Feminist Anthropology 2023; 4: 91–114 DOI: 10.1002/fea2.12097

Obstetric Violence: An Intersectional Refraction through Abolition Feminism

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Obstetric violence, a term coined by activists in Latin America to describe violence during pregnancy, childbirth, and postpartum, is a controversial feminist term in global health policymaking as well as in obstetric and midwifery practice and research. We reflect on the term both theoretically and autoethnographically to demonstrate its feminist value in addressing the problem of violence as embedded within the obstetric institution.

We argue that *obstetric violence* as an activist and critical feminist concept can only be effective for change when it is clearly understood as institutionalized intersectional violence. Therefore, we propose an abolitionist framework for further study. Through this lens, we refract the concept of obstetric violence as institutionalized, intersectional, and racializing violence by (1) making an abolitionist historiography of the obstetric institution, and (2) centering anti-Black obstetric racism as the anchor point of obstetric violence, where the afterlife of slavery, racial capitalism, the impact of systemic racism, and the consequences of patriarchal biopolitics come together.

Abolition provides a unique approach to study obstetric violence since it not only refuses and dismantles violent institutions, but specifically focuses on building futures out of existing alternative practices toward a life-affirming world of care. We locate the abolitionist futures of maternity care in Black, Indigenous, and independent doula and midwifery practices.

Keywords obstetric violence, obstetric racism, abolition, obstetric institution, midwifery, childbirth

> We have to take back, which is to change, transform and move to something new.
>
> —Ruth Wilson Gilmore

Obstetric Violence

Obstetric violence is a global phenomenon and takes place at the hands of obstetric health workers during any encounter in the prenatal, intranatal, and postnatal period. Obstetric violence consists of, but is not limited to, physical, verbal, sexual, structural, and epistemological forms

of violence, such as nonconsensual procedures, neglect, gaslighting, surrogate decision-making, shaming, and discrimination (Bohren et al. 2015; Chadwick 2018; Cohen Shabot 2020; Mayra, Matthews & Sandall 2021; Villarmea 2015). It ranges from failing to get informed consent or refusal for obstetric interventions such as vaginal examinations and episiotomies, episiotomy repairs (often without anesthesia), and cesarean sections, to slapping, pinching, hitting, fundal pressure, and shroud waving. It also includes enforced and nonconsensual family planning measures such as tubectomy and postpartum intrauterine contraceptive device (PPIUCD) insertion (Nazdeek 2020). It is considered to be both gender- and race-based violence (Cohen Shabot 2016; Davis 2019a) as well as colonial violence (Chadwick 2021; Vega 2018; Zacher Dixon 2015), specifically affecting Black and Indigenous communities (Castro, Savage, and Kaufman 2015; Davis 2019a; Vega 2018). Evidence of obstetric violence has been recorded in thirty-four countries, as stated in a systematic 2015 review (Bohren et al. 2015). In 2019, as part of the What Women Want Campaign, the White Ribbon Alliance reached out to 1.2 million people in 114 countries asking them their one key demand for quality and reproductive healthcare (White Ribbon Alliance 2019). Their answer was "respect and dignity during care," constituting, albeit in other words, the abolition of obstetric violence as *the* top-ranking demand in reproductive healthcare globally.

However, many care workers such as obstetric nurses and obstetricians, as well as major NGOs in healthcare such as the WHO, see obstetric violence as an unnecessarily provocative term, believing it to be an accusation aimed at obstetricians and nurses *as* individuals. *Violence* is considered a misnomer since mistreatment by healthcare workers should not be considered intentional (Lappeman and Swartz 2021). It is often argued that the term risks alienating healthcare workers by indicating intentionality, prompting defensive reactions instead of enhancing obstetric care. *Obstetric violence* should, however, first and foremost be regarded, and judged, as a feminist activist keyword that addresses a structural problem in reproductive healthcare from the viewpoint of its victims. As an activist keyword, it is most commonly used in Latin America and the Caribbean (Savage and Castor 2017). Arising in activist circles in the 1990s, it gained momentum in the early 2000s in Latin America in the context of research focusing on medicalization, dehumanized care, discrimination, and more commonly known forms of violence against women (Castor, Savage, and Kaufman 2015). It has already propelled impressive changes, such as the inclusion of obstetric violence in the Venezuelan law regarding violence against women in 2007 (Castor, Savage, and Kaufman 2015). Obstetric violence is hence a struggle concept emerging from experiences of oppression, uniting birth activists globally in constituting an intervention that refuses normalized violence and oppression (Chadwick 2021). Nonetheless, a theoretical defense against aformentioned objections constitutive of an intersectional feminist conceptualization of the term, remains a work in progress (but see for instance Chadwick 2021; Davis 2019a; Mayra, van der Waal, and Chadwick 2021; Villarmea 2015). With this article we aim to contribute to that effort.

Abolition

Abolition is, at its core, the refusal of what has been refused to us by a current institution and the dismantling of the specific violence it produces (Harney and Moten 2013). It understands institutionalized violence as inherent to an institution, developed through its intertwinement with suppressive structures such as capitalism, colonialism, racism, and misogyny. Dismantling "death-making" institutions and building "life-affirming" ones is a key vision of abolition, replacing the widespread attempts to reform institutions (Kaba 2021). Abolition originates in the fight against

chattel slavery, still an international institution in the nineteenth century, and developed further in the fight to dismantle the ongoing logic of chattel slavery in current-day institutions such as the prison industrial complex, the carceral state, the police, and the family regulation system (Davis et al. 2022). Strongly connected to intersectional thought, its current foremothers are Black feminists Angela Davis, Mariame Kaba, Ruth Wilson Gilmore, and Dorothy Roberts.

In this article, we use an abolitionist framework to refract the concept of obstetric violence to be more explicitly understood as institutionalized, racializing violence inherent to the obstetric institution. We understand the obstetric institution as a system of "hierarchical relationships (structures) that persist across time" since the development of obstetrics in the late nineteenth century (Gilmore 2007, 28). It consists of medical care for pregnancy and childbirth relying on the authority, science, and practice of the clearly demarcated obstetric profession, both within and outside of hospital care. We regard the outspoken independent counterpractices of doulas, midwives, and traditional birth attendants as *not* part of the obstetric institution, although they need to rely on the institution regularly. This is because they mostly work outside of the obstetric institution, and their practice is based on different values and foundations. Effectuating an abolitionist framework, we center anti-Black obstetric racism as the crisis and anchor point of institutionalized obstetric violence. Herein, we follow both Angela Davis's abolitionist historiography, where she focuses on anti-Black racism to highlight the connection of chattel slavery and the carceral state (Davis 2003), and intersectional feminism, which centers the invisible violence Black women suffer, to show how systemic violence operates as the glue that holds the axis of oppression together (Collins 2017; Crenshaw 1989, 1991).

Below, we will elaborate on the concept through a short genealogy of the activist term and discuss the controversy surrounding it, specifically tackling the problem of the intentionality of individual healthcare providers. Using an abolitionist framework, we critically define the feminist potential for change of the term *obstetric violence* and the theoretical and activist work done around it through a specifically institutional understanding of violence. This gives us the potential to further understand obstetric violence intersectionally, identifying obstetric racism as the anchor point of institutionalized obstetric violence. With this move, we do not mean to subsume obstetric racism within obstetric violence. We acknowledge that obstetric racism is something qualitatively different (Davis 2019a). Rather, centering obstetric racism as the intersectional anchor point where multiple structures of violence come together allows us to make manifest those structures that are fundamental to the production of obstetric violence. In other words, only through centering obstetric racism as inherently and fundamentally linked to obstetric violence and productive of it will we be able to understand and critique obstetric violence effectively and in its full scope, avoiding white feminist and neoliberal pitfalls suggesting emancipatory reforms or carceral solutions that would only be marginally helpful for some. Centering obstetric racism at the productive intersection of which obstetric violence is fundamentally part makes visible its institutional, historical, colonial, and racializing nature. Consequently, to further understand the intersectional institutional nature of obstetric violence, we study the structural events that have shaped the obstetric institution of today. Following abolitionist historiography, we will discuss two structural events of the violent appropriation of the reproductive subject: first, the witch hunts in Europe, and second, the practice of "breeding" during US slavery.[1] On the basis of this historiography, we are then able to focus specifically on anti-Black obstetric racism as the lens to understand and fight obstetric violence. To close, we will discuss the potential of an abolitionist framework for practice, activism, and theory, which we ultimately locate in independent midwifery and doula work.

