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Rural Pregnancies, City Childbirths: Deterritorializing Scenarios in the Pregnancy, Childbirth, and Maternity Processes in Chubut, Argentina.

Juan Manuel Diez Tetamanti
CONICET – UNPSJB / IGEOPAT / GIGAT – Comodoro Rivadavia – Chubut – Argentina
https://orcid.org/0000-0002-1765-1649

Leticia Curti
CONICET – IDEAus – CENPAT – Puerto Pirámides – Chubut – Argentina
https://orcid.org/0000-0002-1528-1509

Lelis Ailin Feu
CONICET - UNPSJB / IGEOPAT / GIGAT / UNPA – Comodoro Rivadavia – Chubut – Argentina
https://orcid.org/0000-0001-7509-5145

Abstract
The province of Chubut adheres to the Perinatal Care Regionalization, which implies a series of problems related to the organization of the healthcare system in rural spaces. This makes sense when we take into account that Chubut is Argentina's third largest province, but one of the less densely populated at the same time. In this state of affairs, long distances and underdeveloped road and communication infrastructure are obstacles to guaranteeing transportation and mobility dynamics for both pregnant people and their families. In this article, we propose a first approach to the problems that arise from the pregnancy, childbirth and maternity experience, based on a cartographic research approach, supported by interviews and social cartography workshops carried out with health personnel, mothers and families from rural localities. This is how clues to address several lines of flight arise, lines of flight that escape from medical-bureaucratic regulations, and whose approach arises from local community strategies that seek to ensure optimal conditions for rural perinatal journeys, even if their medical aspects are addressed mostly in cities. In this scenario, future reforms to the current organization of the perinatal care regionalization process are hinted at by the deterritorialization processes advanced by the perinatal care regionalization initiative; by the generous, local community strategies; by the domestic organization; and by the construction of generous, transportation networks or the elective changes of reference hospitals and birth cities, all of which go hand in hand with the Respectful Maternity Care Law, which is put forward as an initial approach in this study.
Keywords: Chubut. Maternity. Rural. Patagonia. Health.

Gestar en lo rural, parir en la ciudad. Escenarios de desterritorialización en el proceso de gestar parir maternar en Chubut, Argentina.

Resumen

La provincia del Chubut adhiere a la Regionalización de la Atención Perinatal, lo que implica una serie de problemas referidos a la organización del sistema de salud en espacios rurales. Esta singularidad se comprende entendiendo que la provincia es la tercera en extensión de la Argentina, y que al mismo tiempo es una de las provincias con menor densidad de población. Las distancias, la infraestructura de caminos y de comunicaciones de poco desarrollo, es un obstáculo para garantizar dinámicas de transporte y movilidad tanto para personas gestantes, como para las familias que las acompañan. En el artículo nos planteamos una primera aproximación a la problemática de la experiencia de gestar, parir, maternar; en base a un enfoque de pesquisa cartográfica, apoyado en entrevistas y talleres de cartografía social realizados con personal de salud, madres y familias de localidades rurales. Se vislumbran así, pistas para abordar líneas de fuga de las normas médico-burocráticas que organizan el territorio, recurriendo a las estrategias locales y comunitarias propuestas por la población local, para garantizar buenas condiciones en las trayectorias perinatales vividas desde los espacios rurales, pero transitadas, en gran medida en ciudades. Los procesos de desterritorialización motorizados por la iniciativa de regionalización perinatal, en conjunción con las estrategias comunitarias solidarias locales; como la organización intrafamiliar, la constitución de sistemas de transporte solidarios o los cambios selectivos de hospital de referencia y ciudad de nacimiento, traen pistas para abordar futuras reformas a la actual organización de la regionalización de la atención perinatal, que van de la mano con la Ley de Parto Respetado Argentina, y que en este texto se presentan como primeras aproximaciones.

Palabras clave: Chubut. Maternidad. Rural. Patagonia. Salud.

Gestar no rural, parir na cidade. Cenários de desterritorialização no processo de gestação-parto-ser mãe em Chubut, Argentina.

Resumo

A província de Chubut adere à Regionalização da Atenção Perinatal, o que implica uma série de problemas relacionados com a organização do sistema de saúde nas áreas rurais. Essa singularidade é entendida ao entender que a província é a terceira maior da Argentina e, ao mesmo tempo, é uma das províncias com menor densidade populacional. As distâncias, as infraestruturas rodoviárias e de comunicações pouco desenvolvidas, são um obstáculo para garantir dinâmicas de transporte e mobilidade tanto para as grávidas como para as famílias que as acompanham. No artigo propomos uma primeira aproximação ao problema da experiência de gestar, parir, maternidade; com base em uma abordagem de pesquisa cartográfica, apoiada por entrevistas e oficinas de cartografia social realizadas com profissionais de saúde, mães e famílias de localidades rurais. Assim, vislumbram-se pistas para abordar linhas de fuga às normas médico-burocráticas que organizam o território, recorrendo a estratégias locais e comunitárias propostas pela população local, para garantir boas condições nas trajetórias perinatais vividas a partir de espaços rurais, mas percorridas, em grande parte. Nas cidades. Os processos de desterritorialização impulsionados pela iniciativa de regionalização perinatal, em articulação com as estratégias das comunidades solidárias locais; como a organização intra-familiar, a constituição de sistemas de transporte solidário ou as mudanças seletivas de hospital de referência e cidade de nascimento, trazem pistas para encaminhar futuras reformas à atual organização da regionalização da atenção perinatal, que andam de mãos dadas com a Lei do Parto Respeitado Argentina, e que neste texto são apresentadas como primeiras aproximações.

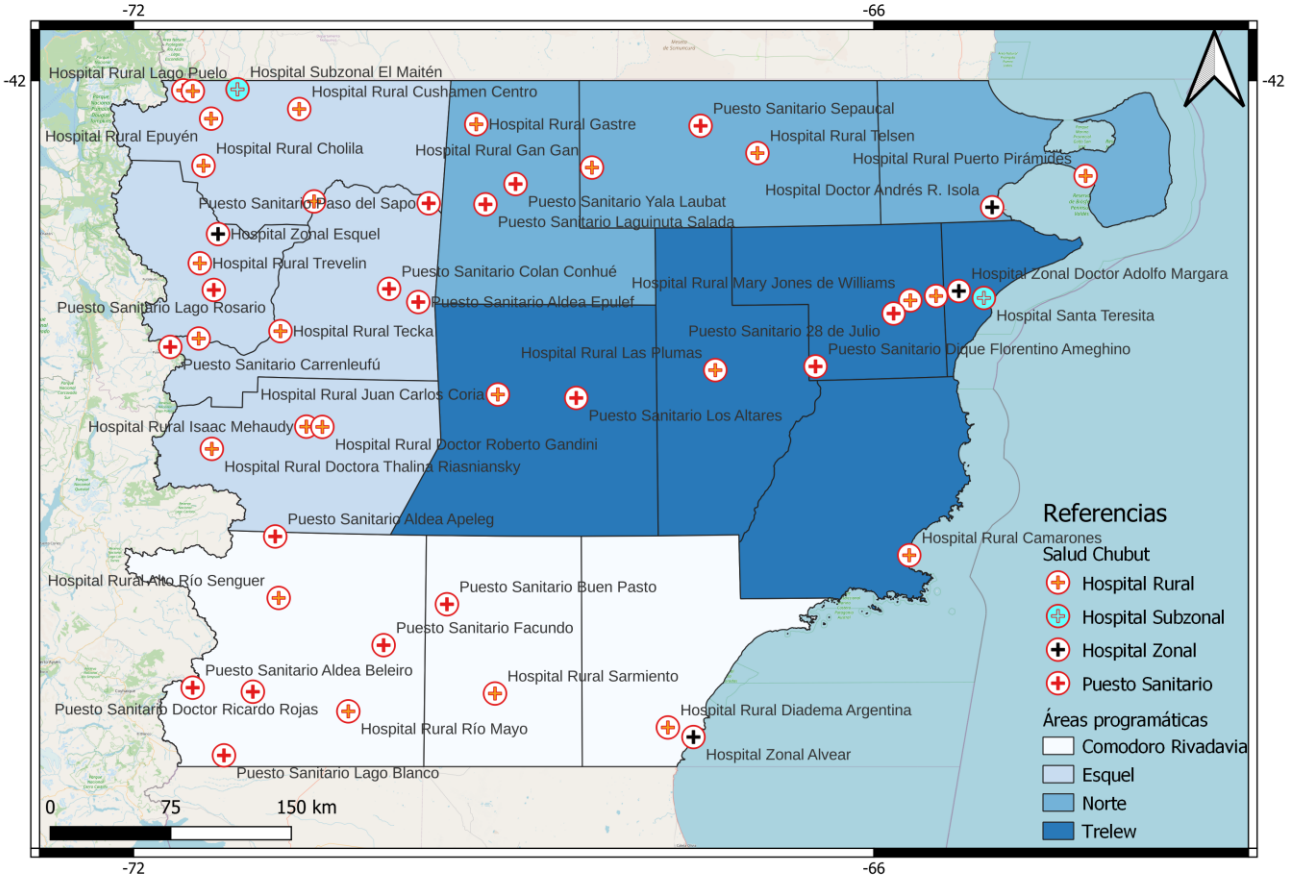
Palavras-chave: Chubut. Maternidade. Rural. Patagônia. Saúde

