childbirth by healthcare professionals within the western biomedical model of medicine has been widely recognized by activists, scholars, and medical personnel alike (Vogel, Bohren, Tunçalp, Oladapo, & Gülmezoglu, 2015). As a consequence of the continuing controversy surrounding the term, it lacks a formally recognized definition. In this thesis, I will be working with a definition that I have created through combing various descriptions: physically and/or psychologically violent acts perpetrated by healthcare personnel against pregnant women and their fetuses/children during pregnancy and childbirth. In recent decades, there has been a growing recognition of the pervasive practice of obstetric violence during facility-based childbirth from activists and medical personnel alike. Concrete examples of patient mistreatment, found in reviewing 65 studies from 34 distinct countries, include: "experiences of physical, verbal, or sexual abuse, stigma and discrimination, failure to

meet professional standards of care, ineffective communication, lack of supportive care, detention in facilities, and extortion" (Vogel, Bohren, Tunçalp, Oladapo, & Gülmezoglu, 2015).

When discussing obstetric violence from a feminist perspective, however, there are a few key dimensions that must be considered including the link between gender and obstetric violence; the role of sexism, androcentrism, and authoritarianism within the medical field; and the power relations during childbirth. In her thorough analysis of the manifestation of obstetric violence in contemporary Spain, scholar Silvia Bellón Sánchez argues for understanding obstetric violence as the consequence of "an intersection of power relations related to gender, knowledge and class hierarchies in the struggles for ownership of legitimate knowledge and the management of health in the field of childbirth assistance" (Bellón Sánchez, 2014, p. 21). I would like to take Bellón Sánchez's conceptualization of the phenomenon a step further, contending that that obstetric violence is not merely the consequence of the intersection of gender, knowledge, and class but also race and ethnicity, building on the intersectional work of scholar bell hooks (2013).

In terms of the nomenclature used when discussing obstetric violence, many advocates for improving women's quality of care during childbirth—including specialists at the World Health Organization (WHO), the current authority on respectful birth practices—argue for the use of alternative terminology for the phenomenon, including "disrespect and abuse during childbirth", "dehumanized care", and "mistreatment of women during facility-based childbirth" (Vogel et al., 2015, p.2). At the heart of the contention with the term "obstetric violence" is a concern regarding the term's implications of intentionality on the part of the healthcare providers in perpetrating the violence. Such specialists contend that obstetric violence is most often

manifested as an omission of respectful practices rather than as an active execution of violence, and that terms such as "mistreatment of women during facility-based childbirth" more accurately reflect the nature of the phenomenon as it situates women's experiences at the center of the definition, removes connotations of intentionality on the part of medical personnel, and accounts for the context in which the violence occurs (Vogel et al., 2015). Despite recognizing the validity of these arguments for choosing alternative nomenclature, I have decided to use the term "obstetric violence" in this thesis with the intention of taking a victim-centered approach and placing their experiences at the forefront of the rhetoric.

However, despite the pervasive use of the concept of obstetric violence in both the academic discourse and in activist initiatives, "obstetric violence" as a formal legal term is only officially recognized in three nations: Venezuela, Argentina, and Mexico. The term first appeared in 2007 in Venezuela's "Organic Legal Text on the Right of Women to a Life Free of Violence", in which it was recognized as one of the 19 different types of violence possible to perpetrate against women. In the text, obstetric violence was defined as:

"the appropriation of the body and reproductive process of women by health personnel, which is expressed as dehumanized treatment, an abuse of medication, and to convert the natural processes into pathological ones, bringing with it loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting the quality of life of women." (Perez D'Gregorio, 2010, p.201)

2.2 Defining "Respectful Childbirth"

Within the popular discourse, respectful childbirth practices often get conflated with pro home birth arguments. While home births may certainly provide a viable

solution to the systemic violence pervasive in facility-based childbirths, respectful childbirth practices are just as applicable in the hospital as they are outside of it. Fundamentally underlying the respectful childcare movement is a desire to reframe pregnancy and childbirth from pathologies back to "normal physiological, social and cultural processes, prone to complications that can require prompt life-saving interventions (Tunçalp et al., 2015). In terms of concrete respectful childbirth practices, it is expected that both women and newborns recieve good quality care that is safe, effective, timely, efficient, equitable, and people-centered (Vogel, Bohren, Tunçalp, Oladapo, & Gülmezoglu, 2015). It is this understanding of birth that I will continue to rely on throughout the thesis, as it is perspective used by the informants of this research.

2.2.1 A Matter of Public Health—WHO Recommendations

The majority of literature dealing with respectful childbirth practices comes in the form of World Health Organization Recommendations, which are nonbinding guidelines issued by the world's leading international authority on public health and health policy. Since its development, the World Health Organization (WHO)—the subsidiary, specialized agency of the United Nations—has played an integral role in the development of public health policy related to childbirth, thanks in large part to its substantive quantity of high-quality evidence-based studies. Among the organization's first priorities were to improve maternal and child health, leading to the development of *Appropriate Technology for Birth*, a series of recommendations for improving women's quality of care during facility-based childbirth. The recommendations included: establishing specific policies regarding birth technology, performing surveys to evaluate the quality of healthcare delivery, providing information and obtaining informed consent from the pregnant woman, catering to the woman's preferred birthing style, ensuring access to a chosen family member during the birth and postnatal period, and

giving the laboring woman the right to decide any and all culturally sensitive birthing matters (World Health Organization, 1985).

The reduction of child mortality and the improvement of maternal health have continued to be among the organization's highest priorities and they were included in WHO's Millennium Development Goals—a collection of eight international development goals that the organization established in 2000 and wished to achieve by 2015. In its attempts to achieve this goal, however, WHO became aware of the extent of the systemic violence being perpetrated against women and realized that the issue required more focused attention. In 2014, WHO released a statement acknowledging the pervasive practices of mistreatment and abuse experienced by women during facility-based childbirth and recognized such practices as violations of their human rights. This statement, known as *The Prevention and Elimination of Disrespect and Abuse during Facility-Based Childbirth*, proclaims: "[e]very woman has the right to the highest attainable standard of health, which includes the right to dignified, respectful health care throughout pregnancy and childbirth" (World Health Organization, 2014). In addition to recognizing the need for respectful healthcare, the statement also expanded of the definition of quality of care, within the formal discourse, from merely striving for survival to one that emphasized dignity in its delivery. This expanded conceptualization of quality of care includes the following operational definitions:

- **safe**—delivering health care services that minimizes risks and harm to service users, including avoiding preventable injuries and reducing medical errors
- **effective**—providing services based on scientific and evidence-based knowledge
- **timely**—reducing delays in providing and receiving health care
- **efficient**—delivering health care services in a manner that maximizes resources and avoids waste

- **equitable**—delivering health care services that does not vary in quality because of personal characteristics such as gender, race, ethnicity, geographical location or socioeconomic status
- **people-centered**—providing health care services which take into account the preferences and aspirations of individual services users and the cultures of their communities (QUALITY, pg. 1045)

In more recent years, following the release of the *Prevention* statement, WHO's Department of Reproductive Health and Research (RHR) has undertaken a number of studies meant to address the continued disrespect and abuse perpetrated against women during facility-based childbirth and to provide recommendations for eliminating the abuse. These evidence-based studies have been instrumental in acknowledging the existence of such systematic violence, which in turn has been essential in the evolution of childbirth rights as a valid subsection of human rights and in the development of the Respectful Birth Movement (Tunçalp et al., 2015) (Vogel et al., 2015).

2.3 Childbirth Rights as Human Rights

As an integral component of reproduction, concern for maternal and infant health has been present within the human rights discourse since the Universal Declaration of Human Rights' (UDHR) ratification in 1948, which stated, "Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock shall enjoy the same social protection" (The United Nations, 1948, art. 25.1). However, despite this continued concern, all matters of human rights related to childbirth have continued to be subsumed under the category of reproductive rights, which is a very expansive category that also includes matters of abortion, birth control, sterilization and contraception, access to reproductive healthcare and sexual education, and protection from violent practices such as female genital mutilation. Often overshadowed in the popular discourse by other reproductive rights matters—such as

access to abortion and birth control—a woman's decision regarding how, where, and with whom to give birth is just as pertinent to the conceptualization of reproductive rights proponed by the Universal Declaration of Human Rights as her right to decide whether or not to become pregnant or to terminate or continue a pregnancy. In fact, as a formal subcategory, "childbirth rights"[5] remain unrecognized within the human rights discourse and without proper nomenclature it is difficult to perceive the gravity of the need for childbirth rights (McCartney, 2015). In the utilization of childbirth rights as a foundational concept in arguing against violence perpetrated against women within facility-based childbirth, the discourse's insufficient terminology, and therefore development, become apparent.

Despite the formal recognition of maternal and infant health in childbirth as a basic human right by the UDHR and the recognition of reproductive rights as a valid subcategory of human rights, maternal and infant mortality and morbidity continued to pose a significant risk for pregnant women well into the late twentieth century. It was determined that increasing access to skilled birth attendants and emergency obstetric care, when needed, would prevent the majority of maternal deaths around the world. In the context of the western biomedicine model of medicine, providing such care takes shape in encouraging women to deliver their babies at healthcare facilities under the supervision of an obstetrician. By the 1990s, the tragedy of preventable maternal deaths was framed as a violation of human rights because it was recognized that women have the right to survive childbirth (Erdman, 2015).

It was not until the beginning of the twenty-first century that the discourse surrounding human rights and childbirth changed from one focused purely on striving

[5] I use the tem "childbirth rights", as opposed to "birth rights", when referring to human rights pertaining to childbirth so as to avoid confusion with the common phrase that refers to a right or privilege bestowed upon a person by the nature of their birth.

for survival to one that sought to ensure quality of care for both mother and infant in a manner that surpassed technical competence to also include respectful and dignified care. Underlying this shift was not a change of priority but rather an expansion of the definition of "quality of care" to include measures such as "providing care which takes into account the preference and aspirations of individual service users and cultures of their communities" (Tunçalp et al., 2015, pg. 1045). This change in definition was instigated by the fact that despite increased access to healthcare facilities, women still continued to die in childbirth. International studies on the subject revealed that women were experiencing systematic violence at the hands of the healthcare facilities that they had been encouraged to use in order to improve their post-natal outcomes, and that the demeaning treatment they were receiving in these facilities was actually contributing to their poor post-natal outcome (World Health Organization, 2014). This realization of the impact of the delivery of care on women's health opened the door to expanding the conceptualization of healthy birth beyond one focused solely on the negative obligations of the healthcare providers—i.e. preventing death—to one that actively sought to promote dignity and respect (Erdman, 2015). It is through this latest lens of understanding childbirth rights as a subset of human rights that the respectful childbirth movement frames itself in Hungary.

2.3.1 Applying Human Rights to Facility-Based Childbirth

Despite the formal recognition of maternal and infant health in childbirth as a basic human right by the Universal Declaration of Human Rights, the development of the Convention on the Elimination of All Forms of Discrimination Against Women[6] to protect women from all types of discrimination, and the recognition of reproductive rights as a valid subcategory of human rights, maternal and infant mortality and

[6] CEDAW was created by the UN General Assembly and was officially adopted in 1979 (The United Nations, 1979)

morbidity continued to pose a significant risk for pregnant women well into the late twentieth century. It was determined that increasing access to skilled birth attendants and emergency obstetric care, when needed, would prevent the majority of maternal deaths around the world. In the context of the western biomedicine model of medicine, providing such care takes shape in encouraging women to deliver their babies at healthcare facilities under the supervision of an obstetrician. By the 1990s, this tragedy of preventable maternal deaths was framed as a violation of human rights as women were considered to have the right to survive childbirth (Erdman, 2015).

It was not until the beginning of the twenty-first century that the discourse surrounding human rights and childbirth changed from one focused purely on striving for survival to one that sought to ensure quality of care for both mother and infant in a manner that surpassed technical competence to also include respectful and dignified care. Underlying this shift was not a change of priority but rather an expansion of the definition of "quality of care". Despite increased access to healthcare facilities, women still continued to die in childbirth. International studies on the subject revealed that women were experiencing systematic violence at the hands of the healthcare facilities that they had been encouraged to utilize in order to improve their post-natal outcomes, and that this demeaning treatment was actually contributing to their poor post-natal outcome (World Health Organization, 2014). This realization of the impact of the delivery of care on women's health opened the door to expanding the conceptualization of healthy birth beyond one focused solely on the negative obligations of the healthcare providers—i.e. preventing death—to one that actively sought to promote dignity and respect (Erdman, 2015).

