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Chapter 7

Female Sexuality and Medicine – Sexualisation of Everyday Life, Desexualisation of Childbirth

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Additional information is available at the end of the chapter

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1. Introduction

There is a widespread belief that doctors are the "real" experts on women's health, sexual health included, and that biomedicine holds the key to improving it. This paper is going to demonstrate the limitations of such an approach, challenging the common perception that medicine alone holds the key to understanding women's sexuality. In considering women's sexuality we have to step outside the biomedical model to explore the ways in which some theories and practices are silenced and others are (re)produced.

The paper will seek answers to the fundamental question about the bond between women and medicine from the perspective of the everyday life of the modern woman: What does medicine have to do with female liberation, particularly in the field of sexuality? We are dealing with complex questions; it is a challenging task to maintain the tension of the controversies and avoid over-simplification. We are particularly interested in the idea of the regulation of female sexuality, and hence the patriarchal management of female bodies through the State and its institutions. This paper will elaborate the idea that one important part of modernization is the regulation, management and surveillance of the human body, with sexuality a particularly prominent feature. Medicine plays an important role in those processes. We are going to explore our topic from multiple points of view, historical, sociological and cultural, with use of concepts like sex/gender, knowledge, power, embodiment, and medicalization. Female sexuality and its controversial bonds with medicine have to be in the centre of interest for those who are dedicated to women's well-being, especially in times of life transitions such as puberty, childbirth and menopause.

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2. The sexualization of everyday life

Let us begin with a short overview of the sexualization of various aspects of everyday life, followed by a look into the controversial links between female sexuality and medicine. Considering the proliferation of sexual messages surrounding us and their use as bait to get consumers to purchase products, whether they are needed or not, it is tempting to see the sex lives of modern individuals as being free from any and all taboos, as if reservations no longer apply – satisfaction and instant gratification are made freely available and cater to every taste, every kind of sexual desire. Sexuality is marketed as a commodity, bought *en masse* and sold on a grand scale.

On the surface, sex and sexual activity are presented as a private matter of individuals and a question of personal choice. The achievements of second-wave feminism [1], along with the accomplishments of the "sexual revolution" (a mass movement of the younger generations in Western Europe and the US between 1964 and 1975, which advocated for "free love", free from traditionalist patterns of sexual behaviour and some of its taboos) have gone down in 20th century history [2] as significant events for women's equality, including in terms of sexuality. For the subject at hand, we can mention specific areas such as violence, including rape [3] (as a form of specific sexualized violence used, among other things, for the reproduction of power relations between genders in the patriarchal family and society), and productive rights (especially safe and reliable birth control, safe abortion and the accessibility thereof to a wide range of women), as well as the questioning of myths about motherhood [4]. This primarily involved the pursuit of the conditions for an active heterosexual life for women, unaffected by unwanted, involuntary motherhood. At the same time, prejudice about socially undesirable or unlawful sexual practices of the time, such as sex before marriage, teenage sexual activity and homosexual love, was being dismantled. The revolutionary undoing of inhibitions in favour of freer sexual expression also meant the undermining of patriarchal sexual attitudes, which signalled a chance for greater autonomy of women, and was supported by the women's health movement in its attempts to establish a body of knowledge different from oppressive medical discourses and practices, including on women's sexuality [5].

Where do we stand now? It seems that we have gone from prohibiting certain aspects of sexuality to imposing sexuality in many aspects of our lives, that sex has been incorporated into the general wave of consumerism and hyper-spending as one form of escapism for the modern individual in today's consumerist society [6]. Modern individuals who are incapable of sufficient self-reflection are exposed to compulsory consumption of all kinds of sexually informed messages, from enormous billboards to short commercial text messages, which use imagery and words to arouse desire solely in order to make consumers spend more and be easier to manipulate. Clever pop mimicry of free, genuine and primal sex, purported to be the essence of free sexuality, has lured in those seeking an escape. They face constant temptation to answer the persistent call to "Choose and enjoy yourself!" based on the nihilist principle of "Everything is permitted" – albeit with the caveat "Only if you have money" in the small print.

What has been proclaimed as liberating has also created new potential for fresh forms of control and subjugation. It is not too much of a stretch to say that the potential of free sexuality to

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enable and embody social progress has been overstated or, at the very least, skilfully diverted. The accomplishments of the sexual revolution have been exploited by neoliberalism to gain new, previously inconceivable profits on the pornography market for example [7], as well as by the proliferating global sex trade, ranging from prostitution to sex trafficking, which treats particularly vulnerable groups, including children, women, the economically disadvantaged and other individuals whose very existence is under threat, as goods, and ruthlessly subjugates them to the logic of the market. At the same time, new technologies have provided new channels for sexual messages, in particular via the Internet, which advances the spread of compulsory sexuality and aggravates phenomena like sex addiction [8].

3. Is female sexuality now free of any and all taboos and coercion?

We assert that the aforementioned issues do not affect both genders to the same degree; answers need to be provided to questions about how female sexuality and procreation in general should be perceived and experienced, and about the role played by medicine in these issues. Living a fulfilling life often involves the ability to decide how to express one's own sexuality in all its shifts throughout life cycles, and to find opportunities to live out that sexuality in relationships on a personal and interpersonal level. The question is, however, whether our personal, intimate and individual sex lives really exist within the sphere of freedom. Many things we may see as spontaneous are not truly spontaneous – we are born into a certain environment which shapes our idea of female and male sexuality through cultural, social, domestic and religious convictions. Beliefs, moral judgements, preferences all shape a number of key relationships between individuals and culture(s) as a consequence of a variety of complex and interconnected factors permeating families, institutions concerned with education and health, the media and so on. The (self-)perception of individuals and their relationship to their own gender, the gender of others and sexuality are linked to responsibility and respect felt for oneself and other human beings – what I (do not) like about myself and others, what I (do not) appreciate myself and others, what I am worth, what is male and female sexuality, what is sexually (un-)appealing, what a sexually (un-)appealing body looks like, what the relations between pleasure, gratification, passion, a sense of belonging, validation and love are.