Introduction

Chubut is Argentina's third largest province, with a population density of 2.3 inhabitants per km2 (INDEC [National Institute of Statistics and Census] 2010). As for its territory, the province is shaped as an urban triangle comprising the cities of Esquel, Comodoro Rivadavia, and Río Chubut Valley (Trelew and Rawson cities) and Puerto Madryn. These cities are 350-600 km apart and are the nodes where high complexity hospitals operate and where the province's largest urban infrastructure development is located. The remaining provincial rural space, hundreds of square kilometers, is covered by rubble and dirt roads that snow, rain, or river floods block throughout the year. Asphalt roads are rare, and transportation services are deficient or nonexistent (Argentina. Plan Estratégico [Strategic Plan]. 2017). In this state of affairs, the four previously mentioned cities concentrate 90.5 % of the population; consequently, the remaining 9.5% lives in the countryside, small towns, rural villages and little communities which are far away from one another and from the main cities (INDEC 2010).

As for the healthcare system, Chubut has 51 complexity level I healthcare centers, 26 level III rural hospitals, 2 level IV subzonal hospitals, 3 level VI zonal hospitals and 1 level VI regional hospital (Chubut. Health Ministry, 2019. Anuario estadístico de salud [Health Statistic Yearbook]), Vol. 2). See Map 1.

Map 1 Programmatic areas of the health system of the province of Chubut. Hospitals and healthcare centers.



Cartography: Diez Tetamanti 2023. Qgis.

Chubut's healthcare system is regionalized according to a mixed model that combines complexity levels and geographic responsibility. Each of the 4 programmatic areas (North, Esquel, Comodoro Rivadavia and Trelew) are also organized according to complexity levels and growing operating capacity, the highest rank being occupied by the zonal or regional hospital. The capacity of rural hospitals and healthcare centers has varied in recent years according to the operating and active equipment.

In order to make the healthcare system organization clear, we quote Jaime, S. (2017), who explains that "the Ministry is organized in 4 Secretariats (Health Programs, Human Resources and Training, Institutional Management and Economic Management), which share the different institutional and ministry management responsibilities. The province is split into 4 jurisdictions, called Áreas Programáticas de Salud (Health Programmatic Areas), which are run by a provincial director depending directly on the Health Minister" (Jaime, Op. cit., pp. 15). In addition to this organizational system, there is the private system, which must be taken into account since 71 % of the province population has health insurance; however, the public health system is predominant (Jaime, Op. cit.). In the following table, the equipment and basic infrastructure status for each Programmatic Area are compared.

Table 1. Equipment and complexity status per Programmatic Area. Source: Adapted from Chubut. Statistics. (2022)

Programmatic Area (colloquial name)	Esquel (The Andean Region of the 42nd Parallel S)	Trelew (Valley of Chubut River)	North (Puerto Madryn)	Comodoro Rivadavia (South)
Districts comprised	4	5	3	3
Population	109071	163629	87351	239561
Main hospital (complexity of maternity wing)	Esquel (IIIA)	H. Zonal A. Margara - Trelew (IIIB)	H. A. Ísola - Puerto Madryn (IIIA)	H. Regional Sanguinetti - Comodoro Rivadavia (IIIB)
Hospital with external maternity residence	NO	YES, in a hotel	YES, within the hospital	NO, under construction
Dependent, Level III Rural Hospitals	12	5	4	4
Dependent, Level IV Subzonal Hospitals	1	1	0	0
Healthcare centers	30	6	6	6
Level I, Dependent				
Beds available	254	239	157	331
Inhabitants per bed	429.5	684.6	556.3	723.7

INDEC (2023).

In Map 1, the distribution of the different hospitals and healthcare centers per Programmatic Area described in Table 1 is represented.

The province is divided in Programmatic Areas following an organizational logic called "regionalization," which is linked to the Estrategia Provincial de Regionalización de la Atención Perinatal (Provincial Strategy for the Regionalization of Perinatal Care, or ERAP). In turn, the ERAP is framed within the same strategy at the national level and has also been adopted by other provinces in the last 15 years (Argentina, 2019). ERAP has been promoted by international organizations such as the Panamerican Health Organization and was adopted in Argentina as a strategy to establish perinatal care regions where service coordination and information exchange can be improved. In this state of affairs, this initiative seeks to break down geographic, social, human resource, and economic barriers.

Maternal-perinatal care regionalization programs have been designed to organize services so that pregnant people and high-risk newborns are optimally taken care of in sufficiently experienced and adequately equipped hospitals. In this state of affairs, maternity hospitals have been classified into three levels of care, from the lowest level of complexity to the highest (II, IIIA, IIIB); transportation systems have been organized, and links between healthcare structures have been built in

order to maintain adequate training in low-complexity levels so as to properly refer high-risk cases (OPS 2017).

In this sense, there are proven and successful examples in both developed and developing countries, such as Canada, the United States, Norway, Ecuador, Chile, and Sri Lanka, the last of which resorts to midwives because of low technological development (Schwarcz, A, Garibaldi et Méndez, 2011). Schwarcz, A, Garibaldi et Méndez (Op.Cit) also highlight that "the concept of regionalization must be discussed for developing countries, especially in South Asia and sub-Saharan Africa, because the developed model aimed at the richest countries may not be applicable in their case. In developing countries, perinatal care is characterized by insufficient healthcare services (in all three levels of care), lack of answers to specific problems, qualified personnel (midwives, nurses, doctors, and specialists), suboptimal service infrastructure, and non-existent service networks. The poorest sectors have little access to health services because of the lack of financing and impossibility of accessing private providers. There is no access to transportation systems."(Schwarcz, A, Garibaldi et Méndez. 2011 pp. 45,46).

As a historical process, "pregnancy and childbirth are no longer considered family and domestic events taken care of by midwives or traditional birth attendants, but hospital events where risk logic defines them as "defective," risky and perfectible through science and technology, considering, of course, that all interventions and instrumentalizations seek the mother and child's safety." (Vallana Sala, V. 2020, p. 98). In this state of affairs, the industrialization of society translates to the industrialization of both health and the reproductive body, where the process is mechanized, intervened, instrumentalized and protocolized (Vallana Sala, V. 2020).

In this state of affairs, Chubut incorporated both the conceptual and operational changes that occurred in the last century. In Argentina, up to the first decade of the XXI century, a new perinatal care system was implemented in which each inpatient healthcare center had a delivery room and offered newborn care, which allowed for most of the care services and "other pregnancy-related health events[1]" occurring in small towns, rural villages, and big cities, as long as they were considered low-risk (Chubut. Ministry of Health. 2019).

In the mid 90s, the World Bank promoted an initiative called "Safe Motherhood," which stated that childbirth should take place within higher complexity institutions (Tinker, A. G., Koblinsky, M. A., & Daley, P. 1994), which excluded rural hospitals and similar institutions.

Initially, this strategy was based on the need to achieve social improvement in terms of maternal and child mortality. Even though this has not caused substantial change in the management modality, there was a series of subsequent national and provincial initiatives that combined elements from Safe Motherhood with a more holistic care model (family centered maternity facilities) that became increasingly important, implicitly adhering to UNICEF's initiative Safe and Family Centered Maternity (SFCM). This initiative summarized the zeitgeists, according to which international organizations strongly promoted regionalization and safe patient-centered care. The initiative proposed that childbirth take place in institutions with the complexity and capacity to hold more than 1000 childbirths per year (Schwarcz, A., Garibaldi et Méndez. 2011).

[1] We refer to abortion, perinatal death, etc.