In a landmark case in 2011, the Brazilian state was found accountable by the UN Committee on the Elimination of Discrimination against Women in causing a

preventable maternal death. In the case of *Alyne da Silva Pimentel Teixeira v. Brazil*, an Afro-Brazilian woman of low socioeconomic status died at the age of 28 from obstetric complications after she failed to receive appropriate and timely access to adequate emergency medical care. The complications were caused by an intrauterine fetal death that had gone untreated. She had been refused care at a number of medical facilities when she ultimately passed away unattended in the hospital hallway (Erdman, 2015). The Brazilian State was found in violation of article 12 (2) of the CEDAW treaty, which "ensure[s] to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary" (The United Nations, 1979). Da Silva Pimentel Teixeira's case is illustrative of the systematic violence being perpetrated against women during institutionalized-birth on the basis of gender, race, and socioeconomic status and was essential in bringing these power dynamics to the forefront of social consciousness in the context of birth.

2.4 Defining "Feminist Organizations"

2.4.1 Self-Identification

For decades researchers have debated the importance of assigning labels to feminist research. For many feminist scholars, there is power in self-identification and simply attaching the label "feminist" to an organization that does not self-elect to use that label is counterproductive and arguably un-feminist. There has been a growing recognition within the Academy of many women's movements and organizations around the world that eschew the label "feminist", while nonetheless advancing a seemingly feminist agenda—i.e. contributing to the advancement of democracy, participating in civil society, and expanding local concepts of rights to apply to women (Moghadam, 2005). This rejection of the "feminist" tag is often contributed to a

widespread suspicion of feminism as a western concept, as was the case in Hungary (Funk, 1993). In an effort to account for both the feminist nature of the organizations and their desire to not adopt the label of "feminism" some scholars have suggested using the term "de facto feminism" to refer to these organizations (Ferree & Risman, 2001).

2.4.2 Defining Characteristics

In her article, "Rethinking Feminist Organizations", sociologist Patricia Yancey Martin provides a working definition for "feminist organizations." Taking the term apart into its two roots words, Yancey Martin claims that an "organization"—as opposed to a "group"—is simply an enduring collection of people that shares commonly recognized goals. In her definition of "feminism", she posits that, at its most basic level, it is the recognition that women are an oppressed group and that because of the discrimination they face as a systematically oppressed group they experience unique problems that the privileged group does not. Furthermore, she claims that feminism is inherently transformational because it imagines a vision of society—free from this oppression of women—that does not currently exist. The bottom line being, a feminist organization must be an organized and enduring pro-woman, political, and socially transformative collection of people working towards a common goal (Yancey Martin, 1990). In the context of this essay, it is this definition of feminist organization that I will be using when I refer to an organization as "feminist".

More significantly, in this same text Yancey Martin proposes a new set of criteria for defining feminist organizations. She challenges the notion of classifying feminist organizations according to a singular ideal, as-to-yet-be-achieved prototypic model in favor of adopting a criterion of ten various dimensions. In this way, she argues, it is possible to analyze feminist organizations through comparing them to other

social movement groups—both feminist and not—in order to see the true plurality within feminist organizations (Yancey Martin, 1990).

Yancey Martin identifies ten characteristic dimensions—which she chose based on her studies of already existing social movements—along which she claims that feminist organizations ought to be analyzed. According to her schema, successful identification with any of the first five dimensions is sufficient for qualification as a feminist organization. It is not necessary for an organization to successfully identify as feminist according to all five dimensions and does not become "more" or "less" feminist based on the quantity of qualifying feminist dimensions it exhibits. In this first group of dimensions, Yancey Martin includes feminist ideology (i.e. does the organization officially or unofficially endorse the tenets of feminism?), feminist values (i.e. does the organization emphasize the importance of feminist values, such as mutual caring, support, cooperation, empowerment personal growth, etc.?), feminist goals (i.e. does the organization have a recognized agenda aimed towards political change to improve the conditions of women?), feminist outcomes (i.e. do members of the organization transform, in terms of empowerment or self-assurance, as a result of belonging to the organization?), and founding circumstance (when was the organization founded and does it correspond with a women's movement?) (Yancey Martin, 1990).

The second set of five dimensions that Yancey Martin identifies features characteristics that are not unique to feminist organizations but do appear frequently in feminist literature as important elements to consider when creating feminist spaces. This set of dimensions includes structure (i.e. in what ways in the organization bureaucratically organized?), practices (i.e. what practices do the members perform in pursuit of their feminist goals?), members / membership (i.e. what requirements are there for membership?), scope and scale (i.e. is the organization local, national, or

international?), and external relations (i.e. how is the organization connected within its environment in terms of funding and legal status?).

Yancey Martin's set of criteria for identifying feminist organizations were clearly developed within the context of the hegemonic feminist movement of the United States—as can be ascertained by questioning whether or not the organization was founded during or in conjunction with the feminist movement. Nonetheless, I believe that her rubric of qualifications is nonetheless helpful in creating a framework for thinking about the various dimensions along which any organization could be classified as feminist. It is using this set of criteria that EMMA Hub, a pro childbirth rights organization in Budapest, Hungary, is analyzed in chapter 5 of this thesis.

2.5 Birth a Cause for Feminist Activism

As a subject for activism, childbirth has remained on the periphery of the feminist agenda. Often overshadowed in the popular discourse by topics such as access to abortion and birth control, a woman's decision regarding how, where, and with whom to give birth is just as pertinent to the conceptualization of reproductive rights proponed by the Universal Declaration of Human Rights as her right to decide whether or not to become pregnant or to terminate or continue a pregnancy. The particularities surrounding women's fight for quality of care during childbirth vary in each cultural context. In terms of Hungarian-specific activism, childbirth was not included on a supposedly comprehensive list of recognized clusters around which women's groups in Hungary have organized from 1989-2008. The recognized clusters for organizing women's activism were: anarchist, communist, conservative, charitable, environmental, ethnically based, Jewish, feminist, liberal, local, professional advocacy[7], service

[7] Amongst the cluster for professional advocacy, "health care" was recognized as a sub-cluster, which did include the National Confederation of Midwives (*Országos Bábaszövetség*) (Fábián, 2009, p. 306)

providers, social-democratic and socialist, women's parties, and women sections of political parties (Fábián, 2009). Following this discovery, it became a personal goal of mine, as the researcher, to highlight the ways in which the respectful childbirth movement in Hungary represents a legitimate cluster for activism and a force of dissonance against the systematic perpetration of violence against pregnant and laboring women.

Chapter 3. Methodology

"There are many tales of the field to be told" –John Van Maanen, organizational theorist (Reinharz, 1992, pg. 54)

It was a goal of mine, as the researcher, to produce quality feminist research in the form of this master's thesis. In an effort to accomplish that goal, I have dedicated an entire chapter of this work to making each step in the research process as transparent and intelligible to the reader as possible, including examining the methodology utilized in the collection, analysis, and presentation of data used in this essay. I also explore my own motivations, positionality, and objectives as the researcher in undertaking the topic of the respectful childbirth movement in Hungary as the subject for my thesis.

3.1 Defining a Feminist Methodology

My conceptualization of feminist research as comprising of a distinct epistemology, methodology and set of research methods derives from the definition outlined by sociologist Sharlene Hesse-Biber in her seminal text, *Handbook of Feminist Research: Theory and Praxis*. In this text, she highlights the key defining features of feminist research as: recognizing the validity of lived experiences as information sources, the utility of connecting research to praxis, the responsibility of using privileged platforms—such as membership in the increasingly exclusive realm of academia—for amplifying marginalized voices, and the importance of taking into account gender, race, and class (among other axes of oppression) in the creation of inclusive bodies of knowledge (Hesse-Biber, 2007). The inclusion of theories of intersectionality in the creation of this inclusive body of knowledge is essential to any truly feminist research project but it is particularly applicable in the analysis of the manifestation of a respectful childbirth movement in Hungary, where ethnic tensions deeply impact the quality of care that women receive during childbirth. The theory of

intersectionality asserts that patriarchal domination operates on various systems—not only according to the axis of sex but also with intersecting axes of race and social class, etc.—that serve to create structural dynamics of oppression, domination, and discrimination (Crenshaw, 1989).

In an effort to conduct truly methodologically feminist research in the development of this thesis, I seek to avoid perpetuating the monopoly of the androcentric values of positivism, objectivity, and neutrality in academic works—a claim that has been asserted by many feminist scholars (Haraway, 1988)(Harding, 1987)(Harding, 1995)—and to actively challenge the dominant academic epistemologies used to create recognized forms of knowledge by embracing both feminist standpoint theory and the concept of strong objectivity as guiding principles for this research. As an epistemology, feminist standpoint theory centers women's experiences as the point of departure for academic investigation (Harding, 1995)(Smith, 2003). In addition to recognizing the validity in women's experiences—which had previously been systematically disregarded as invalid sources of valuable knowledge (Hesse-Biber, 2007)—in the generation of recognized knowledge, strong objectivity calls into question the positionality of the researcher in the role of knowledge creation. Philosopher Sandra Harding argues that positionality can never truly be removed and that research will always be impacted by the lived experiences of the researcher (Harding, 1995). Through de-emphasizing the importance of supposed neutrality on the part of the researcher, strong objectivity seeks to emphasize the voices and experiences of those who are directly impacted by the matter under study. In order to abide by this epistemology and to remove any false claim to neutrality or objectivity in my work, I will make my motivations, positionality, and objectives as the investigator explicit in relation to this research.

3.2 Researcher's Motivations, Positionality, and Objectives

3.2.1 Motivations

I stumbled upon EMMA Hub, a pro childbirth rights organization that seemed to specialize in home birth, serendipitously during an Internet search for local NGOs in Budapest, Hungary. I was preparing to move there for the second year of my masters program in gender studies and I was hoping to become more involved in this new community. I had spent the last year living in Granada, Spain and, despite my high proficiency in Spanish, I had not felt comfortable volunteering in any meaningful capacity while I was there. I was used to being involved with many different organizations in my home community back in the United States and I was eager to throw myself back into a world outside of the ivory towers of Academia. I naively assumed that just because Budapest was a capital city that surely there must be English-speaking volunteer positions available. Despite my lack of Hungarian communication skills, Erika, the program director of EMMA Hub, kindly agreed to meet with me for lunch.

I was initially interested in volunteering with EMMA Hub because I had been intrigued by the idea of home birth for years but I had found it to be a very unapproachable topic. Despite the fact that the rhetoric surrounding home birth is so deeply associated with the same rhetoric of choice and reproduction that permeates feminist scholarship on the body, the subject of childbirth was never mentioned in any of women's and gender study courses. I saw the opportunity to volunteer with EMMA Hub as a unique way to both familiarize myself with home birth and expand the scope of my cultural experiences while living abroad.

Over a vegan lunch in early October, Erika recounted to me the history of the respectful childbirth movement in Hungry, the creation of EMMA Hub, the work the

organization has accomplished, and began to explain Hungary's particularly rich history with home birth activism. I was blown away by the depth of knowledge that she presented me with that day and I knew that I had to get involved with this organization. Unfortunately, my lack of Hungarian language skills ultimately prevented me from being able to engage in formal volunteer work with EMMA Hub, but our talk was so inspiring that I was drawn to pursue the respectful childbirth movement in Hungary as the focus of my master's thesis, with Erika agreeing to act as my key informant for the research.

The fact that I could physically access the community under study was also hugely influential in my decision to choose this particular topic. Having decided to pursue my masters degree at a university outside of my native country of the United States, I wanted to take advantage of the opportunity to perform research that would not have been available to me had I chosen to stay in the United States for graduate school. Undertaking ethnographic research in a country whose sociopolitical climate was unfamiliar to me and where I do not speak the local language was admittedly very challenging from a researcher's perspective, but it ultimately turned out to be a very rewarding experience.

3.2.2 Positionality

In recent decades, feminist scholars have striven to eliminate the binary opposition between "self" and "other" in ethnographic work in favor of using positionality, with its various axes, as a means of understanding difference (Lewin, 2006). There were certainly times when my positionality as a white, upper-middleclass, educated American woman who had never been pregnant nor given birth, and who has benefited from many axes of privilege, was directly challenged in the field. Most of my

informants were friendly and welcoming, but there were some who viewed me with apprehension and distrust and questioned my motives for engaging in this research.

As a researcher, I have most often engaged in works of auto-ethnography or in ethnographic research with communities in which I could not relate to the members' experiences on an intimate personal level. Without these sense of comradery with my informants, I frequently experienced feelings of imposter syndrome, in which I felt out of place and unqualified to be performing this type of research. These feelings were only further compounded by the fact that I do not speak Hungarian and that I oftentimes had to have minute anecdotes explained in great detail to me during the interviews since I simply lacked the necessary cultural capital to understand them in the moment. Simple references to significant events or well-known figures in Hungarian history would send me back to the library for yet another book or would require further clarification at the next interview. In attempting to face these obstacles in my research, I was forced to confront my own limitations as an investigator, which was both humbling and enlightening.

In terms of my positionality to the research subject, I identify as a feminist scholar and I do support the cause of EMMA Hub and the respectful childbirth movement in general. But because I do support these causes personally does not mean that I cannot be critical in my analysis of them. While I do not feign objectivity in research, I do strive to perform my research critically and with integrity.