Autoethnographically-Informed Women's Writing

We write from different geopolitical positionalities: that of a trained nurse-midwife, PhD candidate, and South Asian from India; that of a Black American woman, PhD candidate, mother, and practicing doula from the US, currently pregnant in the UK; that of a white South African woman and senior sociologist; and that of a white woman, PhD candidate, and practicing independent midwife from the Netherlands. We all have intimate experiences with the issue that we draw upon and believe that our positionality, embodied knowledge, and personal understanding of the way obstetric violence has shaped our subjectivities matters. As such, we write in transnational solidarity with one another, aware of the impact of the capitalist, racist, and misogynist global reality that reproduces itself through institutions like obstetrics.

This article is informed by both our study of *and* our experiences with the obstetric institution in more practical and bodily ways as either a midwife, doula, woman, or mother. We therefore use "women's writing" informed by autoethnographic insights (Cixous 1994; Dauphinee 2013a, 2013b; Davis and Craven 2016; Lorde 1984; Mulla 2014). Autoethnographic writing makes it possible to open ourselves up to the ethical implications of our entanglement with the obstetric institution, not only as birth-workers or (pregnant) women, but also as researchers and witnesses (Dauphinee 2013a; Davis and Craven 2016). It involves taking seriously our positionality within this field, which brings to the fore that our experiences are both irreducible to one another and that there is a shocking continuance of severe violence within the obstetric institution globally (Davis and Craven 2016). Women's writing is what feminists have done to transgress abstract, institutional, and academic language and thought, freeing potentialities by connecting to practices and materiality to refract concepts and ideas (Cixous 1994; hooks 1994). Through ethnographically informed women's writing, we can show both what the obstetric institution has done *to us* and what *obstetric violence* as a feminist keyword has already done *for us*, as well as what the concept *could do* to propel change in the future.

Gently Whispering *Obstetric Violence* in Your Ear: A Short Genealogy of the Term and Its Movement

How is a problem named? How many people must suffer before it is deemed worthy of attention, and where should the problem exist geographically, and for whom? I, Kaveri, have observed one such problem, a phenomenon that I could not appropriately name for years. I am a Bengali South Asian woman in my mid-thirties, born and raised in lower-middle income settings in different states in India. I received an undergraduate degree in midwifery combined into nursing from a government college that is affiliated with the largest tertiary level hospital in West Bengal, India, which predominantly served people from lower income backgrounds.

I was selected for one of the only fifteen seats available to millions of young women from the eastern part of the country to study nursing and midwifery. My fee, 250 rupees per year (approx. $4), was affordable, and I was guaranteed a government job thereafter. I started assisting births in a very high case load facility "labor room," side by side with my friend, without rest. Exchanging smiles was the only encouragement for us in a busy maternity unit. There was never a dearth of "cases" to conduct, with four or five "labor tables" placed next to each other and one heavy metal rickety screen, which screamed for attention when dragged and was hence rarely used.

It was common to see doctors, junior and senior, shout at women. Slapping or pinching the outer thigh with artery forceps was normal when assisting births. Slapping the inner thigh or hitting the

vulva with an instrument was common during episiotomy repair without anesthesia. Senior staff nurses would shout and make derogatory and humiliating remarks: "Why did you not think before spreading your legs?"; "Remember the pain next time"; "Your age isn't receding, is it, yet you show up every year"; "This is common in their religion"; and "You must get operated on (tubectomy) or have a Copper-T inserted (IUCD)." I registered this in my mind as unnecessary abusive behavior the women did not deserve.

These violent practices are part of a medical, midwifery, and nursing student's education globally (Van der Waal et al. 2021). Contexts of inequity teach one to take advantage of the power-based imbalance through a vicious cycle, consciously or subconsciously. A lack of privacy and confidentiality, verbal abuse, and repeated nonconsensual vaginal examinations were usual and normalized in our practice. Observing the experiences women were subjected to everyday, some friends, while changing in and out of uniform (a bright fluorescent-yellow saree) after shift, would say "I am definitely getting an elective cesarean, there is no point in this embarrassment!" Some of them saved for years for an elective cesarean in a private hospital. After experiencing sexual abuse and mistreatment myself during a vaginal examination in the hospital I practiced in, while in uniform, I was positive that my position as a health worker had no positive influence on how I will be treated, not even in my own workplace. I decided to never give birth. My decision, as a virgin, involved refraining from sexual intercourse. I could not take a chance on contraceptive failure or an abortion, exposing myself to similar humiliation. It made me go on "birth strike" (Brown 2019). Having experienced sexual violence numerous times, I wanted to steer clear of a circumstance in which I could not protect myself (Mayra 2020a; 2020b).

Around the same time I was engaged in my studies, in 2007-08, the humanizing birth movement was gaining momentum in Latin America. There, they found a specific name to call out the "misbehavior" I had experienced and observed in the obstetric institution: obstetric violence. It captured the materiality and essence of the issue like none of the other terms did. My introduction to the term was shockingly late. I had been researching obstetric violence for almost a decade, yet I only came across the term during my PhD. It still is a commonly unacknowledged form of violence against women and birthing people.

The term *obstetric violence* was first used in the *Lancet* in 1827 (Blundell 1827), though it was only picked up again in the early 2000s, despite ongoing critiques of sadism and cruelty in maternity wards during the twentieth century. Obstetric violence as a concept has been most influential in propelling change in Latin America, where the term originated (Chadwick 2018; Quattrocchi 2019). It has gained a place in the law of Venezuela, Argentina (2009), Bolivia (2013), Panama (2013), and Mexico (2014; Castro and Frias 2020). Several observatories, such as the ones in Argentina, Chile, and Italy, archive obstetric violence in their countries and raise awareness (Quattrocchi 2019). Governments, globally, do not appreciate the explicit use of the term *obstetric violence*. Instead, they prefer being gently made aware that women may be experiencing a "lack of respect" when giving birth (Ignacio 2019). In 2019, however, the UN Special Rapporteur on violence against women, Dubravka Šimonović, took a stance on the issue. Presenting a report on the issue of obstetric violence globally, in which she used the term twenty-six times, she stated that, with respect to the terminology, the Special Rapporteur will use the term "obstetric violence" when referring to violence experienced by women during facility-based childbirth (Šimonović 2019).