In this state of affairs, the initiative of the SFCM turned into a frame engulfing state policy at the national level, according to which each province has attuned its legislation. In some cases, such as in Misiones, the provincial law Ley XVII-157 (Misiones–SAIJ. 2022) was recently passed; in ohers, such as in Santa Fe, Río Negro, Buenos Aires and Chubut, the initiative turned into a series of organization changes of maternity facilities (Ramos, S., Romero, M., Ortiz, Z, & Brizuela, V. 2015.)

In his historic dynamic, the perinatal care process reflects these conceptual and operational changes arising from the healthcare system. Unlike other care-providing processes, this one is produced over a natural phenomenon that cannot be classified as an illness, but which, as it evolves naturally, conveys a series of risks deemed socially unacceptable, and which begins in a historical moment of humanity in which maternity occupies a central position that lies at the heart of social esteem.

In the rural areas of Chubut, this change of model, influenced by the SFCM and ERAP initiatives, implied in practical terms moving the centralization of childbirth from small rural towns or villages to cities, where higher-complexity hospitals (level IIIB and IIIA) can be found. This produced deterritorialization[2] of the perinatal care process, affecting other moments, stages, and movements (pregnancy and puerperium), which will be able to develop in their communities of origin.

This produced a great territorial change in the organization of the healthcare system and in the pregnancy, childbirth and/or maternity singularized community experiences and practices in rural areas, which were accompanied by the abandonment of the installed capacity of certain services, such as transportation, communication and the healthcare system itself, where some local services (such as delivery rooms, dentist offices, laboratories, X-ray rooms, ultrasound, etc.) were dismantled (Diez Tetamanti, Heredias et Martínez 2019) (Vázquez, Schuller Diez Tetamanti, 2019) (Feu, A, Gran et Diez Tetamanti 2019.) Finally, the healthcare system was also modified in terms of patients' referrals, logistics, and mobilization management, such as time, complications, and experiences of the journey to and stay in the city (because not all hospitals have a maternity wing) of pregnant people and their companions throughout the different health and pregnancy, childbirth, and maternity events.

The project's perspective centers on the relationship of the pregnancy, childbirth and maternity triad as a complicated and articulated process, and not just as the medical-perinatal instance between week 28 of pregnancy and the newborn's 7th day of life. Rural pregnancies, city childbirths and movements of the deterritorialization process.

To present the phenomena of deterritorialization of pregnancy, childbirth and maternity, we start from a series of movements present in Deleuze's (2020) territory, deterritorialization and reterritorialization triad, formalized in the vital process presented by Rolnik (2019). Our starting point is the notion of territory as defined by Guattari and Rolnik, where "the meaning we ascribe to it surpasses its usage in

[2] We take Deleuze's (1980) notion of deterritorialization, which describes it as "the movement by which "one" leaves the territory. It is the operation of the line of flight. There are very different cases. D[eterritorialization] may be overlaid by a compensatory reterritorialization obstructing the line of flight: D[eterritorialization] is then said to be negative. Anything can serve as a reterritorialization, in other words, 'stand for' the lost territory." (N.T.: Translation into English extracted from A thousand plateaus. Deleuze (1987)).

ethology and ethnology. The territory can be relative both to a lived space as well as to a perceived system within which the subject feels 'at home.' The territory is synonymous with appropriation, subjectivation confined within itself. The territory can be deterritorialized, that is, it can open itself and take lines of flight, and even crumble and be torn down. Deterritorialization is an attempt at recomposing a territory engaged in a reterritorialization process." (Guattari y Rolnik, 2006: 372.)

According to this theoretical background, we understand that the territory production movement is linked to the relationship between signifiers and signifieds and the way of organizing life in terms of limits, regulations, possibilities and spaces; in this way, processes of reproduction, flight or production of new territories are created.

In this sense, the processes of pregnancy, childbirth and maternity are part of a game of signifiers and signifieds which, in the rural practice, turn into formal-territories-reproduction movements, such as those that arise from the bureaucratic and sanitary organization of perinatal care regionalization. However, other movements outside this organization take place at the same time, articulating new proposals or skipping geographic and bureaucratic limits and institutionalizing regulations to create new trajectories.

The pregnancy, childbirth and maternity triad conveys movements that expose the body to hard-to-predict meanings. In the instituted territory, the rural female body moves to the city, linked to a different spatial and social context lacking the local codes from where she comes. The pregnant woman's "countryside-to-city" movement, as we will see later on, is deterritorializing, but, at the same time, the anticipation of this phenomenon gives the mothers and their families the possibility of producing new alternatives to face that instance, creating lines of flight with a vital and resistance potential.

The new territorial configurations, set by trajectories and experiences different from the institutionally established, force a change in practice due to a disruption that changes the expected dynamics. Consequently, deterritorialization is in a dialectic relationship with its counterpart, reterritorialization, as described by Guattari and Rolnik (2006), as an attempt to recompose and recover the territory.

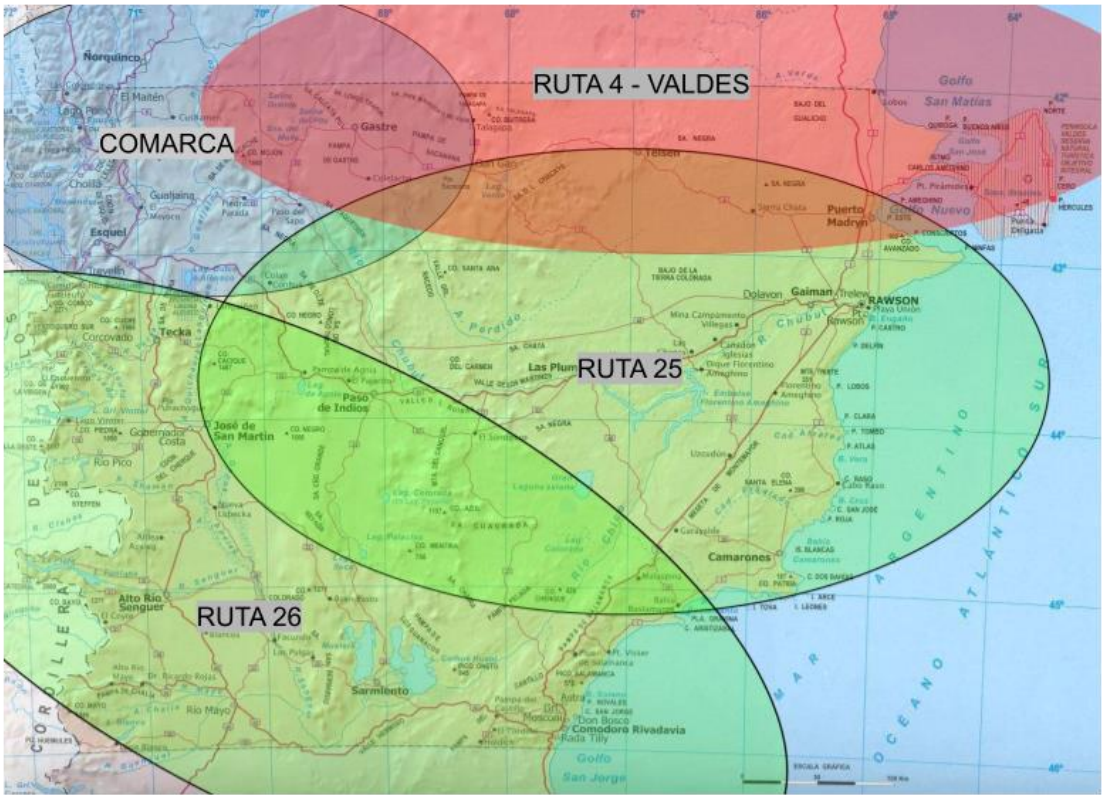
Hence, these deterritorializations can be analyzed as breaking points, changes in the way in which territory is codified, and at the same time, it transforms and reterritorialization itself into a new territory that does not fully abandon the old organization system and adopts new links and dynamics as lines of flight.

In the process of rural maternity, pregnancy, childbirth and the construction of a maternity territory can be considered deterritorialization processes in the bodily, spatial and social planes, where the structures both known and practiced are broken from different angles, escaping from the established order. In this state of affairs, the population creates strategies to construct new territories which are less disruptive to the everyday, local territory, but highly disruptive to the healthcare bureaucracy: "outside the norm." In this sense, there are cases in which the system is sometimes reproduced as a way of repeating what is established, and sometimes reproduced from lines of flight, creating new territories that transform the norm and create new possibilities to consider, as we will cover in the following paragraphs.