3.2.3 Objectives

It was with the combination of Behar's assertion of "[c]all it sentimental, call it Victorian and nineteenth century, but I say that anthropology that doesn't break your heart just isn't worth doing anymore" (Behar, 1996)with Hesse-Biber's urging that it is the privileged's responsibility to use their platform for amplifying marginalized voices

(Hesse-Biber, 2007) ringing in my head that the topic of the respectful birth movement in Hungary resonated with me when it came time to choose the topic for my masters thesis. It was not simply the fact that obstetric violence is being perpetrated at an alarming rate in Hungary that broke my heart. It also the fact that there was so little recognition of childbirth rights or respectful childbirth practices as valid discourses even within the community of my well-educated and well-informed peers in a feminist graduate program in Budapest, let alone within the community at large. And while these circumstances did indeed break my heart, I was also filled with a sense of hope: despite all the obstacles, there was a group of people who were trying to challenge the system and to bring a sense of power back to the women of Hungary. It became my objective with this research to use my privileged voice as an American academic as a platform to bring attention to these issues and to amplify the voices of the people on the ground who are trying to make a difference in their community.

3.3 Data Collection Methods

Due the complex nexus that childbirth occupies at the intersection of private matter, reproductive rights, human rights, public health, State interest, national legislation, and international jurisdiction, the research methods undertaken for this thesis inherently required an interdisciplinary approach. The theoretical framework explored in chapter 2 incorporates literature from social sciences, legal studies—including legal texts and human right instruments, anthropology, and feminist studies to create as comprehensive a perspective on the issue as possible. I recognize that even in utilizing such an interdisciplinary approach, an exhaustive understanding of childbirth as a cultural event is beyond the scope of this thesis but I have strived to make this analysis as comprehensive as possible within the given constraints.

In addition to the vast scope of material pertinent to this research, collecting background information on the topic was further complicated by linguistic barriers. Most resources that deal explicitly with home birth or childbirth rights in Hungary are written in Hungarian and are not translated, as of yet, into English. This lack of accessibility severely impeded my ability to become familiar with the topic from a Hungary-centered approach, an obstacle that I tried to overcome in my other data collection methods—namely, through interviews and participant observation.

In decided which specific data collection methods to use in this research, I chose to use qualitative methods, which provide complex descriptions of how people experience and attribute meaning to research issues in their own lives (Yow, 2005). Furthermore, the specific research methods are essentially anthropological, utilizing participant observation and oral interviews as the primary data collection methods and ethnographic writing as the method for presenting the final analysis. This decision was deeply impacted by my own previous academic training in cultural anthropology and my familiarity with these research methods. In this data collection and presentation, I strove to emulate anthropologist Ruth Behar's model of vulnerable anthropology. Within this model, ethnographic research is understood as a form a witnessing that requires vulnerability on the part of the researcher—in both their research methods and writing style—in order to generate a vulnerable response in the participants and in the reader (Behar, 1996).

Due to temporal constraints, typical anthropological ethnographic data collection methods—including extended fieldwork and full immersion in the community under study—were not plausible for this particular research project. In order to adapt the research methods to the research timeline available for this particular project, I decided to concentrate my focus on oral interviews with members of the respectful childbirth

movement as the primary data collection method, supplemented by participant observation at selected events.

3.3.1 Participant Selection

Participants for the interviews were selected based on one criterion: their self-identified membership within the respectful childbirth movement in Hungary. The principal informant for this research, Erika, played a key role in identifying and approaching individuals who would be interested and willing to participate. It was largely through her connections within the Hungarian civil service sector that it was possible conduct interviews with such breadth of figures within the movement, including childbirth activists, human rights activists, NGO directors, doulas, midwives, and human rights lawyers. As oral interviews were the primary data collecting method utilized in this research, it was preferable for participants to be able to communicate in English.[8] However, English-speaking was not a requirement for participation. Furthermore, while there were no restrictions on the gender identity of the participants, only female-identifying informants participated in the interview portion. However, there were male obstetricians who presented at the community panel discussion on childbirth rights, although they did not attend the subsequent roundtable discussion that was used as participant observation in this research. There was, however, was one criterion that would make potential informants ineligible to participate in the research: being pregnant or having recently given birth. The exclusion of these groups was motivated by the belief that they represent a vulnerable community and that participating in such research

[8] I recognize that it is not ideal to have a researcher perform ethnographic research in a community where they do not speak the native language, in terms of both the power dynamics in conducting the interviews in the researcher's native language and the added layer of cultural translation that must take place when going between languages (Subeidi, 2006). If I were to continue in this line of investigation in the future, I would redouble my efforts to learn Hungarian.

might pose adverse risks for them, as outlined by the protocols of Central European University's Ethical Review Board.

3.3.2 Oral Interviews

As a qualitative research method, oral interviews are beneficial because they situate the researcher in direction conversation with the participants, allowing for "opportunities for clarification and discussion" that would otherwise not be possible in quantitative research methods (Reinharz, 1992). In total, I conduced five interviews: one group interview with four participants and four individual interviews, one of which was conducted in English with Erika acting as the Hungarian-English translator. Each interview lasted between one and three hours. Most took place in the EMMA Hub's conference room, but some took place in the interviewees' homes or personal offices.

In organizing the interviews, I opted for a semi-structured style, which creates a more natural, conversational flow as they rely more heavily on spontaneously asked questions rather than predetermined questions (Yow, 2005). The decision to use this style was motivated by a desire to make the research process as horizontal, in terms of power dynamics, as possible. Through allowing the participants to actively contribute to deciding the direction of the interview and therefore the research, the entire investigation becomes much more collaborative.

An essential part of conducting ethnographic research is building rapport with the members of the community under study (Yow, 2005) In the case of building rapport with my principal informant, Erika, I tried to spend additional one-on-one time with her outside of the interview context in order to have a more personal working relationship. Additionally, I would offer my services as a native English speaker for tasks that needed to be done around the organization. For example, I transcribed English translations of talks given at EMMA Hub events, reviewed the English-language material on their

website, and acted as a scribe during the two-day childbirth rights conference. At one point, it was even discussed that I would attend a data input training session in the United Kingdom on behalf of the organization, but ultimately that did not come to fruition.

Unfortunately, in many cases I met the participants for the first time at the time of the interview without having a chance to build a prior relationship with them. In an effort to make the informants feel as comfortable as possible, I would bring snacks to share—chocolate always proved to be the most popular choice. In addition to making participants feel physically comfortable during the interview, another essential component of building rapport is creating an open and trusting dynamic between the researcher and the interviewee (Yow, 2005). The most basic level to accomplish this is to be honest and straightforward with them about your research and your intentions. At the beginning of each interview, I would go over the informed consent form with the participants. I created the form in English and a Hungarian colleague from Central European University provided a translation of the form into Hungarian.[9] After explaining the research project and going over the procedures and conditions of participation, each participant was given two copies of the form to sign—one of which I kept for my records and the other was for their own records.

Each interview was recorded on my personal mobile device and was later transcribed on my personal computer. I was the only person to have access to both the audio recordings and to the typed transcriptions. In the informed consent forms, participants were asked for their permission to include the transcripts in the final product of this thesis. However, it was ultimately decided that due to the sensitive nature of the topic and the heightened tension surrounding NGOs in Hungary at the

[9] Copies of the both versions of the informed consent forms are included in the appendix of this thesis.

moment, it was in the participants' best interests if I did not include any transcripts in the final version of this thesis.

3.3.3 Participant Observation

In addition to conducting oral interviews, I also utilized participant observation—a qualitative research method in which the researcher actively engages alongside members of the community in activities rather than simply observing them from the sidelines. I attended a two-day childbirth rights conference in Budapest, Hungary as a guest of EMMA Hub, in which members of the pro childbirth rights community gathered from all over Europe. During the first day, I attended an informal lunch for all the out of town attendees, where I was introduced to some of the speakers and made connections with pro childbirth activists from Slovakia, Slovenia, Poland, and the Czech Republic. Later that evening, I attended the panel discussion and the subsequent cocktail hour. At this event, we were able to share some of our reflections from the talks we had just heard and to continue getting to know each other informally. On the second day, I attended a full-day workshop wherein all the guests who had been invited from out of town had a chance to sit informally with many of the speakers and create an open dialogue. It was expected that I actively participate in the discussion, which was an eye-opening and inspiring experience. It was thrilling to hear about all the work being done in other countries to combat obstetric violence—perhaps a topic for future research.

3.4 Analysis of Data

In analyzing the data collected in this research, I relied on grounded theory. Grounded theory propones for the theory to come from the data, rather than the vise versa (Yow, 2005). In practical terms, this means going into to field without a research question and developing the thesis as you go, according to what the findings show. In

order to translate the contents of the interviews and field notes into discernible data that could be analyzed, each interview was coded into various themes and topics. Themes were scaled in importance based on the amount of times they brought up, by the number of participants who engaged with the topic, and for how long it was talked about. Because the interviews themselves had been semi-structured, the topics that were brought up were often of the participants' volition, making the final product truly a collaborative effort. Ultimately, the data is presented in this thesis in the form of a general overview of the respectful childbirth movement in Hungary, as described by its own members, and an in-depth case study of a particular organization within that movement—EMMA Hub.

3.5 Presentation of Data

Feminist research does not only entail collecting data in accordance with feminist principles, but also presenting the results in a way that is accessible to as many people as possible (Reinharz, 1992). That is to say, this research is not meant to stay within the ivory tower of Academia. As such, I have striven to clearly explain all medical terms, include frequent citations, and incorporate footnotes with extra information wherever I can. My hope is that the text reads as accessible and supplies the reader with a plethora of backgrond information to help contexualize the data.

In deciding how to best present this research, I decided to present it via ethnographic writing, since it is advantageous from a feminist methodological perspective because it allows for the use of the participants' own words and voices in the creation of the research narrative (Reinharz, 1992). I also made a conscious decision as the researcher to highlight the active work that the members of the respectful childbirth movement in Hungary, including EMMA Hub, is accomplishing as opposed to placing the emphasis on obstetric violence itself. I wanted to leave the reader with a

sense of gravity of the situation but also with a sense of hope that there are ways to challenge systematic violence.

In addition to having a responsibility as the researcher to the readers and to the data itself, I also feel a deep sense of responsibility in treating the participants, who so generously gave of their time and knowledge in the creation of this research, with as much integrity as I share (Hesse-Biber, 2007). Part of that responsibility is accurately using their words in the sense that they were intended and with proper citation. Another aspect of that responsibility is to ensure to the best of my capabilties that no harm befalls my informants as a result of their particiaption in my research. During the research process, it became clear that participating in this research posed a greater threat to the participants than was originally anticipated as the government's campaign against NGOs continued to persist to new levels of hostility. My initial impressions of an expansive social movement did not reflect the reality of the situation and I quickly realized that providing too many personal details about any of my informants could lead to potentially risky consequences. As such, I have taken great care not to provide too many personal details about the informants in the hopes of protecting their privacy to the greatest extent possible. Some participants were fine with me using their real name,[10] while others have asked to keep their identities private, in which case I have assigned them a pseudonym. Regardless of their preference, they are all referred by first name only. Finally, in the spirit of recognizing how essential their contributions were to the successful completion of this research, all participants were offered a copy of the final thesis for their own records.

[10] I discussed the potential risks involved in using EMMA Hub's real name with Erika and in the end we decided to go ahead and use the organization's true name. For one thing, it would be nearly impossible to hide the organization's true identity in such a small community. Additionally, Erika felt it was prudent to use EMMA Hub as a proud example of a social movement organization.

Chapter 4. Respectful Childbirth Movement in Hungary

"Women's reproductive rights don't only encompass if or when a woman wants to give birth, but also, in what conditions she gives birth to a child: where she will do it, and who will be with her." – Pálma Fazakas, coordinator of EMMA Hub (Langowski, 2016)

The data presented in this chapter was collected during a series of interviews that took place over a nine month period with self-identifed members of the childbirth rights movement in Hungary, including childbirth activists, human rights activists, NGO directors, doulas, midwives, and human rights lawyers. What follows is a general overview of the respectful childbirth movement in Hungary, including its history, the most influential figures, and the top matters of concern identified by the members of the movement.

