

The Medicalisation of Childbirth: A Technocratic Model of Birth in Public Hospitals in Croatia



Medikalizacija poroda: tehnokratski model rojstva
v javnih bolnišnicah na Hrvaškem

Danijela Paska

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ABSTRACT

Beyond its biological functions, reproductive health represents a powerful discursive field. Women's reproductive health has been and continues to be regulated by societal norms, religious doctrines, and political policies. This article examines how regulatory forces manifest in the medical management of childbirth in Croatian public hospitals, particularly through the medicalisation of birth and the adoption of a technocratic model of care. In this technocratic paradigm, the female body is perceived as a reproductive machine, the woman is objectified, and medical personnel become alienated.

KEYWORDS: reproductive health, gender, public hospitals, biopower, medical care

IZVLEČEK

Poleg svojih bioloških funkcij reproduktivno zdravje predstavlja močno diskurzivno polje. Reproaktivno zdravje žensk je bilo in še vedno je podvrženo regulaciji družbenih norm, verskih doktrin ter politik. Članek proučuje, kako se te regulativne sile kažejo v medicinskem upravljanju poroda v hrvaških javnih bolnišnicah, zlasti z medikalizacijo poroda in sprejetjem tehnokratskega modela oskrbe. V tem tehnokratskem paradigmatskem okviru je žensko telo dojeto kot reproduktivni stroj, ženska je objektivizirana, medicinsko osebje pa postane odtujeno.

KLJUČNE BESEDE: reproduktivno zdravje, spol, javne bolnišnice, biomoč, zdravstvena oskrba

INTRODUCTION

The domain of women's health is shaped as a discursive field, framed by a diverse set of patriarchal knowledge systems and practices, religious and national values, and a socialist legacy, all of which are currently interwoven with neoliberal market logics. In Croatian society, both historically and in the present, the prevailing understanding of "women's health" is strongly linked to reproductive health, which predominantly concerns obstetrics and menstruation, that is, the female reproductive organs. This associates the ideal of womanhood with a naturalised role of motherhood (Galić 2006). To understand how such a conceptualisation emerged, the theoretical framework of the French philosopher Michel Foucault proves useful. Foucault posits that no knowledge or meaning about a social phenomenon, occurrence, or issue exists outside the discourse generated by the microphysics of power – power and control disseminated into all domains of human life (Foucault 1972, 1980). The population of citizens is shaped through an invisible form of governance, which Foucault defines as an activity that guides individuals throughout their lives (Foucault, as cited in Rose, O'Malley and Valverde 2006: 83).

The discursive construction of reproductive health and medical care in childbirth is analysed through the combined perspectives of public policy analysis and ethnographic study of lived experiences. Drawing on the anthropology of public policy, public policies are approached as instruments that construct social reality (Shore and Wright 1997) through norms, normalised practices, and representation, regardless of whether they pertain to public health, education, national security, or natality (Wedel et al. 2005: 7–8). According to Božić-Vrbančić (2010: 91), European public policies are shaped in a way that ostensibly seeks public support, while constructing what they propose with the aim of regulating society. This leads us to inquire into what and how certain aspects of women's health and reproduction are being regulated, and which forms of knowledge and practice are established as normative. From a Foucauldian perspective, the individual is born through *knowledge-power*, through disciplinary and regulatory processes most often tied to institutions such as schools, hospitals, prisons, and bureaucracies. Citizens are subject to a range of discourses, interpellated into a web of normalised knowledge about social phenomena, including reproduction, women's health, childbirth, and abortion, which circulate daily through mechanisms of domination, ultimately normalising such practices and forms of knowledge as so-called objective truths (Foucault 1972). Drawing on a Foucauldian perspective, this paper examines how the female body is positioned within the contemporary Croatian public health system during childbirth as a effect of dominant discourses.