Methodology

The work methodology was framed within a cartographic research approach adapted to geographic studies. The approach starts with an active and engaged exercise of the researcher on the composition, contrast, and juxtaposition of experiences and production of territories (Bedín da Costa. L, 2019). The multiplicity category in representation and production is the one that comes into play before the ones that are traditionally represented by data and quantitative results, to which life does not seem to become adapted (Passos, E. et Kastrup, V. et Tedesco, S. 2016).
The interview is presented as the main instrument in the first approach to the field work and is set as "a shared experience of asserting that, in its performativity, always creates world" (Tedesco, Sade et Caliman, 2013). In this way, we consider that the building of the research design constitutes a reflexive process that operates at all stages of the research development (Hammersley et Atkinson. 1994:42). Hence, it became necessary to produce a working regionalization device that involved tracing four large geographical spaces that are tangentially related to the Healthcare Programmatic Areas and potentially related to the circulation schemas of people in the interior of the province. See Diagram 1.

Diagram 1 device that involved tracing four large geographical spaces that are tangentially related to the Healthcare Programmatic Areas and potentially related to the circulation schemas of people in the interior of the province.

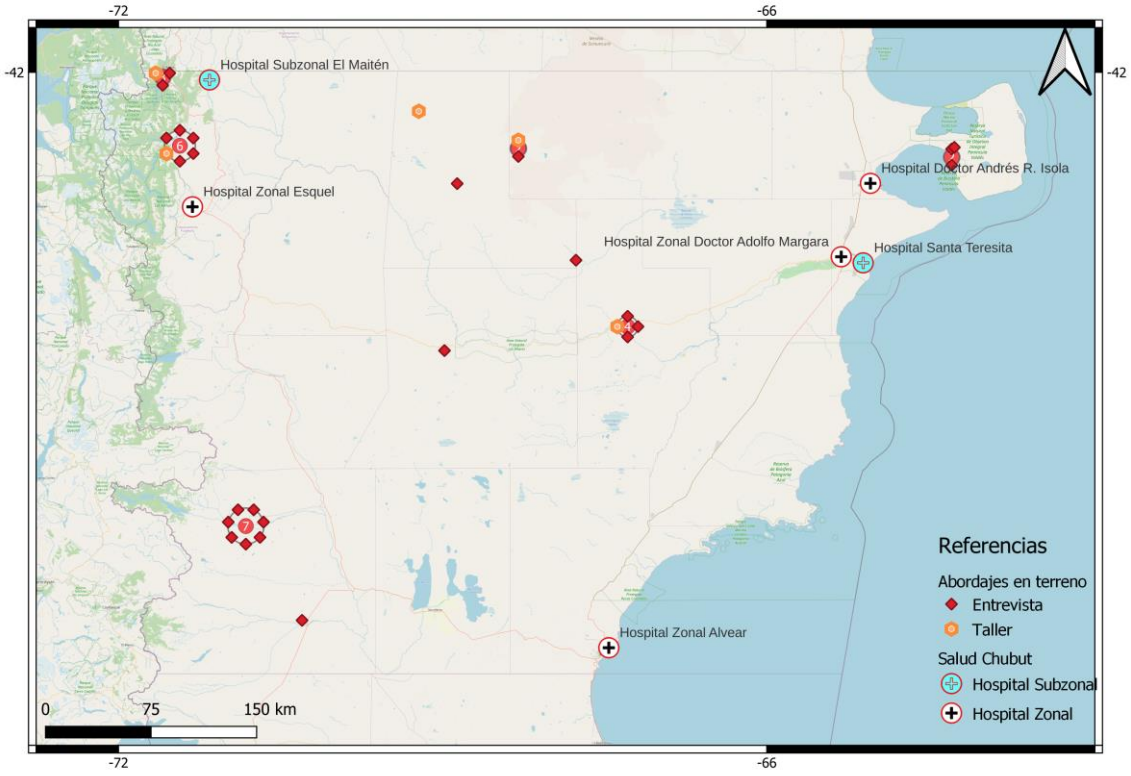


Authors 2023.

On the one hand, this organization facilitated the implementation of a fieldwork device that activated its comparison and promoted debate about it; on the other hand, it permitted it to contain the singularities of each field of approach. The work was carried out along this line, with the main focus on observing practices and their spatiality (Lindón, A.; Hiernaux, D. 2008). Social cartography workshops (Diez Tetamanti 2018) and dioramas (Hagerstrand. 1982), which allow the recognition of subjects' or groups' mobility in a specialized way, were used in tandem with semi-structured interviews within the cartographic research approach (Tedesco, Sade et Caliman, 2013).

The work carried out in the virtual field started in the second half of 2021 and displayed limitations related to post-pandemic restrictions. The devices were restructured to proceed with the research and virtual approach by implementing synchronic interviews via digital videoconference or instant messaging platforms. In 2022, the first in-person fieldworks were completed, where trips were organized to each one of the articulated "work areas" and visits were coordinated to various localities and villages in each mission. Twenty-five interviews were carried out to mothers and health personnel, and five cartographic workshops with health personnel from rural hospitals and an open-invitation one were carried out in Lago Puelo, in the Andean Region area, respectively. See Map 2.

Map 2: Fieldwork approaches. Provincial locations for interviews and workshops, in relation to the location of hospitals.



Cartography: Diez Tetamanti 2023.

Finally, to synthesize both interviews and workshops, chorems, simple graphic representations that allowed for the visualization of spatial dynamics, were

built. This tool allows for the production of texts on spatial connections and their links to particular problems. According to Portugal, "the chorem has a double meaning. On the one hand, it is the fundamental building block, based on combinations, of a spatial organization model, and at the same time, it is the graphic expression of that very same object." (Portugal 1996). Using chorems allowed us to create a schema of the multiplicity of territories built according to the displacements and dynamics that characterize the described processes.

First approaches to the field

As researchers, our point of departure being our urban subjectivity, we define a first concept: "the journey," which is incorporated into the basal observation method and is part of the interaction with the world of senses. According to Hammersley, personal reactions are transformed through a reflexive analysis of personal public knowledge (Hammersley et Atkinson. 1994:183). The journey, which comprises the city-countryside and countryside-city displacements, is also one of the "being there" components of the cartographic-research approach and, at the same time, it creates a singular, intermittent deterritorialization process. This is how a reflexive analysis is performed, as it is faced with the personal reaction; the description of traveling is an element that provides body experience, texture and sensitivity to the object of study. Along this line, we quote Gauber, who claims that "participation is the sine qua non condition of sociocultural knowledge; hence, direct experience, the sensory organs and affectivity do not take us away from, but make us closer to the object of study." (Guber, R. 2001. p66).
In this way, the figure that best allows us to approach the fieldwork process is Luciano Bedín Costas' definition, in which he refers to the cartographer as a researcher. The cartographer, from the cartographic research approach, "does not know beforehand what he will find, what he will go through, which will be the encounters he will have and what could these encounters imply. The cartographer, in a certain way, loves the "maybes," he is available to the randomness offered by his field, to the unpredictable encounter that will come along the way" (Bedín da Costa, L. 2019:4).

The first encounters with the field date back to 2011, with the first approach in the Southwest of Chubut (Chanampa, M.; Jaimes, M.; Diez Tetamanti et al., 2014) where a recurring issue in the interviews was the inconvenience of giving birth in the city while living in the countryside. After many years, projects and publications, it was not until 2021 that we were able to begin approaching the matter once again in the field. Having gone through the pandemic, we started a virtual interview, adapting the possibilities to the media and the available and manageable technological forms (Canali, C. et Cesarini, E., 2021), both for our convenience and for that of our interviewees, who live in areas with low connectivity speed[3]. After the lockdown period, we started fieldwork missions in 2022, organizing 4-day-minimum trips in the localities from the four large work areas. See Map 2. In cartographic research, traveling transforms into an instance of juxtaposition of territories, an event that allows us to meet with things (Boutang, P. et Pamart, M. 1996) and, through things, with others and with the heterogeneity of thinking and doing.

[3] In some localities, Internet speed does not surpass 1 MB.