Human sexuality cannot be reduced to the mere sex act; it involves more than just genitals and procreation. The history of sexual desire tells us that the desire to experience sexual pleasure and total body sex – that is, the expansion of sexuality from a limited focus on the face and genitals to include the entire body – has been known since antiquity [9] and was, disregarding the period of the repression of sexual desire in Christian Europe, kept alive up to its renaissance in the 19th century, which continues to this day. Sexual activity is also importantly affected by sexual desire, which goes beyond a mere instinct: the sex act, be it heterosexual or homosexual, is never a mere spontaneous, instinct-driven biological act; it is necessarily a socially conditioned, complex act with its own symbolic value [10]. Researchers of sexuality have yet to agree on the question of whether there are any differences in sexual desire between men and women, and if so, whether they are caused by nature or nurture. On a hormonal level, sexual desire is

linked to androgens, which are produced in testicles, in men, and androgens and oestrogen in women, produced in ovaries, as well as testosterone and oxytocin. According to some studies, how we experience sexuality may also be gender-specific, but although the belief that men are more sexual than women, and the principal initiators of sex, while women are more passive, and recipients, is still prevalent in some places, it has become increasingly clear that the differences are differences in the expression of sexuality, which is informed by the culture and social (gendered) roles as well as the expected sexual behaviour for men and women. The belief that women's erogenous zones are more widely dispersed on the body than in men is also prevalent. The way women perceive themselves and their own sexuality is also influenced by prevailing culture – women learn to be passive. They respond to visual and other impulses and become aroused as quickly as men, but being sexually liberated is much more socially acceptable for men. Myths persist about female sexuality in relation to the idea that women have a greater need to form an emotional bond.

Where do we currently stand with regard to female sexuality, socially speaking? There are, of course, multiple types of discourse, and we can highlight the abuse of female sexuality on multiple levels, including devaluation, objectification, the focus on the physical female body in the media, and the propagating of a certain ideal female appearance, which currently means a slim body with no cellulite and the right curves in the right places, with shifting ideas of how much curviness is still acceptable. In addition, female sexuality is constantly being redefined, still seen as goods to be traded in order to survive, to provide protection or sometimes to climb the social ladder; in traditionalist environments, female sexuality is the expression of a woman's worth or worthlessness, as evidenced by the revival of the cult of virginity, which must be maintained until entering a monogamous relationship [11]. Even today, the myth of supposedly passive female sexuality as opposed to active male sexuality persists in popular culture; at the same time, female sexuality is perceived as mysterious, or demonized and regarded as a threat to men. Messages in the media reinforce the chosen model of female sexuality through culturally selected behavioural patterns for each gender and selected sexually informed images that only emphasise certain kinds of sexual expression. This model is perpetuated through various types of discourse about the necessity of maintaining health, beauty and youthfulness through self-discipline and through the simultaneous popularization of the post-modern commandment of "Enjoy yourself!"

It is vital to continuously recollect relevant thoughts of feminist authors about the female body, sexuality, health, and motherhood, which take issue with the culturally prevalent "self-evident" and "common-sense" concepts of sex, which are frequently based on the idea of duality and opposition and on the inequality and imbalance of both sides: nature vs. culture, woman vs. man, sex vs. gender. To mention some: Simone de Beauvoir, Adrienne Rich, Shulamith Firestone, Gena Corea, Evelyn Fox Keller, Emily Martin, Ann Oakley, and Barbara Katz Rothman. We must work towards fighting this amnesia, for to forget the findings about the cultural basis of the dominant understanding of sex, bodies and sexuality, which are the result of numerous excursions into these topics in history, sociology, anthropology, cultural studies and the social history of medicine (Edward Shorter), the history of the body (Thomas Laqueur), the history of the family and birth (Phillip Ariès, Jacques Gélis) and the sociology

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of the body (Bryan S. Turner) in particular, would be to accept shallow thought and a superficial reflection of everyday life, the breeding grounds for the myths of a passive masochistic female sexual nature, lower sexual needs of women and monogamous femininity, as opposed to the male, biologically dictated polygamy whose representation has seen a recent revival in some popular media, for example.

4. Sexuality and health

Sexuality is also linked to health issues. People have general health needs regardless of gender, but also face limitations on various levels in meeting those needs and providing the optimal conditions to lead a healthy, or, more generally, a comfortable life, including sexuality.

Both genders have specific health needs; however, women's health has an additional dimension to it due to their reproductive capacity. Throughout history, women have often been reduced to their bodies and their specific biological capacity for procreation (S. de Beauvoir). According to Edward Shorter, a professor of social history of medicine, in his famous work *Women's Bodies* [12], women were victims of their own bodies for centuries, adding that pregnancy, labour and gynaecological diseases constituted high risks. Women could not live out their sexuality due to dismal living conditions and the risks posed to their well-being or life, which also provided grounds for the oppression of women by men. Women were more vulnerable and therefore more closely controlled due to their potential or actual motherhood. Both the biological capacity of the female body to procreate and the social implications of this are more pronounced and more closely linked to subjugation than the biological and social role played by men in procreation. An influential French historian focusing on the history of women, motherhood and sexuality, Yvonne Knibiehler, points out that mothers, motherhood and the "production" of children are stakes of those of power [13]. Control over female fertility is an excellent example of the domination of one gender by the other from a privileged position of power.