Methodologically, starting from discourse as a representational system of knowledge and truth about social phenomena, this paper problematises the medicalisation of women's childbirth experiences in Croatian public hospitals, drawing on both real-life narratives collected through interviews and an analysis of Croatian public policies in terms of reproductive health. To be more precise, a discourse analysis was undertaken by examining public policies and their representations of women's reproductive health, alongside the material-

isation and effects of such representations. This analysis included regulatory frameworks such as laws and declarations on reproductive health, patient treatment, human rights, and pro-natalist policy in Croatian society, as well as statements from medical experts in Croatia and documents from international entities, including the United Nations, the European Union, and the World Health Organisation. The analysis is grounded in the lived experiences and narratives of 25 women who gave birth in public hospitals in Croatia between 2003 and 2023. Thus, the study is situated within an analytical lens that conceptualises public policies as instruments which produce and shape social reality. Within this framework, the analysis explores how forms of knowledge, practices, norms, and truths concerning medical care, hospital conditions, human rights, childbirth, and the position and rights of birthing women are constructed and normalised, thereby exercising control over citizens and materialising in the lived experiences of women giving birth in Croatian public hospitals.

Situating women's childbirth experiences within the context of biomedicine and the public health system in a neoliberal society, medicalisation is articulated as an immanent technique of governance and control. Anthropology teaches us that the medical system is itself a cultural system (Kleinman 1981) and that biomedicine functions as an apparatus of governance and regulation over individuals (Foucault 1980). In this case, the medicalisation of health, specifically women's reproductive health, denotes the expansion of biomedicine (biopower) into areas of life previously considered social rather than medical. It signifies the encroachment of medical authority into human life, sometimes to the extent that medicine assumes control and decision-making power that supersedes human rights (Pool and Geissler 2005: 39). Reproduction thereby becomes the central domain of governance across society, politics, and the economy (Roberts 2015). Analysing how contemporary public reproductive health policies represent this issue, the role of the World Health Organisation appears to be relevant in this global discourse, constructing societal mechanisms throughout its definition of reproductive health. According to the WHO, reproductive health "implies that people can have a satisfying and safe sex life and that they can reproduce and the freedom to decide if, when and how often to do so" (WHO 2018). In this context, the representation of reproductive health is critically examined through a biomedical lens, which, via "cosmopolitical obstetrics" and medicalisation, imposes a particular distribution of power (Jordan 1993: 196).

THE PATRIARCHAL STRUCTURE OF REALITY: THE WOMAN'S BODY AS THE BODY OF THE NATION

The question of women's healthcare within the representation of public policy is articulated through phrases such as "a women's issue", which derive their effects from historical and cultural definitions of gender, sexuality, and identity categories. These categories have been constructed through patriarchal, national, religious, and market-based value systems. Similar to other Western societies, Croatian society contains certain governance practices that produce dominant knowledge discourses (Foucault 1972). In Croatia, these social practices

fundamentally arise from a patriarchal structure of power. In other words, all contemporary political regimes, including the Croatian one, are structurally patriarchal (Galić 2006). Understanding the epistemology of women's health and medicalisation thus requires the analysis of the broader societal context and the constructed nature of social reality.