Experiencing pregnancy, childbirth and postpartum in Chubut rural areas

Perinatal care has gone through different stages: institutionalization, medicalization and humanization, which basically reflect the dominant idea of "correct care" and practice "subject" of the moment. As is the case with most practices in medical institutions, each stage manifests in the form of regulations and protocols, which validate their role as social organizers. As a consequence, pregnancy, childbirth and postpartum care first focused on providing a place within the hospital; then, on ensuring a series of medical procedures in accompaniment, and finally, on incorporating "humanizing" aspects (from a medical perspective) to the process. Consequently, two phenomena with social impact arose: a significant reduction in child and maternal deaths (Ronsmans, C., Graham, W. J. & Lancet Maternal Survival Series steering group. 2006.) and changes in the care process that followed the changes produced in the regulations and procedures. (Baker, S. R., Choi, P. Y., Henshaw, C. A., & Tree, J. 2005).

In addition, this institutionalization of the process brought about a knowledge and practice conflict among the professionals involved as well as the reinforcement of the idea of the inferiority of women and their knowledge. ". . . the medicalization of the childbirth process involved, in practically all countries, a harsh tension with midwives and traditional birth attendants, who, in this competition for the scope of pregnancy and childbirth care, became the target for all types of accusations, criminalization, witch-haunt-like elimination and even discredit of their knowledge in the face of knowledge-power and its subsequent subordination to medical authority" (Vallana Sala, V., 2020, p. 96). These circumstances manifest in the current healthcare system practice, where it is possible to do away with traditional birth attendants.

Modifications are adopted in each territory according to the medical perspective, causing, in many cases, the loss of local idiosyncrasies because notions are taken from the urban area and applied to the rural area, ignoring the territorial peculiarities that are necessarily different. The urban outlook guides the planification process, in which rural idiosyncrasy gets invisibilized. It is interesting to highlight that Argentina's ERAP experiences are concentrated in provinces that are very different from Chubut in terms of space, distance, transport organization, and infrastructure, such as Misiones, Santa Fe, Neuquén, and even the Buenos Aires Metropolitan Area. (Schwarcz, A., Garibaldi, M, Mendez, V. 2011).

Going through the pregnancy-childbirth-maternity triad in the countryside implies the configuration of a territory that is permanently deterritorialized and reterritorialized. This dynamic is constantly disrupted throughout the pregnancy-childbirth-maternity process, since the journey necessary to access adequate care and sanitary services forces the families to devise strategies to both abide by the current regulations and healthcare processes, and adapt domestically, socially and culturally to the institutionalized way of "doing."

These lines of flight turn into the ways of "doing" outside the institutionalized bureaucracy (Oszlak, O. 2006), but at the same time are combined and complemented according to the reality of each constructed territory. These strategies allow pregnant and postpartum people to skip the norm, alter it and adapt it according to their own reality.

Pregnancy and maternity deterritorialized experiences

The spatial system organization of Chubut's Programmatic Areas is radically different from the organization and dynamics of the social and community practices, as well as from the conformation of territories (Llanos-Hernández, L. 2010). In the following section, we introduce a series of dynamics in the production of the pregnancy-childbirth-maternity triad reterritorializations, which go beyond the temporal perinatal instance and are revealed through interviews and workshops in different towns, healthcare centers and rural hospitals. The narrated processes correspond to the last ten years (following the implementation of ERAP) and are what we consider a "deterritorialization of the medical-bureaucratic organization processes," considering the singular, local experience.

The first approach in the field developed throughout the year led us to encounter dissimilar spaces and idiosyncrasies related to the territory, strategies and forms of organization, both institutional and communal. Each of these spatial lines we traveled along faced us with different ways of "doing" and "solving" which we propose to comment on by taking some selected cases from each journey as a point of departure.

Within these ways of "doing and solving," the strategies developed by pregnant people and their families come into play, according to the relationship between the pregnancy-childbirth-maternity process and the bureaucratic-institutional organization of the Programmatic Areas, overlapping in this way different forms of articulation between rural and urban spaces.

Deterritorialization process scenarios

North plateau, Route 4: "We are the ones who are the furthest away and the most forgotten"

Provincial Route 4 crosses Chubut from East to West, as if it were a parallel. In this area, we conducted two social cartography workshops, one in the village of Gastre and another in the village of Gan Gan. The localities of Gastre (602 inhabitants), Gan Gan (660 inhabitants) and Telsen (544 inhabitants), which regionally depend on the North Programmatic Area, have as a referral hospital the Hospital Ísola in the city of Puerto Madryn (127,914 inhabitants according to the 2022 census). In this area of the North of Chubut, there is an urban line of more than 300 km without asphalt, a deficient telecommunications network and temperatures that range between -20 °C in winter and 40 °C in summer.

In Puerto Madryn, there is a maternity house within the premises of Hospital Ísola, to which pregnant people are referred when they are 36 weeks pregnant. In the process between week 36 and childbirth, if there are no complications, pregnant people stay in the maternity house accompanied by a social worker who facilitates the scheduling of their medical appointments and guides them through all types of bureaucratic and medical dynamics inherent to the hospital.

As in the rest of the small towns and villages referred to in this paper, the problems of uprooting, related to the distance from the family or loved ones in the town of origin, as well as to the loneliness felt as weeks pass outside the hometown,

arise permanently.

Each pregnant person or family's particular bonds are determinants when it comes to producing alternative schemes, which represent lines of flight from the circuit drawn by regionalization. Not only is the distance between villages measured according to distance or traveling time, but also according to the comfort directly linked to existing social networks. In this state of affairs, some pregnant people with health insurance prefer going to private clinics in Trelew city, a situation the provincial healthcare system is not able to track.

In these cases, there are particular community organizations around every family and emotional circle that constitute tension points regarding localities that do not belong to the Programmatic Area. For example, as for the villages of Gastre and Gan Gan, it was registered that some mothers have given birth in Trelew or Esquel, which is outside the ERAP regulation, since it states that they should do it at Puerto Madryn's hospital.

In addition, along this deterritorialization process line, some special but frequent cases are registered: Those of women who "wait" until the last weeks of pregnancy so that childbirth takes place, as long as it is possible, in their hometown, avoiding in this way their referral to the city. This phenomenon is repeated at other points in the province, which has caused a series of childbirths happening "on the way," both in ambulances and personal vehicles.

The registers made in the Social Cartography workshops are also remarkable, since pregnant people claim that the bus drivers from the bus company "El Ñandú," which links Trelew and Puerto Madryn with Telsen and Gan Gan three times a week, have denied them access to the transportation service when they notice that their pregnancies are too advanced.

Uprooting, in the perinatal regionalization process, is also reflected in a resistance to "come back" to the Referral Hospital once the birth takes place. This implies that pregnant people, once they arrive back to their hometowns, oppose coming back to Puerto Madryn to carry out studies or a healthy follow-up of the newborn since, in some cases, the appointments scheduled from the town and in the city are not carried through; in others cases, the memory of "being in the city" hampers the establishment of new transfers between rural localities and the city. In the face of this singularity, some mothers organize at a family or community level to carry out checks in Trelew or Esquel, adducing that they have better accommodation or stay opportunities, since they have relatives or acquaintances that can host them.

The Andean Region: the production of alternatives around a good birth

The Andean Region, located in the northwest of Chubut, is composed of a series of small towns with 150-2300 inhabitants. The towns of Lago Puelo, Cholila, Leleque and Gualjaina stand out, having a direct connection with the referral hospitals: Hospital Rural Zonal in Esquel and the subzonal hospital from El Maitén. This is the area where the Programmatic Area Esquel operates. In this zone, the distance between the rural and referral hospitals is relatively smaller than that in the rest of the province; however, complications related to infrastructure, communications and translatability remain. In addition, even though the area has private healthcare centers, there are no hospitals with high-complexity maternity or

neonatology wings[4]; hence, Esquel's referral hospital[5] must resort in several cases to referrals to Trelew's hospital, which is 600 km away.

On the other hand, the towns closer to the 42nd parallel are more dynamic and are more closely linked to urban centers, such as El Bolsón or Bariloche; however, when it comes to healthcare, things become more complicated because they belong to the sanitary jurisdiction of a different province. Along this line, there exist (and have existed) interprovincial reciprocity agreements, even though in the Lago Puelo workshop, the social cartographers expressed systematic infringements when care was required in the Province of Rio Negro, but the domicile of the patient was in Chubut.