4.1 Beginning of a Movement

The early 1990s saw a proliferation of public attention being directed specifically towards matters related to childbirth in Hungary. This increased interest was attributed largely to the success of techniques that had been introduced to the medical field by the acclaimed obstetrician and midwife, Dr. Ágnes Geréb. She was the first obstetrician in the country to advocate for the inclusion of fathers during facility-based delivery, a recommendation that was received at the time with deep skepticism by the Hungarian medical community but is now accepted as common practice. Unquestionably her most well-recognized contribution to the Hungarian medical field is her fierce adovcacy for home birth as a valid and safe option for women with low-risk pregnancies. Originially trained as an obstetrician, Dr. Geréb worked for a number of years in a hospital in southeastern Hungary. One of the few women working in a very male-dominated profession, she grew frustrated by the quality of care the women were receiving during labor and by the way the midwives were treated within the hospital

setting, often being considered as nothing more than an obstetrician's assistant. She began to align herself more with her midwife colleagues and eventually, Dr. Geréb would receive her own certification in midwifery. Her interests in midwifery expanded to include attending home births, which were still not entirely legal in Hungary at the time. As her interest in home births grew, Dr. Geréb continued to expand her network of allies to an international scale, drawing more and more attention to the case of home birth in Hungary. In 1992, she organized an International Home Birth Conference in Szeged, Hungary, which was one of the largest home-birth related gatherings in history (Kitzinger, 2011). Despite the progress that Dr. Geréb seemed to be making for the home birth cause in Hungary, the tension was growing under the surface. Eventually, it all boiled over in 2010 (Harman & Wakeford, 2012).

4.1.1 A Mother and Her Midwife

The year 2010 is very significant in the story of the respectful childbirth movement—not only in Hungary but throughout the world—as two landmark cases went to trial that year. The first case involved the arrest of the world-renowned Hungarian obstetrician and midwife, Dr. Ágnes Geréb, who was accused of four crimes, including causing the death of an infant. The second case was that of Hungarian national Anna Ternovszky, who claimed that the State had violated her right to respect for privacy and family life, which was tried before the European Court of Human Rights (ECtHR). These court cases were mentioned in every single interview, at great length and in great detail. Throughout the research process, I have found that these two cases have played extremely influential roles in framing the contemporary respectful childbirth movement in Hungary as a matter of human rights. As such, these cases merit inclusion in this chapter. The two subsequent subsections recount the details of both cases. While the majority of the details surrounding the cases came up during the

ethnographic interviews, I have supplemented the data with information that I have gathered from legal documents, scholastic articles, and local and international news reports that covered the cases.

4.1.1a A Martyr for Home Birth

Dr. Ágnes Geréb has long been recognized as one of the foremost experts on childbirth in the world. Trained as both an obstetrician and a certified midwife, she has attended over 9,000 births—including over 3,500 home births (Harman & Wakeford, 2012) (Heathcote, 2012)(Kitzinger, 2011). Throughout her 32-year long career, Dr. Geréb has been a controversial figure in her native Hungary. Her most polarizing stance, however, is her fierce advocacy for home birth as a valid and safe option for women with low-risk pregnancies. Beginning in the 1990s and continuing throughout the 2000s, Dr. Geréb attended home births, a professional decision that carried incredible personal risk for her due to the fact that Hungarian legislation at the time was convuluted and unclear regarding the legality of home birth.[11] Her methods were unanimously denounced by the Hungarian Board of Gynecologists and Obstetricians—the governing body that at that time was and continues to this day to be comprised overwhelming by male members—who had already rejected home births in 2002 and again in 2007 on the unproven basis that they endangered the lives of women and children (Sándor, 2013).

In 2007, criminal proceedings were filed against Dr. Geréb following the death of an infant whose birth she had attended at home in 2000.[12] In the charges brought against her, Dr. Geréb was accused of malpractice, citing her unwillingness to perform

[11] According to contemporary legislation at the time, a woman may freely choose to give birth at home. However, any person who attended to a woman in childbirth at home was committing a criminal offense as per government decree 218/1999 (XII.28.) (Kitzinger, 2011)(Sándor, 2013).

[12] During this birth, the infant experienced shoulder dystocia—a medical condition in which one of the shoulders gets stuck in the birth canal. An ambulance was called but the infant tragically could not be resuscitated and ultimately passed away (Harman & Wakeford, 2012).

an episiotomy during childbirth as ultimately resulting in the infant's death. She was found guilty, and her license to practice medicine was revoked effective immediately for a period of five years, during which time she was banned from practicing as either a midwife or an obstetrician. Unable to legally provide medical care to women, she continued to offer her services to pregnant women through organizing educational courses at her birthing center, Napvilág Birthing Center. She continued in this capacity without further issue until 2010, when Dr. Géreb was arrested under charges for "negligent malpractice" after supervising a woman who went into preterm labor at one of her birthing classes.[13] Despite the fact that Dr. Geréb provided critical emergency care to this woman by catching the infant while waiting for the ambulance to arrive to transport the woman to the nearest hospital for immediate medical attention, she was nonetheless taken into custody. It was precisely because she had assisted in the delivery—despite still being without a proper license to practice medicine, a consequence of the malpractice charges from the 2007 case—that she was arrested (Kitzinger, 2011) (Sándor, 2013).

Following her arrest, there was an international outcry regarding not only her arrest—as many home birth supporters, including healthcare professionals, believed she had simply been doing her job—but also for the unprecedented severity with which Dr. Geréb was treated by the Hungarian authorities. She was held in maximum-security prison for 77 days and was subject to degrading treatment while she was held in detention. Conceding to international pressure, the Hungarian government eventually released Dr. Geréb on house arrest. The degradation did not stop, however, as she was

[13] According to Dr. Geréb's testimony, this woman had been discouraged from giving birth outside of the hospital and went into preterm labor at the birthing center, which evolved into a precipitous birth. Following the birth, the newborn developed difficulty breathing and an ambulance was called to attend to the infant. When the ambulance arrived on the scene, it was escorted by the police who had arrived to arrest Dr. Geréb (Bea, Personal Communication, April 20, 2017)

forced to appear in court in handcuffs and leg-irons—a protocol typically reserved for criminals facing more severe charges. In addition to the preterm labor case, Dr. Geréb was also tried in connection to with two previous home births she had attended, both of which ultimately resulted in infant fatalities.[14] In 2012, she was found guilty in all three cases and received a two-year sentence in minimum-security prison with a ten-year ban on practicing medicine, in addition to being prohibited from consulting pregnant women in any capacity and was obligated to pay the legal fees associated with her criminal case, a sum that amounted to more than 1.5 million Hungarian Forint[15] (Sándor, 2013).

Dr. Geréb remained on house arrest for years while her legal team attempted to appeal her earlier trials, claiming they had been mishandled. In February 2014, her sentence for house arrest was replaced with a restriction of movement order, limiting her to the immediate Budapest area. In 2015, the first of Dr. Geréb's retrials was held. Ultimately, the Budapest Court of Appeals upheld the ruling against Dr. Geréb in the case of the twins, citing specific protocol requiring that the birth of twins to take place in a hospital setting. In April 2017, a second retrial was held regarding one of the other cases from 2012. In this case, the court delivered a new judgment, finding Dr. Geréb not guilty of professional misconduct and her two-year prison sentence was reduced to a five-year suspended prison sentence and her professional ban was reduced from ten years to eight (Munk, 2017).

[14] One case involved the birth of twins in 2013, in which one of the infants passed away at six months old due to severe brain damage it had sustained during birth. The other case involved the birth of an infant who suffered severe complications during birth and passed away a few months later (Bea, Personal Communication, Aprll 20, 2017)

[15] Approximately 5,000 Euro.

4.1.1b Ternovszky v. Hungary

In 2010, a case was brought against Hungary to the European Court of Human Rights (ECtHR)[16] on the grounds that the State had violated the applicant's right to respect for privacy and family life—a right she was guaranteed under Article 8 of the European Convention of Human Rights (ECHR)[17]—due to the fact that she "could not benefit from adequate professional assistance for a home birth in view of the relevant Hungarian legislation" (*Case of Ternovszky v. Hungary*, 2010).[18] The applicant was Anna Ternovszky, a Hungarian national who was pregnant with her second child at the time of filing. Ternovszky intended to give birth to her second child at home with the assistance of Dr. Ágnes Geréb, just as she had with her first child. However, Dr. Geréb was unable to legally attend Ternovszky due to the fact that she was facing criminal charges and was unable to practice medicine at the time of the applicant's pregnancy. Given the high profile of Dr. Géreb's case and the intense scrutinity surrounding home birth in the Hungarian media at the time, Ternovszky was unable to find another midwife who was willing to attend her at her home. Ultimately, she used this circumstance as the basis for her claim that her human rights had been violated (Harman & Wakeford, 2012).

The relevant Hungarian legislation referred to in the charges was the very same legal inconsistency that allowed for Dr. Géreb's arrest. Namely, Ternovszky's legal

[16] The EctHR is a judicial body that was created to protect fundamental human rights as are guaranteed under the European Conventin on Human Rights (ECHR). All members states are contractually obligated to abide by the agreements set forth by hte ECHR and are legally bound by the EctHR's rulings. Furthermore, the EctHR is tasked with ensuring teh implementation and enforcement of the articles guaranteed under the ECHR and has the authority to determine compliance amongst member states and may even ask a member state to change its national laws in order to be found in accordance with the ECHR's articles (McCartney, 2015).

[17] The ECHR does not have any articles that explicitly deal with either reproductive rights or childbirth rights. In cases dealing with matters related to reproductive rights, violations of Article 8—the right to respect for privacy and family life—are most often cited (Eggermont, 2012).

[18] This legislation that the applicant was contesting was the same legislation that had been used against Dr. Geréb in her 2007 trial.

team decided to challenge the fact that at the time of filing, it was legal for women to choose to give birth at home in Hungary but it was illegal for any certified healthcare professional to attend a woman during a home birth per Government Decree no. 218/1999 (XII.28), which states: "any healthcare who rendered assistance in a home birth would become subject to legal sanctions" (Sándor, 2013, p. 124). Essentially, in order to be safely within the confines of the law, a woman either had to choose to give birth at home alone with no medical support or to give birth in a hospital under the supervision of an obstetrician. As a result of not being able to feasibly choose the give birth at home—as she was constitutionally permitted to do—Ternovszky asserted that there had been a violation of her right to privacy that she should be guaranteed according to Article 8 of the ECHR in conjunction with Article 14,[19] arguing that "the fact that [she] could not benefit from professional assistance for a home birth amount to discrimination in the enjoyment of [her] right to respect for private life." (McCartney, 2015, p. 370)

Ultimately, the court did rule in favor of the applicant and found that the State of Hungary had in fact violated her right to privacy,[20] and stipulated that new legislation regarding home birth—that was legally accessible and foreseeable—be implemented in Hungary. This ruling was seen as a major success by members of the respectful childbirth movement because it did spur the development of new legislation in Hungary to allow home births, albiet under very strict regulations. However, some were nonethless frustrated with the outcome of the case because the court neglected to impose a schema for positive obligations to be followed on the part of national governments to ensure access to home birth. Scholars like Caitlin McCartney point out that "a state's simple lack of interference with regard to a private right does not always

[19] Article 14 guarantees right to prohibition of discrimination (Council of Europe, 1950).
[20] Ultimatley, the ECtHR dismissed the Article 14 argument (McCartney, 2015).

ensure that citizens have a meaningful choice where that right is concerned" (2015, pg. 577). Furthermore, McCartney contended that the *Ternovszky v. Hungary* case would not have the desired internaional implications in guaranteeing the right to home birth because it was so not much a win for freedom of choice when it comes to home birth as it was a win based on sloppy legislation that in this case happened to benefit the applicant (McCartney, 2015).[21]

4.2 Key Players in the Respectful Childbirth Movement

4.2.1 Midwives

Midwives are not new figures in the story of birth in Hungary. In fact, it was not until the 1950s that facility-based childbirth was even the norm in Hungary. While the word "midwife" still tends to conjure up images related to the days when fundamentally all births took place at home, it is not inherent to the role of the a midwife that her/his services be utilized outside of the hospital setting. In fact, many midwives nowadays are hospital-based. However, within the facility-based context, which abides by the tenets of western biomedicine, midiwives, who had previously been the primary figures responsible for providing care to women and children during chidbirth, are now relegated to a position of a glorified nurse to the authoritative role of the obstetrician.

4.2.1a Midwives vs. "Med"wives

In Hungary, the professional capacity of a midwife working within the context of the western biomedical model of medicine is even more convoluted due to the fact that there is no separate medical training program designed specifically for them. Two

[21] This analysis of the implications of the *Ternovszky v. Hungary* case would prove accurate when two other cases dealing with home birth—*Dubská and Krejzová v. the Czech Republic*, and *Kosaité-Ĉypiené and others v. Lithuania*—were brought before the EctHR. In both of these cases the court found that there had been no violation adn that the State was not obligated to provide legal means for having a home birth because it was already clearly illegal in those countries (McCartney, 2015).

of the women who were interviewed—Émese and Mixi—were in the process of obtaining their midwife certifaction. When reflecting on their experiences in midwifery training courses, they both recounted the deep-seeded tensions that existed amongst the students in their own cohort, explaining that there are two distinct ways to be a midwife.

Colloquially, these two disparate groups are referred to as "medwives" and "midwives".[22] The defining difference between the two groups is that "midwives" continue to use the woman-centered approach to providing care, which is the traditional philosophy underlying midwifery, while "medwives" have developed as a hyrid that uses the term midwife but operates within the confines of biomedicine's structure.In practice, these differences appear in the way that the pregnant woman recieves care. In the case of the holistic, indepdent midwife, the pregnant woman would recieve care not only during her labor but also throughout her entire pregnancy and the postpartum period.