The patriarchal structure of society rests on heteronormativity, which instils in citizens a moral upbringing centred on family life and reproduction, within which the male is assigned a superior position, and the woman is defined by her naturalised role as mother-birther, a role to which she is systemically subordinated (Berlant 1997; Walby 1990). Patriarchy in Croatia, inherited from both egalitarian and truly patriarchal socialist times, has become further entrenched in Croatian society through a wartime paradigm (Koludrović-Tomić 1996: 335), one that relies on the construction and prosperity of the Croatian nation. This process is further reinforced through the development of public policies aimed at national prosperity, in which the postwar formation of the Croatian nation prioritises the family and pronatal policies as central mechanisms for shaping and consolidating national identity. According to Lauren Berlant (1997), this occurs due to the national fixation on the future. Put differently, the only thing the nation can provide for its prosperity is the past, presented as collective memory in the present, to preserve the future. Given Croatia's wartime past and its history as part of the Socialist Federal Republic of Yugoslavia, national identity becomes a traumatic zone in need of political therapy – a therapy that envisions salvation through natality, that is, through the female body as a reproductive machine. The dominant paradigm – what Berlant (1997) refers to as “national pedagogy” – places the family as the primary authority and social value that all citizens must aspire to (Brown 2019). A series of regulatory documents and declarations of the Republic of Croatia, most notably the National Population Policy adopted by the Croatian Parliament in 2006, emphasise the promotion of what is described as a “positive climate towards family, marriage, and children.” This policy orientation not only reflects the prevailing social atmosphere but also exemplifies the construction of a dominant discourse in Croatia, wherein public policies consistently reinforce the family as a fundamental moral, social, and national value. Within this discursive framework, the family is framed not merely as an ideal but also as an imperative and a measure of personal fulfilment that citizens are expected to attain. This understanding of constructed social reality, informed by Shore and Wright's anthropology of policy and Foucault's concepts of discourse and governmentality, is brought into dialogue with Berlant's notion of national pedagogy to strengthen the analysis of how this dominant paradigm is produced through public policies and sustained within discourse. For this reason, family values, heteronormativity, and reproduction are presented as crucial political issues (Berlant 1997: 56). The family, along with reproduction, is established as the primary vehicle that drives the Croatian nation and enforces the self-discipline of its citizens (*ibid.*), creating subjects as national bodies.

In creating such a national pedagogy, the female body becomes what is known as “the body of the nation”. A woman's fertility and body become the core of her health and the knowledge represented about it (Berlant 1997). In other words, the female body becomes a

burden of the Croatian nation and of general well-being, with the woman perceived as both the object and the national category upon which citizenship and national survival depend (Berlant 1997: 98). An analysis of public policy reveals how Croatia's patriarchal structure reproduces an archetype of motherhood, placing reproduction, seen as the only source of value, power, and status for women in their civic role, at the centre (Berlant 1997). The social value of a woman is defined through motherhood, as the pregnant woman represents the principal legitimate space in which the category of "woman" and "femininity" is transformed into a national category (Berlant 1997: 98). This conversion of gender into nationality renders the woman as a public object and political body of the nation, making the body – specifically the pregnant woman – a national fetish (Berlant 1997: 95). The fetishisation of women's bodies, particularly those of pregnant women, as a national body is further evident through the civil pro-life movement, which holds significant influence in Croatian society. The civil pro-life movement, by promoting women's reproductive roles while fetishising both the fetus and the pregnant body, constitutes a key component of the dominant discourse on women's reproductive health. In this vein, by positioning the discourse of women's reproductive health within an androcentric, patriarchal social structure as the Croatian one, the following analysis will focus on the medicalisation of women's childbirth experiences within the contemporary public health system, analysing what is normalised as medical care during childbirth. The medicalisation of women's experiences, particularly through the development of gynaecology and obstetrics, finds its foundation precisely in the patriarchal conceptualisation of the female body, aiming to exert control over female citizens.

MEDICALISATION OF WOMEN'S HEALTH

One of the foundational theses of this paper is the understanding of the medical system as a cultural system, which can only be interpreted within the broader culture of which it is a part (Kleinman 1981, cited in Pool and Geissler 2005: 77). This makes it essential to analyse the complex relationship between the affective-emotional lived experiences of female patients and the broader discursive representations embedded in public policy. Changes in the understanding of the female body, reproduction, and childbirth have not been solely the result of scientific discoveries, but also changes in social power, discipline, and control. These medical branches, focused on women's health and the birth process, provide a rich field for research from Foucault's perspective (1972, 1980), whose analysis of biopolitics and power relations within biomedical practices has contributed significantly to understanding the development of medical disciplines.