The dynamics of the localities that depend on Esquel's Hospital Zonal are similar in this Programmatic Area. Each hospital has a specific day for pregnancy checkups, to which pregnant people arrive in a local ambulance. If the mother has medical insurance, she organizes and travels independently. In addition, pregnancy follow-ups are performed by clinical doctors at each rural hospital. As for its structural conditions, Esquel currently has low-complexity inpatient facilities for newborns in neonatology wings and for their mothers, if necessary; however, if the mother does not need hospitalization, there is accommodation within the hospital, as we learn in the cartographic workshops held in Cholila. However, there are no maternity houses with the capacity to wait for childbirth during the last weeks of pregnancy; consequently, mothers are usually referred from the main locality during labor.

As for low-risk pregnancies, and depending on whether there are specialist doctors, referrals to the subzonal Hospital of El Maitén are authorized. In this sense, in the social cartography workshop held in Lago Puelo in September 2022, women mentioned the inconvenience that traveling implies and the deterritorialization of the pregnancy and childbirth processes. This impacts both the dynamics and the family organization, as well as the sensitive side of giving birth and receiving a new life in the family circle. The referral is an event that violently interrupts everyday life and breaks local dynamics; this is replicated in each locality.

There are various lines of flight linked to the different edges of the pregnancy-childbirth-maternity process. For example, the existence of a network of "allied women" was proposed at the social cartographic workshop as those who accompany pregnant women throughout the whole process and at the moment of delivery, generating a safety and attention network for pregnant people and their families. At the same time, there is a network of traditional birth attendants that provides attention to mothers who choose to give birth at home. This is presented as controversial for the health system since it escapes from the "regulations," producing different complications at the moment of registering the newborns and their checks.

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[4] In March 2023, the neonatology category of the Hospital Zonal de Esquel changed, so complex childbirths cannot be conducted, a situation that complicates the journey of pregnant people and newborns. The province displays permanent problems regarding the covering capacity of professionals and specialists, an issue that replicates throughout the province. See: https://www.red43.com.ar/nota/2023-3-22-12-14-17-se-bajo-la-categoria-de-neonatologia-y-no-se-podran-atender-partos-complejos-en-esquel - Accessed: 04/20/2023

[5] See: https://www.red43.com.ar/nota/2022-6-22-11-54-35-el-hospital-zonal-esquel-cuenta-con-16-camas para-internacion-en-el-servicio-de-pediatria - Accessed: 12/08/2022 6https://rionegro.gov.ar/?contID=52825 - Accessed: 12/08/2022

The situation of being able to decide where and how to give birth arose in the workshop with a double analysis. On the one hand, as Vallana Sala, V. (2020) states, the professional scope within childbirth care, since the traditional birth attendant function arises again together with the tensions it generates in the medical and nursing professional field, even by being condemned as an illegal practice, as mentioned in the workshop. On the other hand, the need to have other options in terms of giving birth. In this state of affairs, the project of "birthing house" arose, facing the triad with accompaniment and safety network logic. This idea is a step forward in considering that a pregnant person can decide, within the corresponding health parameters, how and when to give birth, as mentioned in the workshop and according to the 2004 Respectful Maternity Care Law.

These alternatives are present in the the pregnancy-childbirth-maternity triad territory; nevertheless, both in the workshop carried out in Lago Puelo with mothers and families, as well as in the in-field one in Cholila with agents of community health, it was possible to recognize that, even though they are part of health institutions, many agents actively cooperate with strategies that are formulated as lines of flight and alternatives to the permanent deterritorialization of the process, seeking to accompany the decisions of pregnant people and being in favor of guaranteeing adequate sanitary and social conditions. In this way, it can be observed how these social networks break with the institutionalizing bureaucracies, since they can be understood as ways of "adapting" public policies to the territorial realities of each place.

Valdés peninsula, strategies and distances around pregnancy

Puerto Pirámides is the only urban node within the Península Valdés protected area. The county has 565 inhabitants and the Hospital Rural Puerto Pirámides, which is in the North Programmatic Area. The corresponding and nearest Zonal Hospital is Hospital Andrés Isola, which is 100 km away, in the neighboring city of Puerto Madryn.

When a person who lives in Puerto Pirámides gets pregnant, they initiate their first checks at the Hospital Rural to then embark on a path of comings and goings along the Provincial Route 2, which connects the rural locality to the city of Puerto Madryn.

Puerto Pirámides' rural hospital has generalist doctors, who take care of pregnancies throughout each month of pregnancy; however, all medical studies must be carried out in laboratories and specialized doctor's offices with adequate ultrasound equipment, which the rural hospital does not have; hence, such studies must be referred to Puerto Madryn.

To assist those families without health insurance or a car, the hospital arranges appointments with the corresponding specialists and also counts with an ambulatory referral system that includes accommodation in a neighboring town, which most of the inhabitants resist because it disrupts both their work and personal dynamics. The long distances, the scarce frequency of intertown transport services, and the availability of checkup appointments make "going back home" impossible, which means that families must sometimes stay up to two days in Puerto Madryn to get routine checkups throughout each pregnancy month. In this state of affairs, family and communal network mechanisms are set up to avoid these waiting times

that hinder family organization, which may include other children being unable to travel with their mothers for their checkups. This leads to mothers not showing up to their appointments and excusing themselves under the impossibility to travel, which weakens the commitment with the social worker and stops pregnancy checkups.

Among other strategies used, there is borrowing cars, as well as receiving healthcare attention at high costs at private institutions; some families with health insurance never establish a relationship with their town's hospital, which leads to the institution's loss of this potential relationship with pregnant families.

Deterritorialization, according to Delueze's view, manifests as alternatives chosen by each family that arise from the system proposed for rural contexts.

Whether the pregnancy is at its end or not, when labor begins in Puerto Pirámides, the pregnant person goes to the hospital in an ambulance or by their own means. In addition, the stay of the birth companion is hindered too if they do not have a residence in Puerto Madryn.

Finally, the newborn and mother's checkup can be performed in Puerto Pirámides with a general doctor in charge. SouthWest of Chubut: "The idea is not ending up in Comodoro [Rivadavia]."

The Comodoro Rivadavia Programmatic Area gathers Senguer, Río Mayo and Sarmiento's rural hospitals, which do not currently have a neonatology or maternity wing. The assignment of referrals is governed by the National Route 26 that brings together, in Comodoro Rivadavia, the non-complex and medium complex care in the area's maternity wings. Comodoro Rivadavia is the largest city of the province, with 219,000 inhabitants in the Rada Tilly-Comodoro Rivadavia conglomerate (INDEC 2022). The spatial characteristics of the distance and linearity of the arrangement of rural hospitals with respect to the main hospital are similar to those of the North Programmatic Area, except that, in Comodoro Rivadavia, the circulation and interconnection routes of rural hospitals are mostly paved with asphalt.

This peculiarity became evident when the interviews were carried out: The Hospital Regional Comodoro Rivadavia does not have a maternity house or residency. In this sense, and within the perinatal regionalization frame, Comodoro Rivadavia is presented as a city that both families and pregnant people want to avoid, since the high living cost and the expensive hostelry and gastronomic services hinder their stay in the city for more than one day. This causes 38-week pregnant people to be referred from Hospital Rural Río de Mayo to Comodoro Rivadavia Hospital, considering the shortest possible stay in that city. The expression "not to end up in Comodoro" frequently arises in interviews with pregnant people and their families, as well as with sanitary personnel. Not only is the economic aspect that constructs the stay in the city as problematic but also the feeling of insecurity that Comodoro Rivadavia causes among the inhabitants of the previously mentioned towns.