5. Knowledge and science about women

Hatred or dislike of women has formed the basis for sexist prejudice and ideology serving as justification for the oppression of females in male-dominated societies throughout the long history of our culture; as in the first era of feminism and feminist theory, the reconstruction of knowledge is now at the forefront. The female has been the gender more closely associated with physicality throughout history; that is, the idea of the female is less easily separated from the body than that of the male. This is why it is all the more important to evaluate the investments of science into the reproductive capacity of women, pregnancy, labour and motherhood, as well as female sexuality. In large part this means reconstructing knowledge about the female body in certain scientific fields and expanding our understanding of multiple links between types of discourse and institutional practices which view the female body through the lens of its sexual and procreative functions.

In particular, light needs to be shed on the way our physical "nature" – an indivisible union of biology and nature shaped by human evolution – is shaped, reinforced or repressed by social conditioning. Most of the time, nature and nurture have simultaneous effects, and the filtering and profiling of what can and cannot be expressed also contributes to every culturally specific definition of male and female sexuality. Carefully thinking about the nature of the physical does away with the expectation that removing historical layers from the cultural conceptualization of masculinity and femininity should lead us to the (pre-)historical, pure, natural male and female body [14, 15]. The simplified sex-neutral history of the human body needs to be disregarded [16]. Let us introduce our reflections on female sexuality and medicine by paraphrasing the famed phrase "the body has a history" (of sociology of the body) [17] – "the body has a herstory, too". We have to speak about *historicized* bodies. The body is a location of control and the exercise of both social and medical power; the social and the medical aspects frequently cannot be told apart, because the medical point of view, as regards the modern idea of health and the individualization of responsibility for health and illness, is inherently linked to social control over the health of the population(s) [17, 18].

The history of women is characterized by the desire to exercise control over them and their reproductive functions, in different aspects such as pregnancy, childbirth, and motherhood [19-23]. This means, for example, that the patriarchal social order abuses the procreative capacity of women to create and maintain unjust relationships between men and women. The reproductive capacity of a woman may be turned against her, and she may fall victim to oppression precisely because of this special ability of bearing and birthing offspring. In such systems, the (postulated or actual) specific characteristics labelled as female or feminine, including female sexuality, are underappreciated, degraded, repressed or entirely overlooked and abused, as well as being given mythical properties [24]. Control over female sexuality is connected to the patriarchal need to establish male control over women's fertility and reproduction on the one hand, and to the attempted control over women's gratification and enjoyment on the other, especially if such enjoyment is specific to women. In its extreme, the control of female sexuality is manifested in physical violence: the mutilation of female genitalia, rape (including marital rape and rape in war), brutal punishment of infidelity or sexual activity before marriage, etc. This not limited to violence practised by individual men over individual women; instead, these acts of violence are socially tolerated or even officially permitted as acts aimed at gaining power and consolidating power relations in a community [25].

6. Why women, and women in particular, need health care

Along with benefits for women (and women's health), sexual activity, pregnancy, labour, breastfeeding, menstrual and menopausal cycles also carry risks of a lower quality of life [10]. Half of humankind face specific health issues connected to the biological and sociocultural role of women as key for the proliferation of the species. These issues affect actual mothers as well as women who have no children due to social or personal circumstances. Some of these issues are an added burden on women's health; they may pose a health risk, restrict the maintenance

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and improvement of health or act as a hindrance to recovery; in extreme cases, they can cause illness, injury or death. Compared to men, women are particularly vulnerable due to their biological capacity in particular. Until recently, they risked their well-being and lives in ways that men did not due to unwanted pregnancies, complications during pregnancy or childbirth, consequences of miscarriages, abortions and other reproductive cycle events – in some places these risks are still significant. These are some of the key social conditions in which women live and which determine their worth, their standing in the family and the community, and their access to basic necessities, including education and health care. But women's sexual and procreative health is also threatened by sexual violence, sexually transmitted diseases, insufficient or inaccessible prenatal care and birth control, inaccessibility of safe abortions, and so on: despite modern social changes, women continue to face more hardship and limitations as regards their personal freedom than men.

In traditionalist historiography, medicine was given the role of saviour; medicine was portrayed as key in freeing women from the role of females who need to sacrifice themselves for the human kind to survive [26]. Due to the rise of contraceptives, safe abortion, and hospital childbirth, and the raising of popular awareness about sexual health, medicine has been regarded as a force that freed women from the risks of the unreliable and dangerous reproductive female body. It is a widely accepted belief that doctors are the only "true" experts on women's health, including sexual health, and that biomedicine is the key to improvement [10].

Globally, we strive to provide all women with optimal health care when they need it, and medicine plays an important part in this. Although medicine has undoubtedly accomplished much to maintain, improve and restore women's health and well-being, we cannot overlook its role in propping up women's unjust, subservient position in society, which is linked to reproductive capacity and sexuality in particular, as demonstrated above.

Do these types of discourse and practice contribute to liberation and the provision of free personal choice? Or do they instead restrict and regulate these, participating in decision-making on what is considered good and healthy as regards reproductive life, or risky, pathological or deviant as regards sexuality. As demonstrated by Turner, medical advice on how people should live may function as moral discourse to regulate bodies, control people's everyday life [27], and regulate the "quality" of populations – this is known as "biopolitics", the style of government that regulates populations by applying political power to various biological aspects of human life [28]. This type of medicine is particularly striking in fields like "public health", in measures to "promote health" or "a healthy lifestyle" for pregnant women, in organizing birth care, in the promotion or limitation of breastfeeding, in regulating how a mother should care for her child, in providing advice on how mothers should raise children, and so on [20, 29].