Despite the possiblity to clearly distinguish between the two groups at the linguistic level, confusion continues to ensue in the common discourse as facility-based midwives—who abide by the "medwife" philosophy on childbirth—have appropriated the title for tradtional midwife in Hungarian: bába. "A lot of people think they are just words.", explains Émese, one of the midwifer students, "They are not just words—they are your outlook on how you support birthing women." (Personal Communication, March 2, 2017).

Neither Émese nor Mixi felt comfortable divulging their own personal philosophies on childirth or their previous experiences as doulas with other members of

[22] In Hungarian, the distinction between these two philosophies of care exist at a linguistic level as each group has its own unique title. Respectively, the terms "szülészno" and "bába" are used to refer to either a medwife or a midwife who provides woman-centered care). When translated literally into the English, the term "szülészno" means "someone who makes you give birth." The term "bába" was used historically to refer to midwives before they were subsumed within the biomedical model, traditional independent. EMESE

their cohrt for fear of being identified as one of the "radical midwives". In fact, it was not until over a year into their training that they realized that they both self-identified as "midwives" (Émese, Personal Communication, March 2, 2017). Now in their second (¿) year of the program, 20 of the original 60 students remain. Of these students, Émese estimates that approximately one third of them identify as holistic, woman-cenetered midwives.

Prior to pursuing their degrees in midwifery, both Émese and Mixi had hands-on experiences with childbirth, including attending home births in the capacity as doulas, an experience that further isolated them from other members of their cohort who viewed home births as unsafe and irresponsible. When explaining why the decided to pursue this degree, Mixi explained, "I just realized that when I am present for a birth, this is a siutation when I really feel like I am in my place. That's it." (Personal Communication, March 2, 2017).

4.2.2 Doulas

Doulas, like midwives, are not unique to Hungary. Doulas are a birth companion who offers emotional support to the woman before, during, and after the birth. They are essential figures in woman-centered model of care because their role in the birth is solely to support the laboring woman. In Hungary, there is no formal acceditation process in order to become a doula. In most cases, doulas simply complete a course and obtain a certificate of attendance. When asked if they thought providing more formal training for doulas would be beneficial, Émese offered this insight, "Every woman is a doula. The less she's trained, the better, because the more you train them,… the idea of training is that you go there and you learn how to do something. But as a doula, you don't *do*—you *be*." (Personal Communication, March 2, 2017)

4.3 Matters of Concern

Throughout the interviews, various matters of concern were brought up and discussed at great length.These concerns varied from matters that were very Hungary-specific to matters that seem to impact all communities where obstetric violence is observed. I have selected three matters that were discussed the most frequently and the most passionately amongst participants: the absence of evidence-based care and disregard for established best practices, ingrained attitudes of authoritarianism and sexism, and the legal precarity facing doulas and midwives.[23]

4.3.1 Absence of Evidence-Based Care and Disregard for Established Best Practices

A desire to achieve the highest level of maternal and infant health lies at the root of maternal healthcare. As such, measurements such as perinatal morality and morbidity are crucial to the creating best practices grounded in evidence-based care. There have been numerous studies comparing perinatal mortality[24] rates in facility-based births against those of home births, the results of which indicate that there is ultimately no statistically significant difference between the rates. The same studies did find, however, that home births produced lower rates of epidural and analgesic usage, lower rate of induction and augmented labors, lower cesarean birth rates, and lower rates of episiotomies and instrumental deliveries (Kitzinger, 2011). As a country, Hungary …..

One such practice that is glaringly absent from the Hungarian healthcare system is the use of informed consent—the practice of obtaining permission from a patient to

[23] In the data collection process, I was surprised by the fact that informal payments, or "gratitude money" that is paid by the patient to the doctor as a way of ensuring good treatment, was not one of the most pressing matters of concern. In the supplemental reading I had done to prepare for the interviews, it seemed like it was an especially pertinent topic to facility-based childbirth. However, when I would ask about it in the interviews, the participants would answer my question but would quickly move on to another topic.

[24] According to the World Health Organization, the perinatal period begins at 22 completed weeks of gestation (154 days) and ends at seven completed days after birth. As such, perinatal mortality is defined as the number of stillbirths and deaths in the first week of life per 1,000 total births.

conduct a healthcare intervention after having disclosed the appropriate information regarding possibile consequences of and alternative methods to the said intervention. While I did not give birth in Hungary during my time there, I did experience the lack of informed consent firsthand when I went to the emergency room for a toenail injury. Upon arriving, it quickly became apparent that communication was going to be a problem as I do not speak Hungarian and no one on staff that day spoke English. In order to facilitate communication, the nurse found another patient in the hallway who spoke English to serve as our intermediary. At no point was I asked for my permission to include this random stranger in my medical visit. The visit continued in a similar manner as the nurse proceeded to poke and prod at my very painful injury without explaining what she was doing or what my options for treatment were. Ultiamtely, this lack of communication led to me leaving the hospital before my appointment was other, resulting in a very angry phone call to the university's health center and an embarrassing and frustrating return to the hospital the next day.

The seeming disregard for evidence-based care is especially frustrating for organizations like EMMA Hub, who conduct research in the hopes of providing evidence for new best practices. When asked to reflect on why it is that despite having one of the progressive patient rights laws in the world (Sándor, 2013), established best practices were not followed in the hospitals, Erzsébet stated that it was probably due, in part, to linguistics barriers. Hungarian is a very isolated language and is spoken by a very small portion of the world. Therefore, she argued, there aren't too many textbooks of any kind, let alone of progressive gynecology and obstetrics, that are being translated into Hungarian. In fact, she recalled seeing the medical textbook of a neighbor once—it was ten years out of date. Upon seeing my flabergasted face in response to this

comment, she simply shrugged and said that "such things were not uncommon here" (Personal Communication, March 2, 2017).

4.3.2 Ingrained Attitudes of Sexism and Authoritarianism

As has been explored in depth in the second chapter of this thesis, authoritarian sentiments, paternalistic attitudes, and sexism are all deeply entreched in the western biomedical model of medical. Obstetricians—who are mostly men in Hungary (Sándor, 2013) are recognized as verified experts within the biomedical system, and as such they wield great authority over women's bodies and their health. For example, there is a Hungarian law that stipulates that from 24 weeks of pregnancy until 24 hours following the birth of the child all women are stripped of their rights to refuse medical treatment becuase they are considered "out of their mind" (Kitzinger, 2011). In this case, the laboring woman is relegated to the status of a legal dependent and is unable to execute desicions on her own behalf. As another example, in 1972, a national law was passed mandating that all women must give birth in a hospital setting while being attended by an obstetrician (Kitzinger, 2011). Despite the fact that this law was in direct violation with the European Union Charter of Fundamental Rights and Freedoms—which guarantees women the right to choose where they give birth and protects the rights of midwives to work under the same conditions in all European Union countries. This law effectively stripped women of to the ability to choose who attended her during her birth.

However, it is not only on the part of healthcare providers that these attitudes are apparent—Hungarian women themselves seem to carry the deeply ingrained sense of sexism and authoritarianism that proliferates the western biomedical model of medicine. As victims of obstetric violence, women often report that they do not feel confident reporting episodes of violence that they experience at the hands of their healthcare providers, citing such reasons as not wanting to "draw attention to their negative

experiences", believing that they should simply "be happy that they have a healthy baby", and assuming "no one would care about their negative experiences" (Judit, Personal Communication, April 20, 2017).

These ingrained attitudes of sexism and authoritarianism are especially apparent in childbirths that involve Roma women. These women are disadvantaged not only according to sex, but also to ethnicity and socioeconomic status. As such, they are in a very vulnerable situation and are all too often taken advantage when they enter a hospital in order to give birth.[25] Judit, a Roma rights activist and member of the respectful childbirth movement, recalls visiting a rural Roma village simply with the purpose of listening to women's stories from childbirth in an effort to build rapport with the community. To Judit's surprise, she spent the entire day listening to women's horror stories from when they gave birth. For many of these women, it was the first time that they had told anyone what happened to them: "they were reluctant to talk at first, because they were ashamed. The doctors made them feel ashamed for coming back, for having more children." Some women even reported having forced sterlizations while they were in the hopsital and not becoming aware of it until years later when they could not get pregnant. Judit went on to explain, "[t]hese weren't the sort of things that they were supposed to talk about. They did not think anyone would ever care so they never told anyone before" (Judit, Personal Communication, April 20, 2017). For these women, it was an expectation that they were going to be stripped of their dignity during childbirth, at the hands of the medical providers who were supposed to be helping them.

[25] There have been many studies done on the epidemic of non-elective sterilizations that Roma women are forced to undergo when they give birth in hospitals. Unfortunately, it is beyond the scope of this thesis to go into more detail on the subject here.

4.3.3 Legal Precarity for Midwives and Doulas

All informants expressed a deep concern for the precarious legal status of midwives and doulas in Hungary. For midwives in Hungary who choose to practice independently outside of the hospital, the decision carries significant personal and professional risk. While home births are now legal under certain conditions, which include the midwife being properly registered and certified, adverse birth outcomes can still bring severe legal consequences for the attending midwives due to the fact that they are tried in criminal court. Obstetricians, on the other hand, in most cases, are subject to internal investigations for malpractice in the case of adverse outcomes in birth. Many activists have argued that the stakes are too high for the midwives in these cases, but without a formal regulating body there does not seem to be an available alternative (Émese, Personal Communication, March 2, 2017) (Erzsebét, Personal Communication, March 2, 2017).

In an effort to extend more security to midwives, WHO recommends that midwifery be formally recognized as a profession and that it be regulated, suggesting the following measures to accomplish this task: "setting standards for entry to the occupation or profession; ensuring, as much as possible, the maintenance of standards; providing a mechanism for dealing with professional misconduct; [and] maintaining an effective public register of all those eligible to practice" (McCartney, 2015). Erzsébet, one of the participants in the group interview, sees the validity in the suggestion of regulating midwifery, but she also sees another side to the problem:

"[w]hatever you do, it is going to have bad consequences. Because if you regulated [the doula role] then you have to follow, you know, the framework and then it omits freedom—freedom of doulas, freedom of mothers. If they do not regulate it, then he doula takes the risk. And this is not a country where you be sure not …where there is

an absence of such a risk around birthing" (Erzsébet, Personal Communication, March 2, 2017).

Just as independent midwives face significant personal risk for deciding to operate outside the hospital setting, so too do doulas face serious personal risk, especially in the case of adverse outcomes, due to the legal precarity of their own role in the birthing process. While "doula" is not recognized as a formal profession in Hungary, it is still unclear as to whether or not they ought to be considered healthcare providers. At the heart of this controversy is the fact that doulas are physically present during childbirth and oftentimes are providing instructions to the laboring woman. When discussing the legal precarity facing doulas, Erzsébet explains, "[e]ven being there [at the birth] and not calling an ambulance could be considered a felony" (Erzsébet, Personal Communication, March 2, 2017). The severity of the situation was palpable during the interviews; some participants were either hesitant to acknowledge their status as doulas and some even outright refused to answer the question when asked on tape if they had ever worked as a doula.

The legal precarity of doulas is exasperated by the at-time tense relationship between midwives and doulas. Midwives—especially "medwives" who do not develop relationships with patients before the birth—often state that they feel resentful towards the doulas, who have closer relationships with patients. These midwives also state that they often feel unneeded or under valued when doulas are present at births they are attending. Such tensions can lead to workplace hostilities, which in turn cause poor working relationships between the stakeholders, something that is essential for the wellbeing of the patient (Émese, Personl Communication, March 2, 2017).

Chapter 5. Case Study: EMMA Hub

EMMA Hub is a local pro childbirth rights organization in Budapest, Hungary. Seeking to fill a void in contemporary Hungary's civil society, for the past two decades EMMA Hub has championed for women's fundamental rights to dispose freely and responsibly over the full spectrum of of matters pertaining to their sexual and reproductive health by advocating for women to be able to exercise these rights free of coercion, discrimination, or violence ("EMMA Egyesület," 2017). The story of how EMMA Hub's came to be and how it developed into what it has become is deeply entwined with the stories of two key figures in Hungary's history with childbirth rights, Dr. Ágnes Geréb and Anna Ternovszky, whose court cases were examined in great detail in the previous chapter. I have chosen to highlight EMMA Hub in this chapter because I believe that it is more than just a grassroots organization—it is network, a means for creating dialogue between individual members of the community and a concrete example of transformational change taking place. At the conclusion of this chapter, I have included a brief reflection on EMMA Hub's relationship to feminism, using four of the defining characteristics established by sholar Patricia Yancey Martin in her work on feminist organizations.