Today, health is primarily associated with the system of biomedicine and public healthcare, whereby biomedical classifications are based as much on cultural beliefs and social norms as they are on objective facts (López 1998). In Foucauldian terms, the cultural element of biopower enables a critical analysis of the medicalisation of human life (Foucault 1972), which perpetuates gender inequality in access to and the provision of healthcare (Wilkinson and Kitzinger 1993). To be more precise, biopolitics governs the biological

aspects of human existence, including health, reproduction, and mortality. The state, aiming to enhance productivity and fertility, intervenes in human life through public policies, medical discourses, and pronatalist initiatives. Medicine thus functions as an instrument of power, developing techniques to observe, examine, and regulate bodies, enabling physicians not only to treat but also to objectify and control populations. This process produces medicalisation, in which individuals become subjects of surveillance and their bodies sites of exercised power. With this in mind, this paper addresses the following research question: How do women perceive the medicalisation of childbirth in Croatian public hospitals?

To answer this question, the analysis draws on the work of Robbie Davis-Floyd, one of the most important theorists of the anthropology of birth, who provides the theoretical concept of the technocratic model of medical care during childbirth. Robbie Davis-Floyd (2022) defines technocracy as a society that is capitalist, hierarchical, burdened with institutions, (still) patriarchal at its core, based on the overvaluation of (certain types of) science, and the progressive development of high technologies (Davis-Floyd 2022: 64). Namely, during pregnancy and childbirth, because of the unusual demands placed on it, the female body is treated as a machine at risk of serious malfunction or complete failure (Davis-Floyd 2022: 61). Therefore, the technocratic model of medical care articulates the human body as a type of machine and doctors as mechanics. Anthropologist Emily Martin argues that obstetricians are both supervisors and mechanics, although they act more like supervisors, since their primary role in hospital births is the active management of labour (Martin 1987: 57, cited in Davis-Floyd 2022). Among these core values, in both medicine and the wider society, technology reigns supreme. As has been clear for over twenty years, most routine obstetrical procedures have little or no scientific evidence to justify them. They are routinely performed not because they make scientific sense but because they make cultural sense (Davis-Floyd 1992).

The shift from treating diseases to managing bodies as objects of study is crucial to the growth of the medical profession as an authoritative institution, and is enabled by the technocratic model of medical care that dominates within the (Western) medical system. This technocratic model of medical care manifests in real life through twelve tenets: 1. mind/body separation; 2. the body as machine; 3. the patient as object; 4. alienation of the practitioner from the patient; 5. diagnosis and treatment from the outside in (curing disease, repairing dysfunction); 6. hierarchical organisation and standardisation of care; 7. authority and responsibility are inherent in the practitioner, not the patient; 8. supervaluation of science and technology; 9. aggressive intervention with emphasis on short-term results; 10. death as defeat; 11. a profit-driven system; and 12. intolerance of other modalities (Davis-Floyd, 2022: 70).

Based on the experiences shared by women who have experienced childbirth in the narrative interviews, the most noticeable principles in medical care during childbirth in Croatian hospitals are the first three principles: the body as a machine, the patient as an object, and the alienation of medical staff from the patient. Technocratic medicine divides a person into constituent parts, as well as the process and experience of childbirth from the course of life. But above all, it separates the human body from the human mind, described below in the narrative of one of the women who experienced childbirth in Croatian public hospitals:

They don't deal with the upper body, only the lower body. It's yours to spread your legs, they look at it and leave. So they don't expect the upper body to talk, to have questions and rights. (S2, 14.10.2022)

The objectification of women as patients during childbirth is articulated as a dominant practice of medical care in Croatian public hospitals, as it was encountered by every woman interviewed. This type of objectification is recognised in practices related to the lack of communication between the medical staff and the woman in labour, the lack of information about medical interventions, the unempathetic approach of the medical staff, the lack of privacy, and control of the escort (partner, close friend or family member) of the woman in labour. This type of objectification and viewing the woman in labour as a number or clinical case is additionally perpetuated through the principle of alienation of medical staff, which is set as a learning system in Croatian medical schools. This principle is set as the basis of their system of knowledge and learning practices internalised during socialisation and within their medical discourse (Orešković 1990). Medical staff become emotionally distant or indifferent, and they are taught to view patients as objects or clinical cases. The women's narratives confirm this:

They literally ignored me as a living person in the room. They didn't listen, didn't ask anything, didn't introduce themselves. I was just an object to them, a number. They didn't acknowledge me; they saw me as a task. (S6, 21.10.2022)

They treat you like a factory, a machine that produces people. (S25, 10.02.2023)

These quotes reflect the objectification of women, whose identities are reduced to reproductive machines focused solely on their reproductive organs. While most of the women emphasised that their child's well-being was their top priority, they also expressed how the lack of empathy and communication from the medical staff during childbirth constituted a deep sense of disrespect for them as a human. Objectification was coupled with poor communication, and every intervention was justified by the staff with the phrase: "It's all for the good of your child." Although the women experienced this objectification as a form of violence and disrespect, many consoled themselves with the healthy outcome for their baby and simply moved on from the experience:

In that moment, all you want is for it to end and for your baby to be alive. You feel so helpless that you don't think about your expectations or the lack of information. Women often don't even realise what happened to them; they stay silent because they're just happy to be alive. (S9, 25.10.2022)

This treatment of women during childbirth reflects the previously discussed patriarchal structure of social reality. The national fantasy is driven by the idea of preserving the nation through reproduction. Hence, the foetus and newborn child become central to representations of citizenship (Berlant 1997). They are framed as legal subjects – both medically and juridically – positioned as the solution to human existence. This idealised form of citizenship is accompanied by the archetype of motherhood, rendering the woman within

public health and policy frameworks a reproductive machine carrying the burden of the nation's future (Berlant 1997).

Patriarchal culture has normalised women's otherness and gender-based violence, rendering certain childbirth practices socially acceptable. This is why the social reality and the dominant discourse in Croatia are constructed in a way that limits knowledge about reproductive health and reproductive rights, makes it taboo and stigmatises it as a "women's problem". That is why most women are not informed about their rights as patients and as women in labour, and do not know what is a legally permissible medical intervention and what is not. In this way, doctors are positioned as authorities and great experts.

The problem is that you know nothing, no information is available, no one talks about it, so you don't know what to expect or how to act. I think I went through it normally. (S9, 25.10.2022)

Due to the discursive control over knowledge about their reproductive health and reproductive rights, many women are unaware that certain procedures and medical interventions are not intrinsic to childbirth but indicate dehumanising medicalisation. Consequently, they defer to medical staff, don't articulate pain or discomfort, and assume that "this is how it's supposed to be". This objectification is further reinforced by a culture of silence, a product of the discursive representation of women's reproductive health. Most women do not speak openly about their childbirth experiences, sharing them only with close confidants. The lack of postnatal care also affirms their objectification and the perception of motherhood as a naturalised role:

After giving birth, no one asks how you are, how the birth was. They ask how the baby is and how your husband handled it. For them, it's normal that you gave birth. They treat childbirth like an assembly line. (S2, 14.10.2022)

Because of the dominant perception of motherhood as a naturalised female role, it is considered normal for a woman to give birth, rendering her pain and bodily suffering invisible or negligible.

Furthermore, when discussing specific medical interventions, the interviewees emphasised practices that are normalised within Croatia's public healthcare system yet are prohibited in other European contexts, and which can be interpreted as forms of obstetric violence. These included episiotomies, the intentional rupture of membranes by the medical staff, abdominal expressions (manual pressure on the abdomen to accelerate labour), and other labour-accelerating methods performed despite the patient's desire for a natural birth. Instrumental intervention via CTG monitoring (cardiotocography) was central to their experience of medicalisation, illustrated by this quote:

They have to make sure we're under CTG monitoring in case something goes wrong [...]. I was screaming in pain, and the nurse told me, "Why are you yelling if the CTG is calm?" (S1, 14.10.2022)

CTG monitoring often led to medical personnel expressing mistrust toward women who reported intense and painful contractions or other complications. Several women re-

counted how this mistrust placed them in life-threatening situations because the staff prioritised CTG readouts over the patients' verbal accounts of pain. This experience was particularly common among first-time mothers, where the discourse of reproductive health reinforces stereotypes about "first-timer hysteria", shaping the way these women were treated in hospitals.