Multiple attempts have been made to define obstetric violence (Savage and Castro 2017). In Venezuelan criminal law it has been placed within the nineteen punishable acts of violence against women, defined as the appropriation of the reproductive processes of the body by health care

providers (Hill 2019; Pérez D'Gregorio 2010). It calls obstetric violence out as a dehumanizing treatment, citing the abuse of medication, converting natural processes into pathological ones, and the resulting loss of autonomy and freedom in women's decision-making power. Michelle Sadler et al. (2016) expanded this definition by adding women's marginalization in the larger political economy, as did Rachelle Chadwick (2018) by referring to the fact that the issue is shaped by racialized, medicalized, and classed norms. It has been theorized as structural violence (Solnes Miltenburg et al. 2018), normalized violence (Chadwick 2018), birth abuse (Hill 2019), and symbolic violence (Morgan and Thapar-Björkert 2006)—all ways to explain the structural dimension of obstetric violence connected to hierarchy, power, status, and control. Sara Cohen Shabot (2016, 2020) defined it as gender-based violence that functions to reproduce feminized gender identities through shame, gaslighting, and epistemic injustice. Dána-Ain Davis (2019a) established that obstetric violence is not merely gender-based violence but is caused by racism as well. Obstetric racism is at the intersection of what is commonly understood as obstetric violence and medical racism (Davis 2019a; Davis, Varner, and Dill 2021):

> It is the mechanisms and practices of subordination to which Black women and people's reproduction are subjected that track along histories of anti-Black racism during preconception, pregnancy, prenatal care, labor, birth, and postpartum care. It characterizes situations when obstetric patients experience reproductive dominance by medical professionals and staff compounded by a patient's race or the history of racial beliefs that influences the treatment or diagnostic decisions.

There are seven dimensions of obstetric racism: diagnostic lapses; neglect, dismissiveness, or disrespect; intentionally causing pain; coercion; ceremonies of degradation; medical abuse; and racial reconnaissance, as shown in Figure 1, made by Cheyenne Varner and first published in *Anthropology News* in 2021 (Davis, Varner, and Dill 2021).

In Latin America, obstetric violence has been proven to specifically affect Black, Indigenous, rural, and lower-class communities. Vega (2018) has extensively documented how the obstetric system affects Indigenous and rural communities most, thereby also challenging the narrow focus of birth activism on natural childbirth, something that remains preserved for the white and privileged (Vega 2018; Castro, Savage, and Kaufman 2015). In India, research shows that intersections of oppression—related to education, skin color, caste, religion, gender, socioeconomic status, and other determinants of health—increased people's vulnerability to obstetric violence, which is embedded in India's postcolonial patriarchal context (Mayra, Matthews, and Padmadas 2021).

I find similarities in the history of the speculum and the experimentation needed for its development by Dr. J. Marion Sims, the "father of gynecology," on enslaved Black women's bodies in the US almost two hundred years ago and anecdotes of women being traumatized through unanesthetized episiotomy repairs in the twenty-first century (Davis 2019b; Owens 2018). The expectations for some women to bear more pain based on their race, class, and other social constructs, coined as *obstetric hardiness* by Davis (2019b), is still inherent to obstetrics two centuries later. My mother shared with me her experiences of labor. She was on her "best behavior," not making a sound and clenching her teeth through contractions, which saved her from facing any humiliation. She reports satisfaction from her birthing experience as she had managed to avoid "misbehavior," *baje baibohar* in Bengali—my mother performed obstetric hardiness to avoid obstetric violence when I was being born in the mid-1980s at a government military hospital in western India.

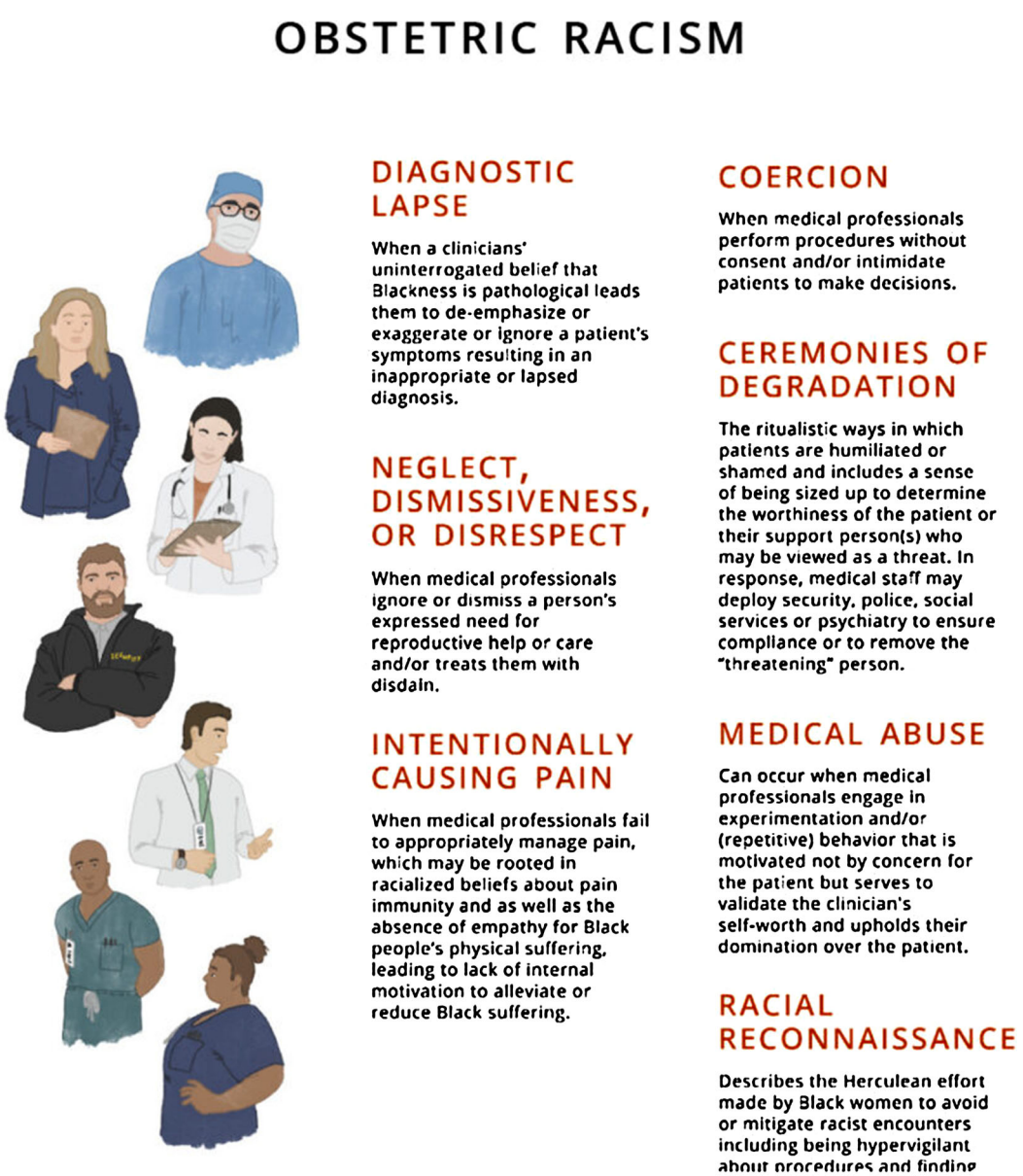

Figure 1 Dana-Ain Davis's elements of obstetric racism (with illustrations by Cheyenne Varner). **Image from:** Davis, Dána-Ain, Cheyenne Varner, and LeConté J. Dill. 2021. "A Birth Story. How Cross-Disciplinary Collaboration Illuminates the Burdens of Racism During Birth." *Anthropology News*, August 27. https://www.anthropology-news.org/articles/a-birth-story/.

Moving Beyond Intentionality

Obstetric, a term treated as holy and sacrosanct, becomes a battleground when the word *violence* is attached to it. A couple of my, Kaveri, articles on obstetric violence were pulled from the final stages of review following internal pressure from partner implementing public health organizations because the issue is deemed controversial and could cause political turmoil (see also Levesque and

Ferron-Parayre 2021). The decision of Brazil's Ministry of Health to drop the terminology from its official documents is an example of a pattern seen in many countries that are still, or again, in denial (Ignacio 2019). More acceptable terminologies include "mistreatment" (Bowser and Hill 2010; Bohren et al. 2015) and "disrespect and abuse" (Freedman et al. 2014), which Gita Sen, Bhavya Reddy, and Aditi Iyer (2018) divide as *disrespect* for lesser violence and *abuse* for the more extreme instances of violence.