It must be stressed that when speaking of medicine, what is meant is not a monolithic structure, but rather a patchwork of complex dispersed processes, struggles, contradictions and inconsistencies; this has varying effects on the lives of people, depending on their gender, social status, age, and so on. We differentiate medicine as an institution with certain types of discourse and practice and health professionals. Among these professionals are individuals who may not always hold power, especially when they are women – midwives and nurses are

often lower in the hierarchy than doctors, for example. On the other hand, being a woman does not always mean more equal cooperation with other members of health teams and empathy towards patients.

7. Medicalization

The concept of medicalization, as developed by Ivan Illich [30], is a useful tool in trying to understand the conceptualization of women's sexuality in the biomedical model of health and sickness; it provides space for a critique of the positivist side of medicine in an age of embodied culture [31-34], in which the body becomes the principal field of political and personal grievances, as claimed by Bryan S. Turner in his theory of modern society as a "somatic society".

Medicalization involves the identification or categorization of a certain feeling, state or behaviour as pathological, as something in need of treatment or intervention; it is a process in the course of which health or behavioural issues begin to be viewed, defined and treated as medical issues, a process in which everyday occurrences, phenomena or living conditions are reinterpreted as medical issues to be subjected to medical control and definitions emphasizing risks, pathology and the importance of intervention treatment or other types of "managing" or handling the issue. Health professionals, and doctors in particular, are the ones defining, studying and treating these issues. "Western" medicine, also known as allopathic medicine, which is supposed to be based on scientific findings, provides a rigorous framework in its many iterations to explain, categorize and classify a variety of symptoms and diseases affecting individuals. Health professionals use a number of different means to treat and prevent illnesses or alleviate health issues as well as improve people's quality of life. Let us not forget, however, that medicine has evolved in a certain conceptual framework like all other scientific fields, and is therefore based on implicit, often ill-defined and unclear presumptions, such as the concepts of masculinity and femininity, which is made apparent in fields like psychiatry, gynaecology and obstetrics; historically speaking, these are disciplines particularly employed as mechanisms of power, and their practices have widely been used to control and define normality, pathology and deviance [35]. Medicalization processes occur in different ways, such as through changes in social relations, the creation and use of language, the development of certain ways to solve problems while disregarding others, and the institutionalization of particular services while others are excluded. The consequences of medicalization include personal or social life decisions being made within a limited specific reference framework.

The expansion of medical authority into various fields has had important impacts on everyday life. Medicalization has become such a self-evident part of our lives that is takes significant effort to distance ourselves and listen to the facts.

Medicalization of individual areas of life does have its advantages. Medicalization can be critiqued in terms of medicine as a scientific authority and health professionals as experts, linking to questions about the control and regulation of individual groups or phenomena and the interplay between knowledge and power [18]. In analysing power relations, their com-

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plexity needs to be taken into account, as the issue of medicalization cannot be reduced to the desire to dominate certain areas of knowledge or its disseminators and the conscious need to regulate populations, even though these two factors are among its essential elements. If authority over the body/in the body, as Foucault suggests, is divided into the disciplining or individual bodies and the regulation of population, or biopolitics, both of these processes simultaneously occur at the same place in the context of controlling human reproduction – that is, on the female body, even *in* and *with* the female body. Maintaining subservience and control inevitably involves a certain degree of violence, which, however, may not always be visible or apparent on sight. Control employing physical force and corporal punishment, isolation and darkrooms frequently morphs into more subtle, yet equally effective tools, such as exposure to other people's gaze, coercion to self-monitoring, self-discipline and disclosure, and manipulation through feelings of obligation and guilt. What does "medicalization of female sexuality" mean, then, and what is the price paid by women, frequently without knowing why and for what purpose?

8. The medicalization of female sexuality and procreative activities

Over the past decades, a persuasive line of argument has been developed which allows us to look critically at the medical usurpation of childbirth and its control of obstetric care while noting both its positive and negative effects [22, 36-44]. Doctors have assumed essentially total control over the pregnant woman, for it has come to be expected to give birth in hospital, and so on. The focal point of our analysis is modern biomedical discourse in gynaecology and obstetrics, as well as selected institutional practices for pregnant women, women giving birth and women after childbirth, with a particular focus on female sexuality. The analysis delineates the extremes, limitations and trappings of the usurpation of female sexuality by medicine and draws attention to its internal contradictions, tensions and struggles.

Let us look at a few keys points. An important aspect of modernization is the regulation, management and control over the human body and sexuality in particular, and medicine has historically played an important role in these processes. Sciences and their application in medical practice are always established and formed within a certain social context, as proven by the historian of sexuality and the body Thomas Laqueur, who studied various conceptualizations of the body through sex differences in great detail. Inter alia, he drew attention to a particularly key shift from the uniform model of the human sexual anatomy in Europe in the 18th and 19th centuries to the dualist conceptual model of two sexes. One-sex theory conceptualized the human body as the same both in men and women – women have the same genitalia as men, only that female genitalia are on the inside rather than on the outside, meaning the only difference was superficial. Two-sex theory considered femaleness as permeating every cell of the body, meaning that the female body fundamentally differs from the male body [45]. This new conceptualization of the woman in medicine as the "other sex" resulted in positioning the female body as a separate entity. The emergence of gynaecology and sex endocrinology in the late 18th and early 19th century is linked to the dominance of a discourse practice in which sex and reproduction are more essential and determine women more greatly than men. Sexual