Technological interventions were frequently accompanied by the administration of drugs and labour-inducing agents, often without explanation or consent:

They injected something into my vein without telling me what it was or asking for permission. Before that, they gave me a cocktail of medications that left me dazed and unable to say anything. (S2, 14.10.2022)

This normalised practice of medical care – including disregarding the women's interpretations of pain, the strict adherence to CTG monitoring, the objectification of patients, and the failure to provide information or obtain informed consent for medical interventions (such as treatments, drugs, or modes of labour) – can be understood as a form of violence and as a manifestation of dehumanised and disrespectful medical care.

Additionally, the women noted that each hospital appeared to have its own set of unspoken rules and informal practices, representing a form of institutional discipline in Foucault's terms, where domination and the power of medical personnel control the patient, leading to women's alienation (Foucault 1980). This discipline is evident from the moment a woman enters the hospital: she parts from her companion, gives her personal data, and her movement becomes restricted. Even the hospital's architecture – from the waiting room to the delivery room – manifests this medicalised control. The unwritten hospital rules often stipulated that the partner could only be present during the final stages of labour. Additional restrictions included immobility, being forced to lie down, prohibition of food and drink, and minimal communication or information from the medical staff. The women described this treatment as subjugation and neglect, as illustrated in the following quotes:

That's just how it is. Nobody gives you any information, no one introduces themselves or gives you a choice about what they'll do [...]. The whole system is designed to meet their needs, not ours as patients. (S6, 21.10.2022)

Your preparation and birth plan mean nothing because no one listens to what you want. There's no: "Do you want this?" They decide instead of you. (S7, 21.10.2022)

As for their attitude toward me as a woman, as a human being, zero. I felt like I was talking to criminals; they had no empathy, no feelings at all. I understand that their situation is difficult, that there are few of them, but I believe empathy is the most basic quality one should have, especially when working with vulnerable women. (S15, 6.11.2022)

Among the women, the hidden knowledge of "that's how it is in Croatian hospitals" and the narrative of "if they all survived, I will survive too" are rampant, so that sometimes in the narratives of their experiences, the concept of luck appears as an important factor in the experience of childbirth. In other words, women's narratives of childbirth frequently empha-

size the central role of luck in shaping their experiences. This sense of luck is particularly tied to the chance of encountering supportive and competent medical staff upon arrival at the hospital. Consequently, the quality of care during childbirth is often framed not as guaranteed, but as contingent on fortune, with Sunday frequently cited as the least favourable day to give birth. In conclusion, the medicalisation of childbirth is intrinsically linked to the objectification of women, not only as patients but also as individuals, citizens, and mothers.

CONCLUSION

Within the framework of Croatian national culture, a patriarchal lens constructs and fetishises the archetype of motherhood, reinforced by heteronormative politics and underpinned by conservative traditional and religious values. The national pedagogy of Croatian society reinforces the ideal of the family as an indivisible social authority. Within the context of such societal values, women's reproductive health becomes subject to control and politicisation. Within the public healthcare system, women are exposed to specific forms of medicalisation and objectification, accompanied by normalised practices shaped by the discursive effects of knowledge and truth. In this discourse, the physician's knowledge, based on technology and procedural protocols, is crucial: without his or her team, the birth cannot proceed even if the woman is ready to give birth to her child. The competing types of knowledge possessed by the woman and others involved in the event are suppressed and managed. What her body says, what she knows (and shows) based on her bodily experience, makes no difference in this environment.