Obstetric violence is the most contested and feared terminology (Sadler et al. 2016), leading to debates in well-known journals such as the *Lancet* and *Violence Against Women*. Melania M. Amorim, Maria Helena da Silva Bastos, and Leila Katz (2020) argued, for instance, that obstetric violence is the right terminology, for it moves beyond contextual and logistic issues by indicating the violation of human rights, equality, health, and reproductive autonomy. Meghan A. Bohren et al. (2020) responded to this critique, stating that the intentionality that the term obstetric violence implies makes it difficult to engage with healthcare workers and policymakers. Two recent examples of the controversy surrounding the term, one from the Global North and one from the Global South, center around the question of intentionality tied in with the defensiveness of obstetricians (Lappeman and Swartz 2021; Ravaldi et al. 2018).

In a response to reported obstetric violence from an online community survey in Italy (Ravaldi et al. 2018), presidents of three obstetrician and one midwifery associations objected to the evidence, calling the use of the term "deplorable," as it is "damaging" and "alarming" to put "violence" next to "obstetric" (Scambia et al. 2018, 133). They state that the findings "do not take into account the power-duty of the professionals to co-decide, guide women's choices, act urgently, even without consent, to avoid serious danger to the person's life or integrity" (Scambia et al. 2018, 133). Similar language has been used in a German medical journal, referring to *obstetric violence* as an attempt to "boil up the problem of violence," constructing obstetric violence as an exaggeration instead of taking birthing people seriously (*Deutsches Ärzteblatt* 2019). Michael Rost et al. (2020) condoned these responses, citing the harsh language devoid of any empathy and the supercilious denial of the issue.

The defensiveness of the obstetric establishment regarding the term ties in with the question of intentionality that lies at the center of debates surrounding obstetric violence. Based on their research in South Africa, Maura Lappeman and Leslie Swartz (2021; Swartz & Lappeman 2021) argued that the lack of intent on the part of the healthcare providers makes the term *violence* debatable and were concerned that its use, and Chadwick's (2018) conceptualization of "gentle violence," is demoralizing for healthcare providers. The importance of intent in questions of violence in healthcare can be traced back to the WHO's definition of violence, which places emphasis on the presence of intent in causing harm (Burnett 2021).

The WHO's definition is outdated, however, as it masks the patriarchal power structures of the world we live in by offering a definition solely based on personal agency and individual motives and attitudes (Davis 2016; Levesque and Ferron-Parayre 2021). The value and potential of the concept should not be measured against intentionality, since this approach is negligent to structural, epistemic, and institutionalized forms of violence and distracts from understanding obstetric violence as intersectional (Salter et al. 2021). Disregarding the perspectives of those who have experienced violence by discrediting the term *violence* and shifting focus to the question of the intent of those working in obstetrics is to endorse the status quo and conceal the experience of obstetric violence with other terms such as "mistreatment," "misbehavior," or "a lack of respectful

care." This refusal to name violence is just as harmful as referring to marital rape and intimate partner violence as "marital dispute" or rape and sexual abuse as "sexual misconduct."

As abolitionist thought argues, in matters of violence and injustice, we should start with the materiality of the violence of those who suffer it (Kaba 2021). Focusing on questions of intent distracts from locating the problem within the larger institution that molds the behavior of healthcare workers in the first place. An abolitionist approach can get us out of the impasse of intentionality, for it explicitly does not aim to hold individuals accountable but to abolish the institution that produces the violence by working with transformative instead of punitive justice (Kaba 2021). To do so, it starts from the intersectional perspective of the one who is suffering, thereon dismantling the intersections of structural violence inherent to the institution (Crenshaw 1991; Collins 2017; Davis 2003; Kaba 2021).

I, Rachelle, write as a white woman who has never given birth or worked as a birth worker or midwife. I thus have no concrete experience with the lived reality of birthing. I have, however, listened to more than one hundred birthers (both middle class and low income, Black and white) speaking about their experiences of giving birth in the South African context. I have been doing research on birth stories since 2004 and listening to stories of birth violence before the term *obstetric violence* was formally recognized. I have witnessed the potent political potential of the term to make visible hitherto hidden and silenced injustices. The articulation of obstetric violence, driven by activists and scholars of the Global South, has resulted in a substantive and increased recognition of the problem. This recognition of unacceptable violations during birth as obstetric violence and as gendered/racialized violence rooted in colonial and capitalist systems of oppression carries the seeds of transformative practice, for we can no longer accept the everyday appropriation of birthers' bodies as "normal," nor the erasure of our subjectivities as the price we have to pay for access to medical technology, support, and care.

An Abolitionist Historiography

In contrast to a lot of birth-workers, the term *obstetric violence* has never made me, Rodante, feel defensive. I am a twenty-nine-year-old white woman, a PhD student, and community midwife in Amsterdam in the same neighborhood where I was born at home. As a midwife in training, *obstetric violence* functioned as a keyword to my feminist understanding of the violence I both experienced and saw so many people going through. The violence I witnessed put me deeply at odds with my desire to be a midwife, which was, coming out of a family of writers, the most real, visceral, and hands-on practice of feminism that I could imagine. Naively, until the first birth I saw, I never realized that it meant having to be complicit in what I gradually came to understand as institutionalized gendered and racialized violence. "Naively" since I did study feminist theory and had two abortions at a young age, so I was familiar with institutionalized reproductive violence firsthand. Even for me, it had been extremely difficult to access abortion care and get out of it without shame and a deep sense of guilt. The look of the bus driver picking me up in front of the clinic consolidated all I had experienced in the clinic: the abortion was done, but I had not been cared for. It was handled as a tolerated crime.

I was told by a teacher once that, to be able to get through her day, every morning she reminded herself that all the women she was going to encounter during her shift were her enemy. She suggested that it would help me to do the same. Learning afterwards of the term *obstetric violence* through an activist group of mothers and midwives dedicated to human rights in childbirth in the Netherlands, the *Geboortebeweging*, was a revelation. The term was a necessary affirmation of a

growing and challenging sense that birth was constructed as something more violent than it had to be, and that the "care" I had to participate in was indeed unjust. By that time, I had already assisted with fifty out of the seventy births mandated for my training and had rarely seen a birth where people were not subjected to vaginal examinations every two hours, where pelvic "support" (the insertion of two fingers of both hands into the vagina before a contraction, giving continuous pressure to stretch the vagina by pulling the vaginal wall, often resulting in an internal rupture) was not the norm, or where people could move freely, push intuitively, and catch their baby themselves—where joy and ecstasy were not bordered by dogma, fear, racist prejudices, and authority (Crowther 2019). Obstetric violence was the concept I needed to understand obstetrics as an institution that effectively produced birth as violence, which included conditioning me through pressuring me to become complicit to successfully graduate as a midwife.

Locating obstetric violence within the institution beyond the question of intent but instead understanding it as a structure of power that inscribes itself in every new generation of birth-workers means that we can study it beyond the intentionality paradigm and refract the problematic through abolitionist feminism. Abolition dismantles the ways an institution is haunted by its past and aims to lay bare the groundwork responsible for the logic that continues to govern it today (Davis 2003; Gilmore 2007; Gordon 1997). In the case of obstetrics, its prehistory reveals a constitutive entwinement with structures of oppression such as capitalism, colonialism, and slavery. Because obstetrics as a biopolitical healthcare institution not only manages life but actively reproduces it, the role of obstetrics here should be understood as an active one in the reproduction and maintenance of structures of racialized and misogynous violence, rather than being merely passively outer-determined by them. We will discuss two events that were foundational to the violence inherent in obstetric practice as we know it today: first, the witch hunts in Europe, and second, the practice of "breeding" during US slavery.