In general, pregnant people and their families, or people with little children, choose to stay in the house of relatives or friends living in Comodoro Rivadavia, but there are several instances in which they have problems getting appointments or complying with the dates assigned for checkups or more specific studies. In this scenario, pregnant people and families with medical insurance resort to private clinics; however, if they do not, there is also a marked tendency to travel to Esquel (32,000 inhabitants according to INDEC) to access care in the city's hospital. Esquel has been presented as the more "long-stay-friendly" city in the interviews and

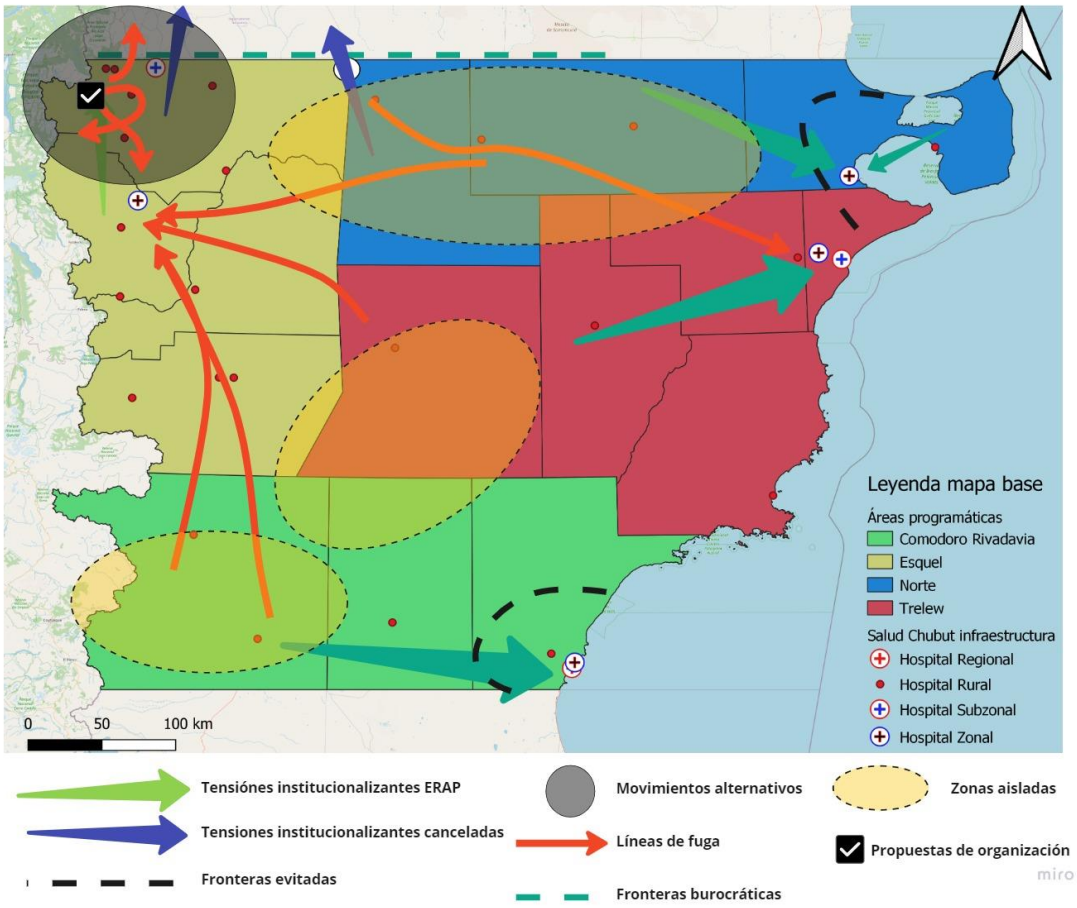
workshops carried out, in addition to having more accessible living costs, which encourages several people to seek medical care in this city.

Prenatal checkups can be accessed in the town of origin, as long as doctors and specialists are available. Workforce shortages (general doctors, pediatricians, gynecologists, OB/GYNs, biochemists, sonography technicians, and other specialties) are a local condition that repeats along the rural hospitals of the three areas considered in this study, which manifests in Chubut's Ministry of Health continuously calling for health professionals to cover vacants on its website.

Results of a first approximation

To present a synthesis of the results, we have elaborated the following chorem graphic (see diagram 2) revealing different tensions in relation to what is institutionalizing and what is institutionalizing and canceled, as well as alternative movements and different lines of flight that overcome barriers that emerged from interviews and social cartography workshops. Thus, in the province, different types of linearity in relation to what we call "institutionalizing tensions" arise, both from the organization of ERAP and the various referral hospitals. With regard to these institutionalizing tensions, all processes related to pregnancy, childbirth and maternity should work in these ways. At the same time, different "institutionalizing canceled tensions" are revealed, which operate sporadically or intermittently in accordance with agreements between Río Negro and Chubut, which would facilitate access to healthcare at hospitals in the neighboring province, overcoming bureaucratic barriers that arise from the existing demographic dynamics. This phenomenon does not hold over time, and as a consequence, this dynamic circulation is canceled or difficult to implement.

Diagram 2 : Chorem of the results, in relation to the social dynamics found in the territory, within the framework of the application of the ERAPs



The province also has urban spaces which families and pregnant people tend to "avoid" in the light of popular beliefs, lack of contention networks or the high prices of transport and accommodation. This phenomenon repeats itself in the relationship between rural localities in the north of the province and Puerto Madryn, and between the Southwest communities and Comodoro Rivadavia.

Finally, in response to this territorial configuration that shapes the current medical-bureaucratic organization, deterritorialization processes arise around the lines of flight, which move away from institutional organization, allowing alternatives for incorporation into the healthcare dynamic to a greater or lesser extent. In this way, proposals were presented for the establishment of birth centers, free choice of referral hospitals and community-organized travels to cities other than those assigned by ERAP's internal organization. Finally, three large isolated areas are highlighted in the chorem according to physical, structural and geographical distance criteria, which we propose to approach in our fieldwork in the second half of 2023.

Conclusion

Our point of departure is an ongoing fieldwork, and applying a cartographic research approach, we were able to explore the idiosyncrasies of the experiences surrounding pregnancy, childbirth, and maternity in four Health Programmatic Areas from the province of Chubut, further studying the existing tension and resistance on

the part of the community.

The distribution of health and maternity-related human resources in the different areas of the province, associated with the perinatal regionalization process, clearly shows access difficulties both in rural communities and in healthcare centers where most births and birth-related care take place. This arises as a structural problem linked to the availability of health professionals in rural spaces and in areas both vulnerable and away from urban centers.

Even though each region has a perinatal care network advanced by their healthcare system, the territory's reality exhibits resistance mechanisms in the face of possible institutional planifications.

In this way, community processes related to pregnancy, childbirth and maternity reflect the devising of strategies and links to face a medical-bureaucratically organized, structurally flawed system.

Chubut's Perinatal Care Regionalization Strategy calls for deep changes to optimize both the quality of care and the transportation and communication system between the different complexity levels. Even though the system organization works internally, difficulties arise when it comes to supporting healthcare personnel in rural areas, the bad condition of transportation and communication systems, and the flaws of the existing infrastructure in terms of communication, transportation networks, roads, and maternity houses in the cities that count with a referral hospital.

In parallel, in some sectors of the province, such as in the Andean Region, potential alternatives are starting to be developed, debated on, and promoted on a community basis, such as the establishment of birth centers, which already exist in other places of the world, to increase the availability of choices within a regulatory framework that grants rights to pregnant people while adapting itself to the local singularities.

Underpinning both the current institutional planification frame and the emerging alternatives, there is deterioration of the health system in terms of the ability to locally adapt to ERAP, which is also shown in the intermittence of the reciprocity agreements in the provincial border area, which negatively affects the quality of care received by pregnant people.

Both the community organization as forms of lines of flight and the alternative movements around the pregnancy, childbirth and maternity processes are clear key proposals to overcome the flaws of the healthcare system. Consequently, the deterritorializing proposals for local birth centers, as well as the organization to travel and the referrals to referral hospitals different from those proposed by the institutional organization, hint at possible reforms to ERAP and even to the Programmatic Areas themselves, proposing a holistic and dynamic outlook and taking into account the idiosyncrasies of the local population, so as to achieve an intercultural, territorially based approach in rural areas.

Finally, in rural areas, we can observe the functioning of a healthcare system designed with urban-centered logic that is sometimes radically different from local dynamics in both cultural and experience planes. Thinking about and organizing the pregnancy, childbirth and maternity rural processes is a challenge that must be presented as a public policy to revert the colonial logic that leaks into the deepest of our territories.

REFERENCES

ARGENTINA. LEY 25.929. SALUD PÚBLICA. Gob.ar. Recuperado de https://www.argentina.gob.ar/sites/default/files/ley_25929_parto_humanizado_decreto_web_0.pdf

ARGENTINA. LEY 25929. LEY DE PARTO RESPETADO ARGENTINA. Recuperado de < https://www.argentina.gob.ar/sites/default/files/ley_25929_parto_humanizado_decreto_web_0.pdf>

ARGENTINA. PLAN ESTRATÉGICO DE INFRAESTRUCTURA CHUBUT. Recuperado de < https://www.mininterior.gov.ar/planificacion/pdf/planes-prov/CHUBUT/PDF-PEI-CHUBUT.pdf> 2017.

BAKER SR, CHOI P. Y. L, HENSHAW CA, TREE J. "I felt as though I'd been in jail": Women's experiences of maternity care during labour, delivery and the immediate postpartum. Feminism & Psychology. 2005;15(3):315–342.