Being confined to a hospital bed, giving birth in a supine position, being attached to a CTG machine – often trusted more than a woman's own interpretation of her pain – the administration of medications and labour-inducing substances without prior information and/or patient consent, as well as practices such as the intentional rupture of membranes, episiotomy, and abdominal expression are recognised as common practices of medical care during childbirth in Croatian public hospitals, which confirms the dominance of the technocratic model of medical care. The institutional discipline of hospitals alienates and restricts the woman as a patient. This form of medicalisation is marked by a profound objectification of the woman as a machine and object – a reproductive machine – thereby absolving medical personnel of any responsibility for the patient's mind and spirit. Thus, within the framework of normalised and routine medical care, elements of obstetric violence can be identified. Thus, the medicalisation of women's reproductive health entails the expansion of biomedicine, at times to the extent that medical authority assumes control and decision-making powers that override human rights.

Therefore, the medicalisation of women's reproductive health must be viewed not only as a response by the state to a perceived public health crisis and to pronatalist concerns about the national well-being, but also as an expansion of diffuse forms of governance and control. The experience of medicalisation thus highlights gender-based inequality in access to and provision of healthcare services. Based on the real experiences of women, it becomes evident that medical care functions as a mechanism of governance, revealing structural

and often invisible forms of violence that reproduce social inequalities. Obstetric violence reflects the disciplining of women's bodies, enforcing passivity and compliance, and serves as a tool to regulate pregnancy and childbirth. Normalised care in these settings thus operates within a continuum of patriarchal power relations.

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POVZETEK

Poleg bioloških funkcij predstavlja reproduktivno zdravje diskurzivno polje, ki ga močno oblikujejo družbeni, kulturni in politični konstrukti. Tako v preteklosti kot tudi danes je žensko reproduktivno zdravje področje, ki je podvrženo regulaciji in na katero posegajo družbene norme ter verska in politična prepričanja, ki opredeljujejo, kaj šteje za sprejemljivo ali moralno vedenje. V članku sta predstavljena kritičen pogled na te regulativne sile in njihov izraz v medicinskem vodenju poroda v hrvaških javnih bolnišnicah, zlasti pri medikalizaciji poroda in na tehnokratskem modelu oskrbe. Raziskava, ki se naslanja na Foucaulta, proučuje izkušnje žensk, ki so rodile, ter ugotavlja, kako bolnišnice kot institucije moči standardizirajo znanje in medikalizirajo naravni proces poroda. V tem tehnokratskem paradigmatem okviru postane žensko telo reproduktivni stroj, porodnica je objektivizirana, medicinsko osebje pa je odtujeno od pacientke. Ta model je postal prevladujoči način oskrbe pri porodu. Analiza se v veliki meri opira na teoretične perspektive antropologinje Robbie Davis-Floyd (1992, 2022), ki je zastavila dvanajst temeljnih načel tehnokratskega modela poroda, ki vključujejo ločevanje uma in telesa, objektivizacijo, odtujenost, hierarhično organizacijo ter avtoriteto zdravnikov. V kontekstu hrvaških javnih bolnišnic se ta model kaže v rutinskih praksah, kot so stalno elektronsko spremljanje ploda, uporaba epiduralne analgezije, pomanjkanje komunikacije, dehumaniziran pristop in visok odstotek carskih rezov. Takšni posegi so včasih medicinsko potrebni, vendar pa so postali normalizirani do te mere, da zasenčijo individualizirano, na žensko osredotočeno oskrbo. Članek v središče postavlja življenjske izkušnje žensk, na podlagi katerih pokaže, kako ustaljeni pristopi hrvaških javnih bolnišnic utrjujejo nadzor nad porodom in normalizirajo zdravniško poseganje. Zdravstveni sistem je tako treba proučevati kot kulturno institucijo, ki jo oblikujejo družbene vrednote. Članek prinaša kritično analizo obstoječih praks, ki kažejo na dehumanizacijo in nasilje, ter izpostavlja potrebo po preoblikovanju porodniške oskrbe v model, ki spoštuje avtonomijo, subjektivnost in individualne potrebe žensk.