Silvia Federici (2004) shows how the witch hunts in premodern Europe were essential in establishing state-control over reproduction, necessary for the constitution of modern biopolitical institutions. They raged through Europe from the fifteenth to the eighteenth century, the last witch hunt occurring in Poland in 1792. Most women and midwives burned in premodern Europe as witches were charged with reproductive crimes, either abortion or infanticide, but also when they had suffered a miscarriage, or their children had died from starvation (88). The appropriation of women's reproductive capacity amounted to the primitive accumulation of bodies needed to sustain social reproduction as the foundation of capitalist progress (12; 22). It was not only land that was primitively accumulated to further accumulate capital; reproductive bodies also had to be primitively accumulated to reproduce subsequent generations of waged labor. The charge of infanticide, which was dominant in the prosecutions of midwives and women, resulted in an ideologically constructed threat through the entanglement of witchcraft and infanticide, constituting maternal subjectivity as dangerous, thereby validating state-control over reproductive matters (89). A direct relation of responsibility of the patriarchal authorities to potential offspring was established, undermining the mother as a responsible self-determining subject, thereby separating the primary relation between mother and her reproductive body and potential children.

This control was established further through the appropriation of midwifery. Midwives were commanded to register all pregnancies, paternities, abortions, childbirths, and suspected infanticides and had to participate in witch trials, publicly examining women's bodies to ascertain whether they had been pregnant or not (ibidem). Midwifery was removed from its autonomous domain within the community and appropriated into disciplining and controlling state structures,

breaking a relation of equity and trust between mothers and midwives. The control of reproduction by secular powers in Europe through the severing of the relations between mother and child and mother and midwife was the primordial premodern foundation of biopolitics, which proved to be essential for the modern development of the obstetric institution within colonial and racial capitalism (ibidem).

A second constitutive event in the history of the obstetric institution was the appropriation of the Black female body during slavery—which led to the birth of modern obstetrics and gynecology (Owens 2018). After the closing of the transatlantic slave trade in the United States in 1808, doctors and plantation owners worked together to increase the reproductive health of enslaved Black women for "breeding" purposes to increase "human stock" for slave labor (Owens 2018).[2] The experiments and knowledge of doctors on slave plantations laid the racialized foundation of modern obstetrics and gynecology, which then traveled to Europe in scientific articles in medical journals (Owens 2018). Echoing the primitive accumulation of the reproductive body during the witch hunts, the appropriation of Black enslaved women served the development of modern medical science and capitalism. As such, Black enslaved women were subjected here to a primary "scene of engulfment" (Silva 2007) that truly constituted the modern obstetric institution, right at the heart of racial capitalism.

Remembering Ruth Wilson Gilmore's (2007, 28) definition of racism as "the state sanctioned and/or legal production and exploitation of group-differentiated vulnerability to premature death", it is uncanny to note that Black people in Western obstetric institutions today not only suffer higher occurrences of premature death from childbirth, but also higher occurrences of premature birth. Premature birth has detrimental short- and long-term health consequences, thereby effectively reproducing and accumulating vulnerabilities, as per Gilmore's definition (Davis 2019b). An abolitionist historiography shows that obstetrics has not only been determined by, but was, and is, itself a significant agent in the racialization of people through the (re)production of group-differentiated vulnerabilities caused by obstetric racism (Bridges 2011; Gilmore 2007). Premature birth and death are, again echoing the witch hunts, the severance of relationality between mother and child by a state-sanctioned institution.

These two violent appropriations of the reproductive body have inscribed a separation of relationality within the obstetric institution that impedes the possibility of emotionally and physically safe maternity care. The appropriation of maternity care by racial capitalism through both the witch hunts and slavery has constituted a separation between mother and child through (1) the increasing state-control over reproduction through the witch hunts, expropriating women's power over their own body through charges of infanticide (Federici 2004), and (2) the "breeding" practices that not only expropriated mothers' power over their bodies, but ultimately separated their children from them because they were not legally theirs, a horrific reality termed "natal alienation" (Guenther 2012; Spillers 1987). These logics of separation are still inherent in the institutionalized violence of obstetrics (Van der Waal & Van Nistelrooij 2022). The "dead baby card" or "shroud waving" is a concealed accusation of infanticide. Gaslighting is the separation of the mother-child relation through the denial of maternal knowledge and responsibility. The multiple court-ordered hospital births and cesarean sections over the last decades make continuous state-control over childbearing bodies explicit (Dyer 2020; Prochaska 2014). The still presumed "dangerous irrationality" of midwives and pregnant people echoes the trope of witchery. Premature Black birth and Black maternal and neonatal mortality is a consequence of the origin of obstetrics in racial capitalism. The relation of animosity between women, midwives, and doctors is the continuation

of the appropriation of care by a disciplinary patriarchal state. The diminished power of midwives integrated into the obstetric institution is indeed the state of the profession of midwifery today (Small et al. 2021). And the demonization of midwives is not a thing of the past, as proven by the recent (2021) attack on midwives by obstetricians in Peru (Colegio Medico del Peru), who circulated an illustration of a midwife wearing a bandit's eye-mask and a uniform with a danger sign, warning women against independent midwifery care.

The first person I, Rodante, ever saw giving birth was a Muslim woman who kept her *çarşaf* on during labor. She was forced to have an internal examination by a male doctor, and I can still feel the panic in the warm room, hear her scream, and see the thin white male doctor force himself into her, deeply convinced that he was doing the right thing. I froze, unable to stand up for her. My first moment of complicity. Then, a midwife came in, screamed at him, and made him stop. Her eyes scanned the room, checking to see if anybody else was going to try anything. "I'm a lion when it comes to the women I care for!" she screamed. I never saw a midwife standing up for a woman like that again.

In any other situation, it would be a criminal offense to insert fingers into someone's vagina without explicit and continuous consent (Pickles and Herring 2020). In her discussion of the prison industrial complex, Davis (2003, 63) cites a scene of disciplinary violence in the women's prison:

> Every woman who has ever been on the rock, or in the old house of detention, can tell you about it. The women call it "getting the finger" or, more vulgarly, "getting finger fucked." … The "internal search" was as humiliating and disgusting as it sounded. You sit on the edge of this table and the nurse holds your legs open and sticks a finger in your vagina and moves it around. She has a plastic glove on.

According to Davis, this infamous example of unjust treatment "exposes an everyday routine" "that verges on sexual assault" (63). In the obstetric institution, this form of sexual assault is increased by labor pain and often occurs at a two-hour frequency. Through abolitionist historiography, the obstetric practice of routine nonconsensual vaginal examinations becomes exposed as the normalized state-sanctioned appropriation of reproductive bodies. That which is clearly understood as assault or violence in a prison remains difficult to call out as violence within obstetrics.[3]

Obstetric Racism

Black bodies are under surveillance and under threat by institutions of power, historically and at present, all around the world. From slaveholders in the American South to police brutality in cities and towns worldwide, institutions have existed to control and abuse Black bodies and subjugate them to violence. I, Anna, am a Black American woman living in the United Kingdom. At the center of my positionality, I am both Black and a woman—a particular intersection of identities that has not always been considered but in recent years has given birth to concepts like Black feminism and intersectional feminism (Crenshaw 1989, 1991). I am also a doula, an anthropologist, and mother to a young daughter with another child on the way. I have and am currently experiencing a maternity care system that has long established traditions of obstetric racism.[4]

Now, in my second pregnancy, with an increased awareness of obstetric violence and its relationship to racism and disparities in healthcare for Black women, both in the UK and the US, I am more attuned to identifying it than I was in my prior experience of pregnancy. I have learned that obstetric violence, much like racism, is not always overt but can often be subtle, falling into a

gray area. Many women, particularly women of color, are then saddled with the burden of proving the violence carried out against them.