BEDIN DA COSTA, L. Cartografiar, otra forma de investigar. Revista Margen núm. 94, septiembre, 2019, p. 1-8
BOUTANG, P y PAMART, M. L'Abécédaire de Gilles Deleuze. Documental. Productores La Femis, Sodaperaga Productions. París. 1996

CANALI, C., y CESARINI, E. La salud en tiempos pandémicos. *Ts. Territorios*, *V*(5). 2021.

CHANAMPA, M. E., JAIMES, M. d. L. A., DIEZ TETAMANTI, J. M., DUARTE, Y., PORCIEL, D., GÓMEZ, P., & MARTINEZ, N. *Accesibilidad a la atención de la salud: Movilidad y traslados en Aldea Beleiro*, 2014.

CHUBUT. ESTADÍSTICAS DE SERVICIOS DE SALUD Y SANITARIAS. Ministerio de Salud del Chubut, Recuperado de < https://drive.google.com/file/d/1epmVKjzh3tP2OZOdAfQWKs2hNCAbweEd/view>2022.

CHUBUT. Ministerio de Salud de la Provincia de Chubut. ANUARIO ESTADÍSTICO DE SALUD VOL. II PERINATAL. Chubut., 2019.

CHUBUT. REGIONALIZACIÓN DE LA ATENCIÓN PERINATAL. MINISTERIO DE SALUD DE LA PROVINCIA DE CHUBUT, 2019. Anuario Estadístico de Salud Vol. II LA ATENCIÓN PERINATAL. Recuperado de http://saludecuador.org/maternoinfantil/archivos/smi_D630.pdf

DELEUZE, G. Y GUATTARI, F. Mil mesetas. Capitalismo y esquizofrenia, Valencia: Pre-Textos, 2020. 676p.

DIARIO Río Negro. Polémica en El Bolsón: Salud afirma que nunca dejó de asistir. Recuperado en <https://www.rionegro.com.ar/polemica-en-el-bolson-salud-afirma-que-nunca-dejo-de-asistir-1025123/>. 2019.

DIARIO Rio Negro. Salud: Río Negro avanza con Chubut en un convenio de asistencia mutua. Recuperado de < https://rionegro.gov.ar/?contID=52825>. 2019.

DIEZ TETAMANTI, J.M. Cartografía Social, teoría y método. Buenos Aires, Argentina, Editorial Biblos, 2018.

DIEZ TETAMANTI, J.M., HEREDIAS, T. y MARTÍNEZ N. Estrategias y dispositivos comunitarios en procesos de desarrollo territorial en Aldea Beleiro; Chubut, Argentina. En Pampa: Revista Interuniversitaria de Estudios Territoriales, ISSN 1669-3299, N°. 21, 2020, págs. 44-64

FEÜ, A.L; GRANÉ, P.D; DIEZ TETAMANTI, J.M. Revisando noções de remoção / exclusão de experiências metodológicas na comunidade rural do Lago Blanco, Patagônia, Argentina. Revista GEOINGA. v. 11 n. 2, 2019.

GUATTARI, F. y ROLNIK, S. *Micropolítica. Cartografías del deseo.* Madrid, España: Traficante de Sueños, 2006

GUBER, R. La etnografía, método, campo y reflexividad/Rosana Guber.- Bogotá: Grupo Editorial, Norma, 2001.

HAGERSTRAND, T. Diorama, path and project, Tijdschrift voor Econ. en Soc. Geofrafie, 73, 6, 1982, p. 323-339.

HAMMERSLEY, M. y ATKINSON, P. Los relatos nativos: escuchar y preguntar. Etnografía. Métodos de investigación. Barcelona: Paidós, 1994.

INDEC. CENSO NACIONAL DE POBLACIÓN, HOGARES Y VIVIENDAS 2022. Recuperado de: https://www.indec.gob.ar/ftp/cuadros/poblacion/cnphv2022_resultados_provisionales.pdf 2023.

INDEC. CENSO NACIONAL DE POBLACIÓN, HOGARES Y VIVIENDAS. Recuperado de https://www.indec.gob.ar/ftp/cuadros/poblacion/cnphv2022_resultados_provisionales pdf> 2022.

INDEC. CENSO NACIONAL DE POBLACIÓN, HOGARES Y VIVIENDAS. Recuperado de: https://www.indec.gob.ar/indec/web/Nivel4-Tema-2-41-135> 2010.

JAIME, S. Trabajo: Aporte Estratégico para un modelo basado en Prestaciones Esenciales Garantizadas en el primer Nivel de Atención en la Provincia del Chubut. (Programa: Certificado Universitario con competencias en Gestión Interdisciplinaria

de Servicios Latinoamericanos de APS). Centro de estudios Interdisciplinarios. Universidad Nacional de Rosario, 2017.

LINDÓN, A; HIERNAUX, D. Los imaginarios urbanos de la dominación y la resistencia Iztapalapa, Revista de Ciencias Sociales y Humanidades, núm. 64-65, enero-diciembre, 2008, p. 7-14

LLANOS-HERNÁNDEZ, L. El concepto del territorio y la investigación en las ciencias sociales. Agricultura, sociedad y desarrollo, 7(3), 2010, p. 207-220.

MISIONES. LEY XVII-157. MATERNIDAD SEGURA Y CENTRADA EN LA FAMILIA (MSCF) CON ENFOQUE INTERCULTURAL POSADAS, Boletín Oficial, 9 de junio de 2022 Vigente, de alcance general Id SAIJ: LPN1700157. Misiones, 2022.

OIBRMAN, A. Historia de las madres en occidente: repensar la maternidad. Psicodebate, 5, 2005, p.115-130.

OPS. Argentina avanza en la estrategia de Regionalización Perinatal. Paho.org. Recuperado en < https://www.paho.org/es/noticias/15-11-2017-argentina-avanza-estrategia-regionalizacion-perinatal>. 2017.

OSZLAK, O. Burocracia estatal: política y políticas públicas. Postdata, Ciudad Autónoma de Buenos Aires , n. 11,2006, 2006, p. 11-56.

PASSOS, E.; KASTRUP, V. Y TEDESCO, S. Pistas do método da Cartografia 2. Porto Alegre. Ed Sulina. 2016.

PORTUGAL, J. Modelos gráficos y coremas. Representación de la información territorial en sus componentes estructurales básicos. Lurralde. San Sebastián. n. 19, 1996, p. 235-253.

RAMOS, S., ROMERO, M., ORTIZ, Z., & BRIZUELA, V. Maternidad Segura y Centrada en la Familia: la cultura organizacional de maternidades de la provincia de Buenos Aires. Archivos argentinos de pediatría, 113(6), 2015,p.510-518.

RED 43. El Hospital Zonal Esquel cuenta con 16 camas para internación en el servicio de Pediatría. https://www.red43.com.ar/nota/2022-6-22-11-54-35-el-hospital-zonal-esquel-cuenta-con-16-camas-para-internacion-en-el-servicio-de-pediatria 2022
ROLNIK, S. Esferas de la insurrección. Tinta Limón, 2019. 192.p

RONSMANS, C., GRAHAM, W. J., & LANCET Maternal Survival Series steering group. 2006.

SCWARCZ, A. Regionalización de la atención perinatal. En De MUZIO, B., FESCINA R., SCHWARCZ, A., GARIBALDI, M., MENDEZ VALDAMARIN, C. Regionalización de la Atención Perinatal: Documentos Buenos Aires: Ministerio de Salud de la Nación-Organización Panamericana de la Salud, 2011, p. 20–73.

TEDESCO, S.H.; SADE, C. y CALIMAN, L.V. A entrevista na pesquisa cartográfica: a experiencia no dizer. Fractal, Rev. Psicol., v. 25, n. 2, 2013, p. 299-322.

TINKER, AG., KOBLINSK, MA y DALEY, P. Hacia una maternidad segura. Banco Mundial. 1994.

VALLANA SALA, V. "La enfermedad normal" Aspectos históricos y políticos de la medicalización del parto. Sexualidad, Salud y Sociedad – Revista Latinoamericana. N.34, 2020, p.90-107.

VÁZQUEZ, A. SCHULER, L.J.; DIEZ TETAMANTI, J.M.; SALAZAR, M. Vida cotidiana en una pequeña localidad del sudoeste de Chubut. Estrategias de acceso y prácticas espaciales en la Patagonia central. Estudios Rurales, 10 (19), 2020.