anatomy and sexual differences were used to support the superiority of men over women. The subordination of women by men was based on hierarchical ordering of two different bodies and helped to establish a new understanding of gender with firmly defined roles. The one- and two-sex models and the victory of the latter over the former have been consolidated through their use in anatomy, gynaecology and practical diagnoses and treatment of women. According to Laqueur, no differences between male and female sexuality emerge in the one-sex model, and attention is drawn to the importance of female pleasure and orgasm in order to conceive, which later lose any visible role in the two-sex model, where the woman is designated a passive recipient of male active sexuality. Specific gender theories and gender differences or similarities are shaped in interdependence with social conditions, and the culture was the force which denied women the ability to experience sexual pleasure and gratification despite the already existing anatomical evidence about the role of specific female body parts and the importance of the clitoris.

In the 20th century Freud's theory about the vaginal orgasm, which replaced the adolescent clitoral orgasm and was a sign of a woman's maturation, and whose absence signified frigidity, turned out to be based on the two-sex model, which requires women to adapt their pleasure to their expected social role in spite of their bodily structure and neurology, rather than because of it. This theory, labelled "the cultural myth of the vaginal orgasm" by Laqueur, was followed by a number of male and female authors and made many women wonder about their inappropriate, infantile sexuality and undergo therapy.

After the Second World War, sexuality began to be studied empirically. American biologist Alfred Charles Kinsey published the Kinsey Report in two volumes, *Sexual Behavior in the Human Male* in the 1948 and *Sexual Behavior in the Human Female* in 1953. These findings were built upon in a confidential study at a St. Louis clinic carried out in the late 1950s by the American gynaecologist William Howell Masters to observe and empirically study the human sex act under laboratory conditions, along with his assistant Virginia Eshelman Johnson, who had no degree or official medical credentials. The pair carried out controversial studies about sexual experience in men and women. Their findings regarding female sexuality were relatively straightforward – almost all female orgasms are caused by direct or indirect stimulation of the clitoris. This empirically disproved Freud's theory about an "immature" clitoral and a "mature" vaginal orgasm.

What is important is to understand how particular knowledge is incorporated in mainstream discourses, medicine included, and used for normalization and control in the everyday lives of women. Medicine tends to commodify female sexuality. The emergence and acceptance of particular theories on female sexuality are linked to the social conditions of the time in which supposedly objective and independent scientific findings become a convenient tool to achieve goals not related to the wellbeing of individuals; at the same time, the conditions for the emergence and development of certain knowledge are themselves an intrinsic part of a certain reference frame of the dominant culture.

Medicine has contributed both to the improved sex lives of women and of their reproductive lives more generally; however, let us not forget its contributions to blaming mothers for a

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variety of social problems supposedly caused by inappropriate motherhood [20], ranging from various addictions to the increase in violence and the emergence of a narcissistic society [46].

Female sexuality has been pathologized with diagnoses like "hysterical" and "neurotic", and these so-called disorders treated in a variety of ways with differing levels of brutality; during the obsessive preoccupation with masturbation in the 19th century, even clitoridectomies were in use, among other methods, and contributions to reducing women to specific desirable and acceptable aspects were made by theories such as the concept of women's masochism [12].

Medicine facilitates the expansion of a market providing modern services modifying the female body to (socially) desirable norms, which women either voluntarily or involuntarily adhere to. For-profit medicine, with the express cooperation of physicians, markets absurd plastic-surgery procedures on the hymen, known as hymenoplasty or "re-virgination", which is problematic from an ethical standpoint. As long as a few drops of blood determine the value of women, women will be forced to undergo surgery to replace a potential "lost" patch of tissue with a couple of stitches. On the one hand, young women who live under specific religious or social norms regarding the "virginal", sexually "not-yet-tainted" female body, which is to belong to a particular man – often not of her own choosing – believe they need to undergo this procedure to protect themselves and their families. On the other hand, with every such procedure, medicine contributes to the perpetuation of "virginity", a construct affecting entire generations of women.

Other procedures promoted by the plastic-surgery industry include "vaginal rejuvenation", breast augmentation, facial cosmetic surgery, body-contouring surgery and facial procedures in the absence of any pathological condition, which are frequently, though not necessarily, based on the patriarchal idea of the sexual and sexualized female body as seen through the male gaze; this is at the very least controversial, if not outrightly upholding and consolidating the remnants of the patriarchal social order.

Currently, some branches of medicine also participate in the development of some ethically questionable new reproduction technologies, which have been proven to involve misuse and even abuse of women, like trafficking with eggs and embryos to offer commercial services of surrogate motherhood.

In history, discourses in medicine feature assumptions about the female orgasm, the lesser capacity of women to enjoy sex, or women's passive and men's active sexuality, as well as questioning of lesbian love and sex. Contrary to common (self-)perception, even today medicine is not neutral regarding sex expressions of gender and still participates in attempts to normalize certain sexual practices while pathologizing others, based on obsolete and disproven concepts – as seen in recent history in relation to the provision of access to infertility treatment for single women in Slovenia in 2001, for example. In public debate, those who opposed the proposed law problematized among other things the supposed motherhood of single or maybe homosexual women, where the sexual activity of a man is not desired or needed – with the support of some medical professionals.