Halfway through my first pregnancy, I received a phone call from my general doctor urging me to go to the hospital; I had called earlier in the day to complain of pain in my lower calf. Concerned that it may be a blood clot, a risk that increases during pregnancy, I rushed from work to the maternity unit where I was receiving care, just as the doctor had asked. I was scared, confused, and all on my own. The midwives at the front desk were not sure why I had arrived, but I was eventually assigned a bed. The next midwife to come to my bedside, whom I had never met, started applying technology to my body for monitoring. I started to cry, worried for myself and my baby. The midwife, who was also Black, firmly replied, "Why are you crying? There is nothing to cry about." She made it clear that my tears were a nuisance. I wiped them away and waited for news from the medical staff. I retreated, said nothing, and tried to be invisible. I was shocked that a midwife would speak to anyone in that way.

As a doula, I too often hear of devastating experiences from the Black women and families I support. Many of them are unable to put the name obstetric racism to the violence they experienced in maternity care but are left with the insidious and unsettling feelings that many people of color know too well. A Black pregnant woman shared with me that in a consultation appointment with a doctor to discuss future surgery for her unborn baby, she expressed a concern about the development of keloids on her baby, a scarring condition that occurs most often in people with dark skin. The doctor replied, "Well … [the baby] is only half Black," making a reference to the woman's white partner. Then the doctor asked, "Are you completely Black?" When the woman, a light-skinned Black woman, answered yes, the doctor responded, "I doubt it!" The doctor had no qualms about disputing the woman's own racial identity and that of her baby—even with two junior doctors present—attesting to the medical racism underpinning the doctor's decision not to address the woman's concerns appropriately and respectfully. It seems that, for this doctor, Blackness can be measured and quantified.

As is often true of experiences of racism, there is no objective measure for obstetric violence, as highlighted in the debate around naming obstetric violence. It is impossible to compare the severity of these acts of violence because the act and its impact can only be identified by the victim based on their own positionality, power, perceptions, and past experiences. Many Black women, myself included, find it difficult to report on racist acts, especially in formal institutions such as healthcare, in part because they often sit in a gray area that allows them, when they are believed at all, to be explained away as something other than racism.

The consequences of obstetric racism reach further than the incident itself. Let us take, for example, the situation I described where the woman's concerns were dismissed and the racial identities of both her and her child were questioned by the doctor. First, this may not have been the only act of obstetric racism experienced by this woman during her pregnancy care or the only act of racism that she had experienced in her life. Therefore, we cannot determine the severity of this particular act for her or the harm it caused her. It may fall into previous trauma, or it may co-constitute continuous trauma or stress, as systemic racism and violence establish weathering and the Sojourner Syndrome, making Black women more vulnerable to premature birth—as well as any direct adverse health outcomes that derive from her concerns not being adequately addressed (Davis 2019b; Mullings 2005). Second, this act of obstetric racism shows how the fundamental logic inherent to the system continuously reproduces itself. From the behavior modeled by the senior doctor, the two junior doctors learn (1) how to dismiss a patient's concerns, (2) how to enact racist views in a medical diagnosis (because race is not biological, being "half Black" as the doctor declared

does not necessarily decrease the baby's chances of developing keloids), and (3) how to practice obstetric racism against people in their care.

Typical for obstetric racism is the contradictory way Black women have been viewed since the beginning of the obstetric institution and how these views have determined how we are cared for, including being denied self-determination or self-expression. In both the scientific literature and anecdotal stories of women's lived experiences, the contradictions between Black woman's "superhuman strength" or "hardiness" and their vulnerable disposition continue in the discourse around Black women's experiences and bodies (Bridges 2011; Davis 2019b). Medical and public health articles often describe Black women in different contexts across the globe as medically high-risk and/or socially vulnerable (Holdt Somer et al. 2017; Knight et al. 2020a; Martins 2006; Pícoli et al. 2017). Perpetuating this single narrative, without any examination of the context and structural causes of inequity in healthcare, creates the danger that individual practitioners will equate Black skin with medical complexity rather than contextualizing the wider sociopolitical drivers of health inequalities that disproportionately impact Black women in maternity care (Bridges 2011).

Alongside the vulnerable poor Black woman narrative is the well-known anecdotal trope of the strong Black woman, often thought to require little pain relief during labor (Davis 2019b). The assumption that Black women are built, both physically and culturally, to endure pain, because we have always done so, has stripped many Black women of the opportunity to receive the support they need in maternity care. For example, in the UK, where Black women are more likely to breastfeed compared to white women (McAndew et al. 2010), many on-the-ground narratives from Black women express concern about receiving less infant feeding support because Black women are deemed to be "natural" at breastfeeding. Similarly, in South Africa, Black women often give birth alone, neglected by healthcare workers due to a presumed 'natural ability' to birth (Chadwick 2018).

As a result of obstetric racism, Black women globally fall through the cracks and are denied physically, emotionally, spiritually, and culturally safe care. Maternal mortality is often used as a marker for the quality of health systems (Say et al. 2009) and a measure of strides toward health equity (Kramer et al. 2019). In my adopted country of the UK, MBRRACE-UK, a national maternal and infant health survey, has outlined trends of racial inequalities in maternal deaths (Knight et al. 2020b). Black women face the highest odds of maternal death in the UK, being four times more likely to die than white women (Knight et al. 2020b).[5] Meanwhile, the national government released a report, following an investigation, concluding that there is no evidence of systemic racism in the UK (Sewell et al. 2021). The report received much criticism for its objection to macro-level racism in the UK (Lacobucci 2021). In the US, findings on maternal mortality show a spectrum, with Black women experiencing a maternal mortality risk between three and seven times higher than white women (Holdt Somer et al. 2017). Epidemiological data from Brazil also show that risk of maternal death for Black and Indigenous women are nearly fourfold compared to white women (Martins 2006; Pícoli et al. 2017). Hence, we may conclude that transnational anti-Black obstetric racism is *the* epidemic crisis of the obstetric institution, with detrimental consequences.

Obstetric racism is part and parcel of the origins of obstetrics and has grown to take different shapes, depending on the local sociohistorical context. Davis (2019a) establishes the importance of understanding racism as an independent contributor to poor health outcomes and experiences for Black women and their babies. Building on Davis's (2019a) description of obstetric racism as an intersection between medical racism and obstetric violence, we argue that obstetric violence itself is indeed not only gender-based violence but, being a consequence of the origins of obstetrics in racial capitalism, first and foremost racialized and racializing violence. Obstetric violence then, is not only

part of the intersection of obstetric racism, but should indeed first and foremost be understood as reproduced by this intersection wherein multiple systems of oppression are glued together and reproduced within the obstetric institution (Collins 2017). Without being understood as part of this intersection, theorists and activists of obstetric violence risk seeing only part of the structures that produce obstetric violence, understanding it merely as a problem of emancipation, autonomy, medicalized versus natural childbirth, or a few bad apples within a lifesaving institution.

Violence against Black women and girls is often experienced in the shadows. Meanwhile, the pain experienced by white women ignites social movements and campaigns to end violence against women and girls (BBC 2021). We must be careful that the same does not happen with obstetric violence, with it being configured merely as something that either threatens the birth experience of white women during labor in the Global North or is, in its most violent forms, present in the Global South due to "underdevelopment." Centering the experience of anti-Black obstetric racism as an intersectional lens makes it clear that racism, obstetrics, and violence share a synergistic origin. From an intersectional abolitionist perspective, not taking anti-Black obstetric racism into account when fighting obstetric violence would not only miss the crucial historiography and reality of the violence, but also the right strategy for change. The Black Lives Matter slogan "When Black lives matter, everybody lives better," also counts for birth. It would require a revolutionary change of the obstetric system to honor the fact that Black people's births matter on their own terms. To make way for this realization means building a wholly different system to care for birth—a call for abolition that could easily be missed through a one-dimensional focus on white women.