5.1 History of EMMA Hub

5.1.1 Origins

EMMA Hub: Women's Association for Birth Rights in Hungary was founded in 1995 by Dr. Ágnes Geréb and her fellow midwives and doulas as a part of Dr. Geréb's efforts to bring home birth out of the margins and into the public discourse. The founders of EMMA Hub realized that all too often women seek "most women realize the potential for birth after a negative birthing experience….How could we avoid this negative experience? And that many women experience the facts that birth matters

when they have experience a negative experience" and decided to create a place where women could go to gain this information. This place would become EMMA Hub (Erika, Personal Communication, February 28, 2017).

The organization was established with the purpose of increasing public knowledge about the merits of home birth and educating women on their right to choose home birth, as was legally available to them by law. In fact, this initial goal is reflected in the organization's original name, *Születesház,* which translates directly to "birth house"[26] in Hungarian. At this time, Hungarian legislation was vague and unclear reagrding the legality of home births as it was not explicitlity prohibited for women to choose to give birth at home but it was illegal for medical professionals, including midwives, to attend women outside of the hospital setting. (Erika, Personal Communication, February 28, 2017).

The first service EMMA Hub provided was the EMMA Helpline. Clients could call the line and get any information they needed about home birth. The helpline was successful, but it quickly became apparent that there was a much greater need in the community they were serving for services related to facility-based births. Women were experiencing violence at the hands of their healthcare providers and did not have a support system to help them process their experiences or a safe place to voice their concerns regarding their traumatic experiences during childbirth. In order to meet this need, EMMA Hub created a legal advocacy system. This new program was meant for new parents who had questions or who needed help. For example, registering their infants after they were born at home and were therefore not included in the State's registry of newborns. However, the program was also intended for midwives and other

[26] The term "birth house" was used by Dr. Geréb to refer to an independent institution that provides home birth care; similar to a "birthing center", a home-like facility that exists in many countries as an alternative to hospital or facility-based birth (Schmidt, Personal Communication, February 28, 2017).

healthcare professionals who were interested in home birth and might perhaps need legal counsel were they to decide to attend a home birth ("EMMA Egyesület," 2017) (Erika, Personal Communication, February 28, 2017).

However, it was not until 2010, when Hungary found itself at the center of international attention for its stances on home birth, that Születesház became truly active as an association. During the first half of the year, the organization increased the services it was offering its clients by launchign a legal aid service for both parents and medical professionals who opted for home birth. EMMA Hub also began to carry out sociological research regarding home birth in Hungary. The aim of this research was to obtain hard evidence regarding the safety of home birth in order to encourage a change in legislation (Erika, Personal Communication, February 28, 2017). It was the second half of the year, however, when Dr. Ágnes Geréb was arrested and Anna Ternovszky brought her case to the European Court for Human Rights that EMMA Hub's new chapter officially begun.

5.1.2 Aftermath of *Ternovszky*

EMMA Hub was very active in both Dr. Geréb's cause and the *Ternovszky* case for the getgo. As the founder of the organization, Dr. Gerén held a special place in the EMMA Hub family—after all, she had been the powerhouse behind the home birth movement. Immediately following Dr. Geréb's arrest, EMMA Hub joined with other pro childbirth rights organizations and groups of local parents who supported Dr. Geréb's work to create a huge internationl campaign in favor of her release. For a time, the organizaion also provided legal support to Dr. Geréb and her team but the cases drew on and it eventually became too much work (Bea, Personal Communication, April 20, 2017).

It was successful ruling in favor of Ternovszky, however, that signaled the real period of significant change for EMMA Hub. Hungary was now in at the center of international media attention surrounding home birth and EMMA Hub was continuously being contacted by other pro childbirth rights orginizations in other countries to share strategies and advice.

There was another big change following the successful ruling in favor of the applicant: there were significant change made to the Hungarian legislation regarding home birth. As a direct consequence of the *Ternovszky* ruling, Government Decree no. 35/2011 was passed in 2011, which established a legal framework for home births in Hungary. Under this law, which came into effective in March 2012, for-profit companies are able to receive permission to lead home births. The original legislation was very restrictive, but it did get ammended and the first independent midwife opened her business in 2012.

As EMMA Hub adjusted to its new role in the international childbirth rights community, the members realized that their organization's name needed to reflect the more expansive resources they were offering, rather than just information about home birth. These new services included a roma outreach program, which brought EMMA team members to rural Roma villages to the hopes of taking the first step towards equal access to respectul maternity care, and the socialogical research the organization had undertaken in conjucntion with local obstetricians. Eventually, they decided to change the name to EMMA Hub. When asked about name change, Pálma explains, "[i]n 2016 we changed our name to EMMA non-profit association. EMMA [a common female name] stands for us, you and me, everyone in Hungary who is in any way connected to giving birth, being born, and obstetrics more generally" (Langowski, 2016).

5.2 Challenges Facing EMMA Hub

Among the most pressing challenges currently facing EMMA Hub is obtaining sufficient funding to continue offering its services to the public. As an NGO, EMMA Hub receives its funding from donations, grants and foundations. Historically, the organization has received the vast majority of its funding from international sources, such as the Norwegian Grants program, but following basing funding on grants is unreliable for longterm planning.[27] This year, 2017, marked the first time that they had received any funding from the national NGO fund in Hungary (Erika, Personal Communication, February 28, 2017).

Compounding an already difficult financial situation, new legislation has been passed this year, in the spring of 2017, that is targeting foreign-funded NGOs because the majority of such organizations receive funding from the Open Society Foundation, an international grant-making network that was founded by Hungarian-American philanthropist billionaire George Soros. Soros is renowned for his support of American progressive and liberal political causes. As such, many of the organizations who receive funding from his foundation also reflect similar values in their work and inherently represent dissenting voices against the current Hungarian government's conservative political views. The Hungarian government—headed by Prime Minister Viktor Orbán of the Fidesz political party—does provide financing for some NGOs, but only to NGOs

[27] For many years, EMMA Hub received almost all of its funding from the Norwegian Grants, an agreement between the European Union and Norway, Iceland and Lichtenstein with the purpose of funding projects in European countries with less developed economies. At the time, this organization was funding basically all of the Hungary civil society, including organizations that challenged the conservative Hungarian government. In 2014, the Hungarian government launched a criminal investigation into various civil NGOs who were receiving funding from this international organization. Following the investigation, the Hungarian government claimed that this Norwegian organization was funding NGOs that were not politically neutral and, therefore, that the Norwegian government was attempting to influence Hungarian politics. This incident initiated a hostile smear campaign against Hungarian NGOs, labeling them as enemies of the state who serve international interests over State interests, and can be seen as the forerunner to the new legislation passed in the spring of 2017 targeting Hungarian NGOs that receive foreign funding (Dunai & Koranyi, 2014)(Erika, Personal Communication, February 28, 2017).

that support the government's political agenda. In effect, this division has created two competing civil society sectors. ("Hungary submits bill targeting NGOs," 2017)(Serhan, 2017).

The financial situation for EMMA Hub has gotten so dire in recent years that they have had to cut services, including their research endeavors and much of their educational programming in rural Roma communities. As of now, the only plan of action is to continue applying for foreign grants, in the hopes of being able to offer all their services again (Erika, Personal Communication, February 28, 2017).

5.3 Relationship to Feminism

When the topic of feminism was brought up in the interviews, it always elicited an interesting response. In the first interview—which was conducted with Erika, the principcal informant for this research—I naively assumed that feminism played a central role in the organizing structure of EMMA Hub. When I asked about which feminist theorists were particularly influential in designing EMMA Hub's mission, I was shocked by the reaction I received. Erika was hesitant about aligning the organization with feminsim in any direct way, confessing "I am not sure what feminims means…if we are saying that feminism is simply the belief that men and women are equal then yes, I suppose EMMA is feminist" (Erika, Personal Communication, February 28, 2017). At the time of that interview I did not understand Hungary's tense relationship with feminsm and with its own women's movement but I became fascinated with this complicated relatinoship between an organization that to me seemed so clearly feminist in its goals and structures yet did not embrace this label.

I got some clairty on the issue when I asked other informants about any relationship that they saw between feminism and the work they did as midwives and feminsm:

Mixi: "In my view, yes, it is absolutely a feminist issue. My experience in Hungary is that first it was when Ágnes Géreb was arrested—in this period the Hungarian feminist movement, if we can say that, realized that birth was a feminist issue and at this time, so it's around 2010. In my experience, the birth movement wasn't absolutely open on this issue, it wasn't interested in this issue but now, which is…"

Erika (interrupting): "You mean 2010? Neither the movement nor the midwives were interested, so they not interested in feminism?"

Mixi: "Yeah, I mean, the mass of these families who supported Ágnes…"

Erika (interrupting): "I completely agree."

Mixi: "Yeah, but now just three days ago there was an article…so now very often we experience that the feminist movement doesn't count us in [laughs]. There was an article three days ago about the International Women's Day—what should we reclaim—and there was a longer paragraph about reproductive rights and, I don't know, maybe six or seven subjects and birth wasn't there. So I think if we ask the question, they would say yes, it is a feminist issue but it is not integrated in their minds" (Personal Commnication, March 2, 2017).

Given Hungary's terse history with feminism, it is not all together surprising that EMMA Hub has been resistant to embracing the feminist label for its organization. Upon closer review, however, it becomes clear that many aspects of EMMA Hub's organizational structure do seem to fall in line with the definition of "feminist organization" put forth by scholar Patricia Yancey Martin: an organized and enduring pro-woman, political, and socially transformative collection of people working towards a common goal (Yancey Martin, 1990). In the following section I analyze EMMA Hub according to Yancey Martin's rubric for "feminist organizations." While it would be

interesting to go through all ten points of Yancey Martin's criteria, that is simply beyond the scope of this thesis. As such, I have selected four dimensions—two from her first set and two from her second set—by which to analyze Emma Hub's possible qualifications as a "feminist organization."

While her criteria for identifying feminist organizations was designed with organizations created within a western, capitalist country—like the United States—in mind, I still believe that the rubric she has laid out is still very useful for framing the way feminist scholars think about the organizations participating in respectful chidbirth movements—as is exemplified in the case of EMMA Hub for the purposes of this essay. My interest in analyzing EMMA Hub in this way is not to assert that it is in fact a feminist organization or that it is not. Rather, my interest and my intention lie in wanting to expand and complicate the conversation to include as many voices and representatives as possible.

5.3.1 Feminist Outcomes

When I asked Erika what she saw as the primary goal for the training for EMMA Hub volunteers, I was surprised by her answer. I expected her to list the key phrases any volunteer should know to help a caller on the hotline or advice for how to best manage a distraught client on the phone. Instead, Erika's response was that her greatest priority in the training was for the volunteer "to learn about herself" (Erika, Personal Communication, February 28, 2017). She explained—

> "We did the normal rounds—asking, 'how are you? what is in your head?'—and one woman said she was good because last evening she told to her family that service was over. And she's very happy to give them dinner, to cook them dinner, to have sex with her partner, to take care of her children as a free woman. But service, providing service for the family is over. And I just love this

sentence so much. And I said, 'ok, wow this is what EMMA Hub is about.' " (Erika, Personal Communication, February 28, 2017).

5.3.2 Founding Circumstances

According to Martin's criteria for identifying a social organization as feminist based on the dimension of its founding circumstance, the organization must have been established during a woman's movement. Given Hungary's terse history with feminism and the lack of a centralized woman's movement, it would appear that EMMA Hub would not qualify as "feminist" based on this criterion. However, I would argue that EMMA Hub's founding circumstances were essentially feminist in that the organization's founder, Dr. Geréb was inspired by a series of pro home birth collective actions to create her own transformational organization in Budapest.

5.3.3 Structure

It is one of EMMA Hub's explicit goals to create as safe an environment for everyone who uses their services—including volunteers—as possible. While this philosophy clearly abides by the feminist structural tenets as established in Yancey Martin's text, that does not necsesarily mean that these efforts are well-received by the volunteers themselves.

The trainings were designed to provide the volunteers with information about childbirth rights and obstetric violence, and to teach them how to effectively communicate with clients who called the helpline. That is, the goal of the trainings was to teach these volunteers how to treat women who have experienced trauma as competent individuals who are capable of making informed decisions about their own health and welfare. In addition to teaching the volunteers to recognize these attributes within the clients, the training also sought to instill these values in the volunteers themselves. It is part of EMMA's volunteer policy to recognize that each volunteer is a

fully capable, independent agent and that she be allowed to choose when to volunteer, as it suits her. As Erika explains, "[w]e want the volunteers to feel empowered in their work with EMMA Hub. If they cannot decide to stay home and take care of their sick child when they need do, how can they feel empowered?" (Erika, Personal Communication, February 28, 2017).

This method of treating volunteers with a great deal of autonomy, which was meant to show a mutual respect from the perspective of the organizers, caused some problems with the volunteers who were not accustomed to so much freedom and found it difficult to cope this level of autonomy. Volunteers reported frustration about not having more supervision and some even said that they felt useless because if they "weren't being policed, surely they weren't doing anything important" (Erika, Personal Communication, February 28, 2017).