8.1. Female sexuality and childbirth – The modern desexualization of childbirth

Female sexuality and its controversial links to medicine should be the focus of everyone dedicated to women's well-being, particularly during important transitions in life, such as puberty, childbirth and menopause. The medicalization of female sexuality is a phenomenon that affects women around the world and requires a detailed structured critique. As can be inferred from data obtained by studies, analyses of delivery-room procedures and available literature, the practices in modern obstetrics are frequently at odds with women's autonomy, ignore their feelings and knowledge and harm their bodies, mind and soul time and time again. It is part of a structural issue connected to the status of medicine, its position in the modern understanding and management of life, its power over transitions in life such as childbirth, the transfer of childbirth into the hospital, the use of specific prosthetic means to control life, illness and death, the "objective" and "legitimate" definitions of the normal and the pathological, the technologization of pregnancy, and the specific attitude to female sexuality.

This paper studies some of the types of medical discourse and practices in relation to the female gender, particular attitudes to female desire, pleasure and gratification that evolve with time, the control over reproduction, and the definition and construction of "good" motherhood.

How should we interpret the relationship between medicine and female sexuality, which is perceived as a gender-specific experience and practice in the life-cycles of ordinary women? We study the contributions of medicine to the everyday lives of women, which remain closely linked in many ways to caring for other family members and bringing the family into existence in the first place, that is, to the "production" and "reproduction" of people in general. In order to facilitate understanding of the issue of the medicalization of female sexuality as an important issue for midwives, quotes will be used below from archived statements made by women on their experience with care in maternity wards over the last decade – the testimonies were gathered by the author. This approach aims to facilitate greater awareness of the issue by using a research method that gives women a special position and is particularly esteemed in women's studies and feminist theory. Women's voices are heard and listened to, which is an important way of empowering women and one that may promote their contributions to thinking about cultural childbirth practices and their influence on the practice of perinatal care, which is supposed to be about helping and supporting mothers and their newborns.

Medicine aggressively participates in the development of new reproductive technologies and various practices which make parenthood possible despite any number of physical or medical obstacles – these are practices ranging from a variety of medically assisted conception methods to the overseeing of individual surrogacy procedures. Medicine's attitude to women, the female body and female sexuality is often full of contradiction; on the one hand, it assists women in achieving their goals or becoming a mother, while at the same time contributing to the exploitation of women's reproductive capacity by the privileged. Conception itself no longer requires sexual intercourse, and as specific knowledge and technology develops, medicine has begun looking into ways of reaching the phantasmatic goal of creating human life in a way that would eliminate the need for a female body to carry the child to term and give birth [47].

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A special element of the medicalization of female sexuality, which this paper shall focus on, is the participation of medicine in separating motherhood from sexuality, excising female sexuality from childbirth and erasing the sexual component of the experience of giving birth. Paradoxically, the desexualization of childbirth functions as a component of control over female sexuality – that which is obscured or pushed aside and denied is just as important as that what is manifest or even excessive. The exclusion of certain knowledge and the link between knowledge and power is something to which Foucault has already drawn attention [28]. As noted by anthropologist Robbie Davis-Floyd, routine care for the mother at the maternity ward is so effective in masking the sexuality of childbirth that the majority of modern women are not even aware of the sexual character of childbirth [38]. It can be said that the culturally dominant image of modern childbirth has been "cleansed" of anything implying sexuality, and that any discourse involving a link between childbirth and sexuality is marginalized – what you would see in a typical birthing room is a woman in a hospital gown lying on a bed and covered with a sheet, looking more like a patient than an empowered woman giving birth to her child.

Let us take a closer look step by step. The entry of men into the process of childbirth as healers, medicine men and male midwives [40], which only expanded with the medical takeover of childbirth [48], also reopened questions about female sexuality. On one hand, this is interconnected with the need to control women's reproductive ability, while on the other, the idea of female sexuality as a threat to patriarchal order creates discomfort and anxiety and demands regulatory tools be developed. In light of this, some characteristics of the modern "design of childbirth" need to be reconsidered – including the institutionalization of childbirth, routine care and the implementation of certain procedures, such as the shaving of pubic hair, enemas, vaginal examinations and episiotomy, while foregoing others, such as nudity of the birthing women, body support and close contact between the birthing woman and her support network, the restrictions on audibly expressing labour pain and other feelings, pleasure included, and so on.

We can use a historical case to make the point. The emerging use of chloroform rather than ether to alleviate labour pain triggered a fight in the scientific community, which was detailed in the prestigious *Lancet* magazine. Some interpreted the "hysterical behaviour" of mothers in labour who had been given ether as an expression of sexual arousal, which was a threat to the obstetrician. According to certain medical opinions, labour pain merely masked sexual pleasure not requiring the involvement of a male. To prevent labour pain might then stop the mechanism neutralizing sexual arousal. A woman who is medicated to a pain-free state and whose sexual arousal is therefore unhindered regresses to an animal state and can no longer be controlled by a physician. This is the contradictory idea of the woman in the 19th century – is the woman primarily a sexual or a moral being; is she a seductress of men (doctors included) or a moral guiding light? The line of thought of the time, based on the two-sex theory discussed above, is easy to follow: the woman is a primarily reproductive being, meaning that her character is sexual, that is to say, animalistic; considering that the biologists of the time observed that animals were keen to copulate after giving birth, the idea emerged that childbirth could be a sexually arousing event for women. Physicians were suddenly trapped in their own

contradictory (mostly unreflected) conceptualization of the woman. They considered the idea of "sexually aroused" women going through labour under anaesthesia to be "a danger to the patients, doctors and medicine in general". To assume as great a degree of control as possible, they recommended chloroform, which was to be administered in quantities that exceeded the dosage needed for mere pain alleviation. Anaesthesia during labour was approved not only to ease women's labour pain, but also to protect the physicians from unwanted reactions of the women in their care [19].