Abolitionist Consequences and Alternatives

My, Rodante, complicity did not evaporate. Even as an independent midwife, I cannot escape the violence within the system. I rely on hospitals, on colleagues, on insurance money, on the government who stopped providing us with free translators, on a world wherein violence against Black people, pregnant people, and people of color is normalized, on an obstetric institution that remains morally unchallenged despite its violence. I am forced to be complicit even when I know there is a better way. I know that I would stand up for people in a situation similar to the first birth I saw. But many situations are more ambiguous, gray, invisible, and complex, as highlighted in the previous section. They are the consequence of structural intersectional institutionalized violence that one cannot stand up to alone.

One of the reasons for the invisibility of obstetric violence as a problematic that ought to be morally challenged is that the obstetric institution works with a negative conception of life as non-death, or as avoiding death, and sets as its task to save lives. In light of that, everything else is relativized as long as one survives childbirth. It also masks that the practice of saving lives is bio- and necropolitically racialized, making some people live closer to death than others (as not only maternal mortality rates of marginalized people, but also maternal near misses and neonatal premature births show), thus producing a group-differentiated proximity to death (Gilmore 2007, 28). This group-differentiated difference counts for every community encapsulated in the obstetric system and hence produces context-specific intersections of racializing violence. We see a group-differentiated proximity to death in colonized and former colonized countries where Indigenous communities (for instance from Latin America, Australia, Canada, the Unites States, and Palestine) continue to suffer higher maternal and neonatal mortality rates, underscoring the continuous relationship between obstetrics and state violence, echoing eugenic practices of the previous century. Regions

like Latin America and India highlight how a spectrum of social categories, such as class, caste, rurality, indigeneity, and skin color, are intersectionally incorporated into the institutional logic, reproducing a differentiation in the existence, duration, and quality of life through the production of differentialized proximities to death. Within the practice of saving lives, and hence within the definition of life as non-death, death is understood as unavoidable for some, while for others neonatal death has become the ultimate tragedy that should be avoided at all costs, effectuating unnecessarily high rates of medicalization, which in turn lead to obstetric violence. Following this merely negative conception of life, and hence birth, as non-death, while proximity to death is at the same time group-differentiated and relationalities between mother and midwife and mother and child continue to be broken through obstetric violence, we can wonder if we obstetrics can be a life-affirming institution.

One of the key insights of feminist abolition is that it is highly unlikely that institutionalized violence will stop through reforms or inclusivity (Davis 2016; Kaba 2021; Silva 2007). The institution of the police, for instance, does not transform magically when there is a Black woman in charge; neither does police violence diminish because of a reform like the mandatory wearing of bodycams (Davis 2016; Kaba 2021). In obstetrics, shared decision-making and informed consent prove that reforms too easily become another box to check and do not amount to real change, but rather hide or relocate the violence inherent to the institution. The fact that more and more gynecologists are women, or that a significant amount of care within obstetrics is done by (Black) midwives, does not necessarily lessen obstetric violence or racism within the institution. This is because, as we have shown, the obstetric institution we have today has its origin in racial capitalism and is constituted through a severance of relationalities between mothers and children and mothers and midwives. It glues multiple forms of oppression present in obstetric violence together in obstetric racism. Birth-workers have very little possibility to resist because they are overworked, burned out, and traumatized as laborers in a deeply unhealthy neoliberal capitalist institution.

To reform an institution is to remold it out of what was good about the original idea (Kaba 2021). Through centering anti-Black obstetric racism, we have shown that obstetric violence is so deeply entrenched in the institution that it might be impossible "to eliminate one without eliminating the other" (Davis 2003, 26). We are stuck in a paradigm wherein we think that the problems of obstetric violence and obstetric racism have to do with individual intentionality and could therefore be fixed without having to fundamentally transform the logic of this system. This means that we keep missing how the obstetric institution is haunted by its past, namely how it is historically and currently linked to state violence, racial capitalism, and neoliberal labor exploitation. At the same time, we continue to undermine valuable age-old alternatives to the comparatively recent invention of the obstetric institution, such as midwifery and doula work, regardless of ever-increasing evidence of better health outcomes in midwifery care (Nove et al. 2021). We think of doula and midwifery work as possible valuable reforms to parts of the obstetric system and at best we try to imagine an obstetric system that is midwifery-led. But there is no such thing as a midwifery-led obstetric system that stays loyal to midwifery's history and philosophy.

Therefore we propose another strategy. Instead of merely focusing on a racialized and racializing avoidance of death, we must focus on facilitating life beyond mere survival. Rather than remolding obstetrics into something less violent, we plea for a revaluation of doula and midwifery work. To prevent obstetric violence, we must have the time and space within our care to heal the relationalities that have been broken. Because the severance of relationality is so deeply entrenched within the obstetric institution, we cannot turn to the same institution for healing. Instead, we

call upon the distinct genealogies and philosophies of midwifery and doulas that have always existed within communities, long before the emergence of obstetrics, as relationality, spirituality, equity, care, and creativity. Doulas and independent midwives already counter obstetric racism and obstetric violence most effectively by practicing relational care, resulting as well in better maternal and neonatal mortality and morbidity outcomes. They are not trying to reform the system in place but rest on a fundamentally different genealogy, philosophy, and organizational structure. Instead of reforming a system that cannot be fundamentally changed, we propose that we see and value the alternative that is in front of us. Not as an addition to, but as the starting point for everything that we need to care for birth emotionally and physically in a life-affirming way; in a way that does more than negate death, but instead imagines birth as joy, as transgression, as spiritual, as radical friendship, and as love.

This does not mean that essential and lifesaving medical discoveries and treatments should no longer be used. Rather, this alternative approach aims to delink these interventions from the institutional logic of obstetrics and deploy them within a different organizational structure. The system we have now has resulted in unequal access to medical interventions, with interventions used "too much too soon" for some and "too little too late" for others. This can be seen, for example, in the recent recommendation in the NICE (National Institute for Health and Care Excellence) (2021) guidelines to induce all "Black, Asian, and ethnic minority" pregnant people at thirty-nine weeks to prevent neonatal mortality. To delink lifesaving obstetric interventions from obstetric racism and obstetric violence, we must figure out how to use medical interventions on an individualized basis when necessary.

Centering obstetric racism in activism and theorizing obstetric violence leads us toward the foundations of the obstetric institution. Though obstetric racism is something qualitatively different from obstetric violence, centering obstetric racism reveals its function as the intersectional anchor point of violence in the obstetric institution where multiple structures of oppression fundamental to the production of obstetric violence come together. Hence, only through centering obstetric racism will we be able to understand and critique obstetric violence effectively, making manifest its institutional, racializing, and intersectional nature. Locating, consequentially, obstetric violence not merely in individual actions or aberrations but in the institution of obstetrics makes it necessary to ask: How do we abolish obstetric violence rather than merely prohibiting, controlling, or masking it? Building on the work done to identify, describe, and challenge obstetric violence, we locate the theoretical and activist potential of the term in abolitionist thought. Obstetric violence helps illuminate how violence is normalized in and foundational to what is still commonly understood as a progressive, lifesaving institution. Obstetric violence refracted through an abolitionist perspective that centers obstetric racism challenges this perception to the core. By highlighting the institutional nature of obstetric racism and obstetric violence, it questions if this truly is the life-affirming institution we need. This is why this concept is controversial; because it challenges one of the main institutions that reproduces the world as it is. But just because it is controversial does not mean that it is destructive. Many people think that abolition is about absence, about the destruction of institutions, but, as Gilmore often says, abolition is about presence —about the presence of all the already existing alternatives, about being present with the ghosts of history, and about being present with each other through care—what Saidiya Hartman calls the "antidote of violence" (BCRW Videos 2017). The presence of obstetric abolition, then, is the praxis of Black, Indigenous, and other independent midwives and doulas globally. They are already our abolitionists.