5.3.4 External Relations

One of the EMMA Hub's greatest priorities as an organization is facilitating open communication between all stakeholders involved in childbirth, including healthcare providers, policy makers, politicians, and patients. Erika states that she firmly believes that it is necessary to get everyone on the same team in order to see real change happen at a meaningful level. It is in this spirit of inclusion that EMMA Hub always extends invitations to obstetricians to participate in their community panels, including the childbirth rights conference that took place in Budapest in March 2017 (Erika, Personal Communication, February 28, 2017).

The favors are not always returned in kind, however. During our interview, Erika lamented how frustrating it was to work with these various stakeholders. She recounted hours spent with hospital personnel making educational pamphlets about respectful childbirth practices only to find them suspiciously absent from the patients'

bags. She also described the frustrating circumstances surrounding NGO funding and organizing. The week before our interview there had been a large exposition held in Budapest for NGOs. EMMA Hub, whose mission does not sit well with the current conservative Hungarian government, had not been invited (Erika, Personal Communication, February 28, 2017).

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Conclusion

Despite the fact that EMMA Hub does not self-identify as a feminist organization, when analyzed through the framework laid out by scholar Patricia Yancey Martin it does appear to qualify as a "feminist organization" on a number dimensions that she has identified. Some scholars, including Ferree and Risman, would argue that EMMA Hub ought to called a "de facto feminist" organization. Ultimatley, my opinion, the importance in EMMA Hub's work does not rest in its categorization as either feminist, de facto feminist, or none of the above. What matters is that it is advancing the feminist cause as an organized and enduring pro-woman, political, and socially transformative collection of people working towards a common goal—respectful, woman-centered care for mothers.

Suggestions for Future Research and Concluding Remarks

I see this work as, hopefully, the first of many feminist projects to tackle the topic of respectful childbirth movements. There is still much scholarship to be done on the movement in Hungary, but the conversations surrounding obstetric violence and respectful birth practices must continue to be expanded as new movements and perspectives are brought into dialogue with one another.

There are a number of voices that were not featured in this particular analysis but that nonetheless deserve to be included in the discussion about respectful childbirth in Hungary. I had initially been planned to engage in more vigorous participant observation, including traveling with Erika to villages outside of Budapest to help with educational workshops for women in Roma communities and to expand the participants to include obstetricians and even an interview with Dr. Ágnes Geréb herself was discussed at one point. Unfortunately, as is always the risk when conducting ethnographic research, these opportunities did not come to fruition and I had to adjust the research plan to fit the data I was able to collect.

In regards to the informants who did participate in the research, there was admittedly little diversity in terms of gender identity and race. All eight informants who participated in the interviews were white, Hungarian females. I did not include any surveys in my research, so I cannot speak to any other biographic features of the participants—such as socioeconomic status—but it is clear that more diversity amongst the participants would create a more comprehensive overview of the movement.

The inclusion of a more detailed and thorough analysis of how Roma women are impacted by obstetric violence and how they interact with the respectful childbirth movement was unfortunately beyond the scope of this project, but it is a pressing issue that merits further scholarship.

In a more ambitious research project, it would be very exciting to include the voices and experiences of pregnant women and women who had recently given birth in the conversation. Unfortunately, due to ethical considerations regarding this group's increased vulnerability no such participants were included in the data collection process for this research. The perspectives and experiences of these women who have experienced childbirth firsthand are undoubtedly essential to further expanding the conversations regarding obstetric violence and respectful childbirth practices in Hungary and I recommend that future research be pursued that would include their voices and insights on the matter.

Despite the proximity of motherhood to the subject of birth, the topic of motherhood was never mentioned in any of the interviews, including in discussions regarding the participants' motivations for getting involved with the respectful childbirth movement. In part, I did not approach this topic during the interviews because I wanted to avoid placing myself in any ethically ambiguous situations but also because I simply did not feel that I had built enough rapport with this community, in the short amount of time that I was working with them, to ask about such intimate and personal experiences.

In terms of pragmatics for conducting this type of research, I would also suggest that this line of investigation by undertaken in the future by a researcher who is more familiar with the particularities of the Hungarian context or at least with the Hungarian language. I have used my positionality as a outsider to the best of my capabilities, but I do believe that more nuanced research could be achieved if the research had access to both Hungarian-language literature and more tacit cultural knowledge.

Finally, as this essay is genuinely one of the first English-language academic works to analyze the respectful childbirth movement in Hungary, I could not go into as

much specific detail as I would have liked. Any of the themes explored in this thesis—including the matters of concern identified by the members of the movement themselves—are substantial enough topics in their own rights to merit more in-depth analyses, a task that is simply beyond the scope of this master's thesis. The aim of this particular investigation was to provide an introductory framework for understanding the particularities of the manifestation of a respectful childbirth movement in Hungary and I hope that future researchers will pick up where I have left off.

This particular chapter of the respectful childbirth movement in Hungary has had ample dimensions for analyzing including the controversial figure of Dr. Ágnes Geréb, Ternovszky's successful case against the Hungarian government, the creation of home birth legislation, and the governent smear campaigns against NGOs like EMMA Hub. There is plenty still left to uncover, especially considering when Erika's final remarks at the end of our last group interivew, "I think [Émese and Mixi] will be the first generation of midwives [in Hungary] who have a feminist approach to birth. Really" (Erika, Personal Communication, March 3, 2017).

References

Arpad, S. S., & Marinovich, S. (1995). Why Hasn't There Been a Strong Women's Movement in Hungary? *Journal of Popular Culture, 29*(2), 77–96.

Bea. (2017a, April 20). Personal Communication [In Person].

Behar, R. (1996). *The Vulnerable Observer: Anthropology that Breaks Your Heart*. Boston, MA, USA: Beacon Press.

Bellón Sánchez, S. (2014, August). *Obstetric Violence: Medicalization, Authority Abuse and Sexism within Spanish Obstetric Assistance*. Utrecht University; University of Granada, Utrecht, Netherlands.

Bollobás, E. (1993). "Totalitarian Lib": The Legacy of Communism for Hungarian Women. In N. Funk & M. Mueller (Eds.), *Gender Poltiics and Post-Communism: Reflections from Eastern Europe and the Former Soviet Union* (pp. 201–206). New York City, NY, USA: Routledge.

Case of Ternovszky v. Hungary, No. 67545/09 (European Court of Human Rights December 14, 2010).

Council of Europe. (1950, November 4). Convention for the Protection of Human Rights and Fundamental Freedoms.

Crenshaw, K. W. (1989). Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics. *The University of Chicago Legal Forum, 140*, 139–167.

Davis-Floyd, R. E. (1987). The Technological Model of Birth. *The Journal of American Folklore*, *100*(398), 479–495.

Dunai, M., & Koranyi, B. (2014). Hungary raids NGOS, accuses Norway of political meddling. *Reuters*. Retrieved from http://www.reuters.com/article/us-hungary-norway-funding-ngo/hungary-raids-ngos-accuses-norway-of-political-meddling-idUSKBN0ED1QW20140602

Eggermont, M. (2012). The Choice of Child Delivery is a European Human Right. *European Journal of Health Law, 19*, 257–269.

Émese. (2017b, March 2). Personal Communication.

EMMA Egyesület. (2017). Retrieved from http://www.emmaegyesulet.hu/

Erdman, J. N. (2015). Bioethics, Human Rights, and Childbirth. *Health and Human Rights*, *17*(1), 43–51.

Erika. (2017c, February 28). Personal Communication [In Person].

Erzsébet. (2017d, March 2). Personal Communication.

Fábián, K. (2009). *Contemporary Women's Movements in Hungary: Globalization, Democracy, and Gender Equality*. Baltimore, MD, USA: John Hopkins University Press.

Ferree, M. M., & Risman, B. (2001). Constructing Global Feminism: Transnational Advocacy Networks and Russian Women's Activism. *Signs*, *26*(4).

Funk, N. (1993). Introduction: Women and Post-Communism. In *Gender Politics and Post-Communism: Reflections from Eastern Europe and the Former Soviet Union*. New York City, NY, USA: Routledge.

Haraway, D. (1988). Situated Knowledges: The Science Question in Feminism and the Privilege of Partial Perspective. *Feminist Studies*, *14*(3), 575–599.

Harding, S. (1987). Is There a Feminist Method? In *Feminism and Methodology*. Bloomington, IN, USA: Indiana University.

Harding, S. (1995). Strong Objectivity: A Response to the New Objectivity Question. *Synthese*, *104*(3), 331–349.

Harman, T., & Wakeford, A. (2012). *Freedom for Birth*. Alto Films.

Heathcote, J. (2012). *Birthrights - Hard Labour in Hungary*. Al Jazeera.

Hesse-Biber, S. N. (2007). Chapter 1: Feminist Research: Exploring the Interconnections of Epistemology, Methodology and Method. In S. N. Hesse-Biber & S. Nagy (Eds.), *Handbook of Feminist Research: Theory and Praxis* (pp. 1–26). London, UK: Sage.

hooks, bell. (2013). *Writing Beyond Race: Living Theory and Practice*. New York City, NY, USA: Routledge.

Hungarian Central Statistical Office. (2017). *Table 6.1.4. Vital Events (2001)*. Retrieved from https://www.ksh.hu/docs/eng/xstadat/xstadat_annual/i_wdsd006b.html

Hungary submits bill targeting NGOs. (2017, April 7). *Euronews*. Retrieved from http://www.euronews.com/2017/04/07/hungary-submits-bill-targeting-ngos

Jaroslav, M. (2014). The Rise of Anti-Roma Positions in Slovakia and Hungary: A New Social and Political Dimension of Nationalism. *Baltic Journal of Law & Politics*, *7*(2), 179–208.

Judit. (2017e, April 20). Personal Communication [In Person].

Julianna. (2017f, April 20). Personal Communication [In Person].

Kitzinger, S. (2006). *Birth Crisis*. New York City, NY, USA: Routledge.

Kitzinger, S. (2008). Letter From Europe: Home Births, Midwives, and Doulas. *Birth*, *35*(3), 250–252.

Kitzinger, S. (2011). Human Rights and Midwifery. *Birth*, *38*(1), 86–87.

Koulish, R. (2005). Hungarian Roma Attitudes on Minority Rights: The Symbolic Violence of Ethnic Identification. *Europe-Asia Studies*, *57*(2), 311–326.

Langowski, J. (2016, August 22). "Stop Bawling" - Obstetric Violence in Hungary [European Young Feminists]. Retrieved from http://www.europeanyoungfeminists.eu/2016/08/22/stop-bawling-obstetric-violence-in-hungary/

Lewin, E. (2006). Introduction. In E. Lewin, *Feminist Anthropology: A Reader* (pp. 1–38). Madlen, MA, USA: Blackwell Publishing Ltd.

McCartney, C. (2015). "Childbirth Rights"?: Legal Uncertainties under the European Convention after Ternovszky v. Hungary. *North Carolina Journal of International Law & Commercial Regulation*, *40*(2), 543–596.

Mixi. (2017g, March 2). Personal Communication [In Person].

Moghadam, V. M. (2005). *Globalizing Women: Transnational Feminist Networks*. John Hopkins University Press.

Munk, V. (2017, April 20). Gerén Ágnes Mitigated Punishment, No Need to Withdraw from Jail. *Index*. Retrieved from http://index.hu/belfold/2017/04/20/gereb_agnes_itelethirdetes/

Perez D'Gregorio, R. (2010). Obstetric Violence: A New Legal Term Introduced in Venezuela. *International Journal of Gynecology and Obstetrics*, *111*(3), 201–202.

Reinharz, S. (1992). *Feminist Methods in Social Research*. New York City, NY, USA: Oxford University Press.

Rich, A. (1995). *Of Women Born: Motherhood as Experience and Institution*. London, UK: Virago Press Limited.

Sándor, J. (2013). Demographic Influences on the Regulation of the Female Body in Hungary. In B. Feuillet-Liger, K. Orfali, & T. Callus (Eds.), *The Female Body: A Journey through Law, Culture and Medicine* (Vol. 9, pp. 115–129). Brussels, Belgium: Groupe Larcier.

Serhan, Y. (2017). Hungary's Anti-Foreign NGO Law. *The Atlantic*. Retrieved from https://www.theatlantic.com/news/archive/2017/06/hungarys-anti-foreign-ngo-law/530121/

Smith, D. E. (2003). In S. Harding (Ed.), *The Feminist Standpoint Theory Reader: Intellectual and Political Controversies* (1st ed., pp. 21–33). New York City, NY, USA: Routledge.

Subeidi, B. (2006). Theorizing a "Haflie" Researcher's Identity in Transnational Fieldwork. *International Journal of Qualitative Studies in Education*, *19*(5), 573–593.

The United Nations. (1948, December 10). Universal Declaration of Human Rights.

The United Nations. (1979, December 18). Convention on the Elimination of All Forms of Discrimination Against Women. UN General Assembly.