The current prevailing attitude to labour pain leads women to dissociate from physical sensations and pain as well as joy, pleasure and ecstasy. Some women, such as individuals recovering from sexual abuse, consider it vital to keep at least minimal control over the process of childbirth and dissociation is one way to achieve that, for example with effective medication to treat labour pain, such as epidural anaesthesia. Due to forgotten or at the very least incredibly marginalized knowledge about the integrity and interconnectedness of childbirth on the physical, mental and spiritual level and the physiological laws of labour, which (may) include both pain and pleasure, it is entirely understandable that many women consider the medical alleviation of labour pain to be a requirement, while seeing discussions about the internal power and capacity of the body to respond with its own way of alleviating pain as pushing women back to (ruthless) nature.

Assuming the vantage point of tension between pain and pleasure, intertwined during childbirth, let us think about how women experience usual childbirth practice in hospital with predetermined routine procedures. These have the woman lying on her back in bed, "hooked" on IV with induced and/or augmented contractions, with no constant midwife presence, making her feel that she has lost control of the situation and the procedures of the medical staff: she feels objectified – *"like being a walking uterus"* – and reduced to her physical body – *"I felt like a slab of meat*" – and has no say in what happens to/in her body: *"The doctor entered and without looking at me, pushed his hand inside of me, which hurt horribly, mumbled something and left."* Routine vaginal examinations are particularly revelatory, as this is the body part considered to be the most intimate of all. An interviewee recounts acts by the medical staff once she felt the need to push that she thought were wholly inappropriate. The medical staff carried out a vaginal examination, which she experienced as an act of violence: *"When the midwife called them over, they said, 'Impossible, it's impossible that she would be this dilated.' They go inside, 'Fantastic, fantastic, so soft, feel it, come and feel it.' They're just wriggling their hands inside of me! /the speaker is extremely distressed, note by Z. D./ Look at that, oh.'"* [49].

Ignorance about the interconnectedness of sexuality and childbirth is the consequence of induced amnesia, which, however, is not total and is visible, for example, in jokes made by doctors and sometimes midwives who act more like obstetrical nurses, at the expense of women – jokes they can make because of their status within the health-care hierarchy. For example: "It'll come out the same way it went in!" or "A woman of normal sexual health should enjoy childbirth a lot, considering that the child is so much larger than the penis" (as I find written in the notes I made during an interview with a Slovenian obstetrician in 1993). The problem lies in power relations; power is used to define how (if at all) female sexuality may be expressed at the maternity ward and to define what is normal and what pathological, and

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frequently what is moral as well. That a specific medical idea of childbirth is prevalent in maternity wards is precisely why the idea that childbirth could be aided or labour pain alleviated with practices involving, for example, a woman stimulating her nipples or clitoris is unacceptable, and such advice is met with derision or disgust by health professionals. The problem is not that medical professionals are unaware of the effect of nipple stimulation on contractions, since understanding of this mechanism was the basis for the construction of a special device patented in the US to achieve stronger uterine contractions [50]. The device does not cause the same discomfort usually expressed by medical professionals when confronted with an explicit expression of female sexuality during childbirth, because it allows them to establish a distance. According to women's testimonies, as little as requesting perineal massage during labour, which can prevent rupture and injuries if applied gently, can meet with the disapproval of midwives in maternity hospitals. The medical approach to childbirth in modern hospitals is very much the "high-tech, low-touch" approach, in opposition to the "low-tech, high-touch" approach where understanding of the needs of women during birth includes the sexual aspect of the birthing process. Established ignorance about certain aspects of female sexuality and the potential for abuse is illustrated by a delivery-room case documented by the author, which involved the obstetrician "helping" the woman in labour during her vaginal examination by stimulating her clitoris without informing her beforehand or obtaining her consent; according to my personal notes, none of the experts moved in to stop this, acting rather as voyeuristic witnesses.

The desexualization of childbirth was also significantly advanced due to the relocation of childbirth into institutions, which largely occurred in the second half of the 20th century; this involved the creation of a new norm stipulating that women should give birth in a hospital setting, and the forcible enforcement of this norm – despite current efforts to expand the choice of childbirth settings. This shift was initially presented as an important factor for maintaining the good health of women and children and the prevention of illnesses and death, while overlooking or disregarding the effect of institutionalization on the process of childbirth, the lack of privacy, the failure to provide certain aspects of care and the introduction of new routine procedures as well as the increased participation of men in a field where technology and routine procedures are given priority. What emerged was a desexualized female body in labour, shaven, genitals exposed, exposed to a controlling gaze and authoritarian touch, while ignoring sexual content, forbidden expression or care that would evoke the institutionally undesirable sexual aspect of childbirth; this, too, is an important vantage point from which the consequences of the framing of the maternity ward, with professional care provided by the public health-care system, as the mandatory childbirth setting, need to be examined.

The issue of desexualizing childbirth is multi-layered – childbirth is more difficult when women are forced to disassociate from what their bodies are telling them and bow down to a procedure imposed from the outside, when they have to ignore their own expression and sounds and control themselves in order for the professionals to find their behaviour acceptable. It is especially ironic considering that the institutionalization of childbirth was intended to provide higher-quality birth care. The routine use in hospitals of artificial oxytocin, which induces contractions and/or stimulates them, may be interpreted as an anticipated response

to the conditions of childbirth in an institution where the logic of the natural progression of childbirth is devalued or even ignored. Physiological childbirth is on one level based on a sensitive, changing hormone cocktail in the birthing woman and baby, and is closely connected to the well-being of the woman and child. If we obstruct or hinder otherwise functioning patterns, external interference becomes a necessary replacement for the physiological dosing of oxytocin in birth care that places the woman at the centre and respectfully supports her – this becomes more likely to happen outside of an institution. In contrast to authentic midwifery [51], taking natural body responses into account is not a strength of modern obstetrics, and staff, both doctors and medicalized midwives, frequently interfere and express a sense of hurry – or even, completely inappropriately, impatience. One example from data collected in an Internet questionnaire about birth experiences in Slovenia in 2005: *"What bothered me the most was that the staff kept saying, 'Come on, ma'am, everyone else gave birth already!"* [49]. In order to understand the basic needs of women during childbirth, we need to find a gender-specific understanding and sensibility and then develop appropriate approaches. Authors who acknowledge the interconnectedness of childbirth and sexuality compare the usual conditions under which we have sex, which provide intimacy, a relaxed environment and the knowledge we are not under anyone's control, with the conditions for successful childbirth, which are exactly the same: privacy, a warm, darkened space, no control or comments on appearance or behaviour. It is clear that pressuring your partner to have an orgasm will almost certainly have the exact opposite effect; similarly, scolding and expressing disapproval of a woman and her partner for kissing while she is in labour is only going to hinder the process, as often remarked by Marsden Wagner, a medical dissident who dedicated his work to supporting the well-being of mothers and babies and supporting autonomous midwifery [52].

Women need their individual course of pregnancy and childbirth to be respected, with the lowest possible degree of interference and forced adherence to routine; they do not wish to be told to hurry up or slow down, as corroborated by modern studies of childbirth physiology – childbirth is optimal when interference and intrusive procedures are the fewest. What is more, it has been proven that women and children benefit hugely from the presence of support networks and staff who deliberately try to be as non-intrusive as possible in order to allow the individual to relax and let the natural progress of childbirth take over. It must also be taken into account that every individual mother has her own particular way of giving birth, and she must be offered support, which includes adapting the setting. If individuals are able to relax and focus on giving birth, they will find it easier to listen to their own body, which in turn makes the midwife's job easier and more fulfilling. The degree of restrictions and expectations imposed by medical staff on women in labour, especially regarding her physical expression, is illustrated by another example from my notes of a consultation with a mother of a newborn in 2011, who bared her breasts during childbirth and was subsequently scolded by the midwife, *"Put your clothes back on, will you, this is not a beach."*

Ensuring privacy is one of the important aspects of a birth setting. Individual women have differing definitions of privacy. However, the feeling of one's privacy being limited definitely has no positive effects on childbirth; too many people in the delivery room, unknown personnel performing care, having to disclose personal information or even undergo a physical

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examination, even a vaginal examination, in the presence of others, e.g., during the rounds in post-natal wards, etc., are all intrusions on privacy. It should be kept in mind that, rather than being irrational, the institutional bans or restrictions on the presence of people the mother-to-be feels close to – her partner, other supportive women or doulas – are based on the understanding of power and control over the woman in labour and her freedom, and on the expectation that she must conform to the social expectations imposed by the institution during birth.

The widespread practice of episiotomy during typical childbirths is a classic example of a specific conceptualization of the female gender and her body in obstetrics, which is based on doubts over the capacity of the female reproductive system to deliver a baby without harming it. A decade ago, episiotomies were performed in over 50% of vaginal births in Slovenian maternity wards [49]. Episiotomy has adverse short-term and long-term consequences – more bleeding, pain, vaginal deformity – and affects women's sex lives both mentally and physically. Scientific data on when an episiotomy is justified show that an acceptable rate of episiotomy that would not increase the number of injuries in women and babies would be about 10%. There are midwifery practices with significantly lower rates of episiotomies or even none, but the disassociation from the sexual dimension of childbirth in modern obstetrics is made abundantly clear by the generous use of the procedure. One cannot help but agree with authors who have labelled the practice "sexual mutilation of women" [53].

9. Conclusion

If modern obstetrics does not rethink and expand its ethical principles, it will continue to deliver inhumane treatment to women – ignoring their needs, objectifying them, marginalizing their sexuality during the birthing process, and taking their power and control over a situation where these are of the highest importance. The challenge before us is to instigate a shift towards cooperation between birthing women, midwives and doctors. Midwifery is considered a caring profession, where midwives provide care to each woman and child individually during pregnancy, childbirth and early motherhood. The core tenet of midwifery is its positioning on the side of the woman; today, midwifery is undergoing modernization and it is therefore vital to recall what we have learned about the medicalization of female sexuality. Having reviewed the discourse and practices in which many midwives in institutions participate and perpetuate, we must call for more awareness about the midwife principle in modern society. We cannot ignore the question of midwives' (dis-)comfort with female sexuality, and the importance of understanding this as well as the connections with procreation capacities. Physiology and culture, which permeate every woman, her personal history and family traditions, continuously fluctuate and seek balance. Are we, as women, sufficiently self-aware that we know what we and our counterparts need in order to be able to say yes or no with a degree of responsibility to ourselves and others during childbirth, as in intimate relationships which include sexual activities?

We are still searching for answers to questions regarding, for example, the price women pay for (a semblance of) reproductive freedom. What has liberation won for us or taken away as

regards sexuality? Why do women partake in this? How do women fight back? Is there a way of moving past the medicalization of women's physiological sexual and procreative processes that we can embrace now and in the future? We all have to ask ourselves how to exist in a woman's body; we must be brave in taking on questions, empowering each other and working together to create opportunities to make our personal freedom a reality. To carry out decisions, to use our brain and not let others decide about important aspects for us. To stop definitions from limiting us. To dare to see, think and know in order to live well and work well, and, most importantly, to do good.

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