Tunçalp, Ö., Were, W. M., MacLennan, C., Oladapo, O. T., Gülmezoglu, A. M., Bahl, R., … Bustreo, F. (2015). Quality of Care for Pregnant Women and Newborns -- the WHO Vision. *BJOG*, *122*, 1045–1049. https://doi.org/10.1111/1471-0528.13451

Vogel, J. P., Bohren, M. A., Tunçalp, Ö., Oladapo, O., T., & Gülmezoglu, A. M. (2015). Promoting Respect and Preventing Mistreatment During Childbirth. *BJOG*, 1–3.

World Health Organization. (1985). Appropriate Technology for Birth. *Lancet*, *2*(8452), 436–437.

World Health Organization. (2014). The Prevention and Elimination of Disrespect and Abuse During Facility-Based Childbirth. WHO/RHR/14.23.

Yancey Martin, P. (1990). Rethinking Feminist Organizations. *Gender & Society*, *4*(2), 182–206.

Yow, V. (2005). *Recording Oral History: A Guide for the Humanities and Social Sciences* (2nd ed.). Walnut Creek, CA, USA: Altamira Press.

Appendix A. Informed Consent Form – English Version

INFORMED CONSENT FORM

This is to certify that I, _____, agree to participate in the research being conducted by Nora Peterson of the Gender Studies Department at Central European University. The extent of my involvement in this project will be to participate in one or more interviews with Nora Peterson, the primary investigator, in which I will be asked to speak about my own life and my experiences. I am aware that my participation in this project is voluntary, and that it is possible to participate in this research anonymously. I recognize that I will not receive any material compensation for my participation. I may refuse to participate, withdraw at any time, and/or decline to answer any questions without consequence.

A. PURPOSE

I have been informed that the purpose of this research is to gain a broader understanding of the current state of the alternative birth movement in Hungary and Spain. The interviews will be combined with critical policy analysis to produce a master's thesis and may potentially be used for future publications. This research is being performed under the tutelage of Dr. Judit Sándor, professor of political science, legal studies and gender studies at Central European University (Budapest, Hungary), and Dr. Teresa Ortiz-Gómez, professor of history of science and gender studies at the University of Granada (Granada, Spain).

B. PROCEDURES

This component of the research consists of a series of interviews conducted between the researcher, Nora Peterson, and the interviewee. Interviews will take place at a predetermined and preapproved location—most commonly the EMMA Hub office—and will typically last around an hour in length. The interviewee has the right to request a change of location and time for the interview for any reason. The interview(s) will be recorded on the personal cell phone of the researcher and the audio from the interview(s) will remain in the private care of the researcher for transcription purposes. Written transcripts will be included in the final publication of the research, unless otherwise indicated by the interviewee, and all files of the audio recordings will be erased at the conclusion of the research process. Interviewees will be provided with a copy of the written transcript and/or audio files if so desired. In the resulting papers and publications, the interviewee will be identified by name, subject to her/his consent. Should the interviewee wish to remain anonymous, a pseudonym will be used in place of her/his real name. In the case that an interpreter may be required she/he may be provided either the interviewee or the interviewer but must be approved of by both parties. The master's thesis will be written in English.

C. RISKS & BENEFITS

There are **minimal risks** to participation in this interview. However, the researcher does recognize that the topic of alternative birth movements in Hungary is sensitive in nature and discussing such a topic may be uncomfortable for the interviewee. The interviewee can withdraw their participation from the interview at any time without prejudice. During the interview the interviewee may request to stop the recording at any time to discuss or clarify how she/he wishes to respond to a question or topic before proceeding. In the event that the interviewee chooses to withdraw their participation

entirely from the project during the interview, any tape made of that particular interview and any previous interviews will either be given to the participant and/or destroyed, along with any transcripts made from previous interviews.

Furthermore, if the interviewee, for any reason, would prefer to remain anonymous, she/he may request the use of a pseudonym in the published presentation of the research.

If so desired, the researcher will provide the interviewee with copies of the recorded interviews, written transcripts, and any/all related academic papers and publications written by the researcher. Requested copies will be provided to the interviewee after the final submission of the master's thesis, unless otherwise requested by the interviewee.

Upon completion of the interview, the tape and content of the interview belong to the researcher, Nora Peterson, and the information in the interview can be used by Nora Peterson for the purposes of the completion of a master's thesis, and in any further publication or presentation of research.

D. CONDITIONS OF PARTICIPATION (please initial to give consent)

_____ I understand that I am free to withdraw my consent and discontinue participation at any time during the interview process

_____I agree to have my interview(s) recorded

_____I agree to be quoted directly ***OR*** _____ I agree to be quoted anonymously in the presentation of the research

_____I request copies of _____all recorded interviews, _____ written transcripts, _____ the final publication of the research

To be sent to me at the following email address:_____

_____I request to be informed of any future attempts the researcher pursues to publish the research following submission of the master's thesis

E. INTERVIEWEE'S COMMENTS

Please identify below any desired restrictions related to the collection and publication of information from your interview(s).

I HAVE CAREFULLY READ THE ABOVE AND UNDERSTAND THIS AGREEMENT. I FREELY CONSENT AND VOLUNTARILY AGREE TO PARTICIPATE IN THIS STUDY.

Interviewee Name:

_____

Interviewee Signature:

_____Date:_____

Interviewer Signature:

_____Date:_____

Should you have any questions or concerns about this project or your rights as a participant, you may contact Nora Peterson, the researcher (Peterson_Nora@student.ceu.edu / nora.peterson@gmail.com / +36 70 233 9195), Judit Sándor, the faculty advisor (sandorj@ceu.edu), or Vlad Naumescu, the Chair of the Central European University Ethical Research Committee (naumescuv@ceu.edu).

I WILL BE GIVEN A COPY OF THIS FORM FOR MY OWN RECORDS.

Appendix B. Informed Consent Form – Hungarian Version

BELEEGYEZŐ NYILATKOZAT

Ezen nyilatkozat igazolja, hogy Én, _____, hozzájárulok a Nora Peterson (Gender Tanulmányok Tanszék, Közép-európai Egyetem) által végzett kutatásban való részvételhez. A részvételem egy, vagy több interjúra terjed ki, amelyeket Nora Peterson, a tanulmány elsődleges kutatója fog végezni. Az interjú(k)ban a saját életemről, és saját tapasztalataimról kérdeznek majd. Tisztában vagyok vele, hogy a projektben való részvételem önkéntes, és hogy lehetőségem van anonim módon szerepelni a kutatásban. Elismerem, hogy a részvételért semmilyen anyagi juttatásban nem részesülök. A kutatásban való részvételt bármikor elutasíthatom, visszavonhatom és/vagy bármely kérdés megválaszolását megtagadhatom, következmények nélkül.

A. A KUTATÁS CÉLJA

Tájékoztatást kaptam róla, hogy ezen kutatás célja a magyar-, illetve spanyolországi alternatív szülészeti mozgalom jelenlegi helyzetének szélesebb körű megértése. Az interjúk kritikai jogi elemzéssel kerülnek ötvözésre, és egy mesterdiplomához, illetve esetleges jövőbeni publikációkhoz kerülnek felhasználásra. Ezen kutatás Dr. Sándor Judit, a Közép-európai Egyetem politikatudományi, jogi, és gender tanulmányok professzorának vezetésével zajlik.

B. A KUTATÁS MENETE

A kutatás ezen szakasza interjúk sorozatából áll, amelyek a kutató, Nora Peterson, és az interjúalanyok között zajlanak. Az interjúk egy előre megbeszélt és jóváhagyott helyen – legtöbbször az EMMA Hub irodában – történnek majd, és átlagosan 1 óra hosszúságúak lesznek. Az interjúalanynak joga van helyszín-és időpontváltoztatást kérni, bármilyen okból kifolyólag. Az interjú(k) a kutató saját mobiltelefonjával rögzítésre kerül(nek), és az interjú(k)ból származó hanganyag(ok) a kutató magán használatában marad(nak), leiratok készítésének céljából. A leiratok részét képezik a kutatás végleges, publikált verziójának, kivéve, ha az interjúalany másképp rendelkezik. A kutatás végeztével a hanganyagok megsemmisítésre kerülnek. Kérésükre az interjúalanyok megkaphatják az interjúk leiratának és/vagy hanganyagának másolatát. A kutatásból származó tanulmányokban és publikációkban az interjúalanyok névvel szerepelnek majd, előzetes hozzájárulásuk függvényében. Amennyiben az interjúalany anonim kíván maradni, a valódi név helyett álnév kerül felhasználásra. Abban az esetben, ha tolmácsra lenne szükség, azt akár az interjúalany, akár az interjúztató biztosíthatja, de mindkét félnek jóvá kell azt hagynia. A mester diplomamunka angol nyelven kerül megírásra.

C. KOCKÁZATOK ÉS ELŐNYÖK

Az ezen interjúban való részvételnek **minimális kockázatai** vannak. Ezzel együtt a kutató tudatában van annak, hogy az alternatív szülészeti mozgalmak érzékeny témának számítanak Magyarországon, és hogy az ilyen témáról való beszélgetés kellemetlen lehet az interjúalany számára. Az interjúalany bármikor visszaléphet az interjúban való részvételtől, anélkül, hogy bármilyen sérelem érné. Az interjú során az interjúalany bármikor kérheti az interjú rögzítésének felfüggesztését, hogy megbeszélhesse, illetve tisztázhassa hogyan szeretne válaszolni egy adott kérdésre, mielőtt az interjú

folytatódik. Abban az esetben, ha az interjúalany az interjú során teljes mértékben vissza kívánja vonni a kutatásban való részvételét, az interjúról, illetve az azt megelőző interjú(k)ról készült felvételek átadásra kerülnek az interjúalanynak és/vagy megsemmisítésre kerülnek, az összes előzőleg elkészített leirattal együtt.

Továbbá, ha az interjúalany bármilyen okból kifolyólag anonim szeretne maradni, kérheti álnév használatát a kutatás puplikált verziójában.

Az interjúalany kérésére a kutató biztosítja számára a rögzített interjúk hanganyagának, leiratának, illetve bármely/összes, a kutató által írt kapcsolódó tudományos kutatásnak és publikációnak másolatát. A kért másolatokat az interjúalany a mester diplomamunka leadása után kapja meg, kivéve, ha az interjúalany mást kérvényez.

Az interjú végeztével a hanganyag és az interjú tartalma a kutató, Nora Peterson tulajdonát képezik, aki azokat felhasználhatja mester diplomamunkája megírásának céljából, illetve bármely jövőbeni publikációban és kutatásban.

D. A RÉSZVÉTEL FELTÉTELEI (Kérem, monogramja beírásával nyilvánítsa ki hozzájárulását)

_____ Megértettem, hogy a hozzájárulásomat bármikor szabadon visszavonhatom, az interjúban való részvételemet felfüggeszthetem.

_____Hozzájárulok, hogy a velem készített interjú(k) rögzítésre kerüljön/kerüljenek.

_____Hozzájárulok, hogy közvetlenül (névvel) idézzenek tőlem ***VAGY*** _____ Hozzájárulok, hogy a kutatás ismertetése során anonim módon idézzenek tőlem.

_____Másolatot kérvényezek _____az összes rögzítésre került interjúról, _____ a leiratokról, _____ a kutatás végleges, publikált változatáról.

Amelyeket a következő email címre kérem elküldeni:_____

_____Kérem, hogy értesítsenek, ha a kutató a kutatást a jövőben, a mester diplomamunka leadását követően publikálni kívánja.

E. AZ INTERJÚALANY MEGJEGYZÉSEI

Kérem, alább jelezze, ha bármilyen fenntartással kíván élni az interjú(k)ból származó információk publikálását és az adatgyűjtést illetően.

A FENTEBB ÍRTAKAT FIGYELMESEN ELOLVASTAM, ÉS A HOZZÁJÁRULÁSI FELTÉTELEKET MEGÉRTETTEM. SZABADON BELEEGYEZEK, ÉS ÖNKÉNT HOZZÁJÁRULOK AZ EZEN KUTATÁSBAN VALÓ RÉSZVÉTELHEZ.

Interjúalany Neve:

_____

Interjúalany Aláírása:

_____Dátum:_____

Interjúztató Aláírása:

_____Dátum:_____

Amennyiben bármilyen kérdése/fenntartása van az Ön, mint kutatásban résztvevő alany jogait, vagy a kutatást illetően, kérem forduljon a kutatóhoz, Nora Petersonhoz, (Peterson_Nora@student.ceu.edu / nora.peterson@gmail.com / +36 70 233 9195), Sándor Judit Kari tanácsadóhoz (sandorj@ceu.edu), vagy Vlad Naumescuhoz, a Közép-európai Egyetem Etikus Kutatás Bizottságának elnökéhez (naumescuv@ceu.edu).

EZEN NYOMTATVÁNY EGY PÉLDÁNYÁT SAJÁT HASZNÁLATOMRA MEGKAPOM.