Abolish Obstetric Violence: Points for Direction and Closing Statement

Following our abolitionist analysis, we want to close with some suggestions for directions for further study and activism:

- We[6] cannot proceed with the theorization of obstetric violence without a strong intersectional focus, which includes connecting better to reproductive and birth justice frameworks. We can only dismantle the obstetric institution if we center obstetric racism as the *intersectional anchor point* of obstetric violence.[7]
- Following feminist abolitionism, the obstetric institution can be regarded as both a postslavery and a neoliberal capitalist institution (Davis 2003). We have to better understand how obstetrics functions within neoliberal racial capitalism and how to challenge it.
- We must focus on the institution as the source of obstetric violence and not on the persecution of individuals. Not only does individual persecution increase fear among birth-workers, and hence increase obstetric violence, we also cannot let the fight against obstetric violence become another form of white carceral feminism.
- We need to think about the ideological dimension of institutions (Davis 2003). We must ask ourselves why we need the obstetric institution to function as it does within our cultural ideological sphere: Why is obstetric care the only form of maternity care that is accepted as safe despite evidence of the safety of alternative forms of care? This is especially urgent in neocolonial initiatives for safer maternity care globally, where the obstetric institution is understood as the only possibility, forcing local midwives and traditional birth attendants out.
- We must strengthen alliances with other abolitionist and social justice movements to build coalitions and solidarities that allow us to create life-affirming institutions together. A society built on life-affirming institutions will decrease the need for obstetric intervention; a need that often arises from a lack of healthy food and affordable housing, stress, racism, financial problems, and lack of access to healthcare.
- We should affirm childbirth as a potentially transgressive, life-changing experience and protect its possibility for joy, relationality, and radical love. We focus on liberating the potential of experiences like sex in feminism, and birth should be part of that same exploration. For birth to have a place on our abolitionist horizon, we need to work, as midwives, doulas, mothers, and parents, on nourishing the transgressive potential of birth in our daily practices. This means making "practical strategies for taking small steps that move us toward making our dreams real and that lead us all to believe that things really could be different. It means living this vision in our daily lives. An abolitionist vision means that we must build models today that can represent how we want to live in the future" (Critical Resistance 2021).
- Obstetric violence already has its abolitionist movement, which continues to be neutralized, discredited, and appropriated by the obstetric institution. Black, Indigenous, minority, and independent midwives and doulas are our abolitionists (Zacher Dixon 2015, 2019). We must unite independent doula and midwifery movements and offer an abolitionist alternative to the obstetric institution. We must engage with how these individual practices are organizing, resisting, and providing alternative forms of care so that we can learn from and align with each other to reimagine how we care for birth.

We started our refraction of the term *obstetric violence* with the controversy surrounding the term as it is regarded to put the blame on individual health care workers. We have argued

that the concept *obstetric violence* should *not* be understood in such a carceral way, i.e., as a tool for individual persecution. We have demonstrated how obstetrics *as an institution* has been constituted historically through reproductive violence fueled by white supremacy, capitalism, and patriarchy. Instead of understanding violence as exceptional, caused by individuals within the obstetric machinery, we recognize and accept it as constitutive to the obstetric institution. Therefore, we argue that the real controversy that the concept *obstetric violence*, as *institutional* violence, brings to light, is the question of the abolition of the obstetric institution. While direct acts of obstetric violence are rife across diverse geopolitical contexts, the subtle violence of obstetrics plays out as a coercive, hierarchical, and systemic force that shapes and constrains the actions and subjectivities of birth-workers and birthing people. Hence, we must dare to ask ourselves if the obstetric institution, forged through histories of racialized appropriation, can be reformed from within, and dare to embrace the possibility of its abolition through our resistance, refusal, and alternative forms of care. Our task, then, is to work with birth-workers from all disciplines to create alternatives to the obstetric system, being rigorously self-critical to how the severance of relationality of obstetric violence still haunts us, and fully aware of the difficulty of creating truly relational care. But we are hopeful, since we believe that every birth has the potential to be an abolitionist future. For the event of birth is not only shaped by context and history, it also forges relations through its spiritual capacity to break down the borders of the self and lure everyone in the room into the openness of its event.

Acknowledgement

We are grateful for the support and feedback of the editors, Dána-Ain Davis and Sameena Mulla, in addition to the time and constructive suggestions of the anonymous reviewers. Our research is underpinned by the parents who graciously shared their stories and lives with us and we are indebted to their openness - thank you. Lastly, we'd like to thank each other, co-authors, colleagues and now, friends. Crafting this paper together bonded us over shared philosophies, scholar-activism and a desire for change in maternity care systems. To borrow a term from Natasha Smith, the founder and managing director of the Women's Health and Maternal Well-being Initiative C.I.C., we have begun to develop a "radical friendship" which we hope will lead to impactful scholarship that centres the margins.

Notes

1 There are more, of course, such as colonization and the expropriation of Indigenous midwifery, eugenics, etc. Due to limited space we choose to discuss these two, located in the "prehistory" of obstetrics, following Angela Davis's (2013) abolitionist historiography of the prison industrial complex.

2 Granny midwives in the US were the only alternative practice of maternity care emerging on the slave-plantations, serving women from their own community until they were expropriated in the twentieth century through campaigns and disciplinary legislation reminiscent of the treatment of midwives in Europe during the witch hunts.

3 At the same time, it is important to note that obstetric and reproductive violence is worse within jails, prisons, and detention centers in the Global North (Amiri 2020; Sufrin 2019). This is evidenced in Europe as well in the recent case of the death of a baby in a prison cell in the UK (Taylor 2021).

4 Obstetric racism is defined by Davis, Varner, and Dill (2021) as at the intersection of obstetric violence and medical racism: It is the mechanisms and practices of subordination to which Black women and people's reproduction are subjected that track along histories of anti-Black racism during preconception, pregnancy, prenatal care, labor, birth, and postpartum care. It characterizes situations when obstetric patients experience reproductive dominance by medical professionals and staff compounded by a patient's race or the history of racial beliefs that influences the treatment or diagnostic decisions. There are seven dimensions of obstetric racism: diagnostic lapses; neglect, dismissiveness, or disrespect; intentionally causing pain; coercion; ceremonies of degradation; medical abuse; and racial reconnaissance. See also Figure 1.

5 Many recently funded initiatives and research studies have launched to investigate racism in maternity care, such as the Royal College of Obstetricians and Gynaecologists' Race Equality Task Force, Five x More maternal health

grassroot organization, and Birthrights' inquiry into racial inequality in maternal care. See https://www.rcog.org.uk/en/news/campaigns-and-opinions/race-equality-taskforce/; https://www.fivexmore.com; https://www.birthrights.org.uk/inquiry-into-racial-injustice-in-uk-maternity-services/.

6 The "we" referred to here includes all those (including birth-workers, activists, academics, mothers, and policymakers) who are united in the struggle to transform birthing care against systems of oppression, racist violence, and discrimination.

7 A way to do this would be to focus on how the obstetric institution interrupts the emotional, social, and physiological process of pregnancy and childbirth in peoples' lives, following Richards-Calathes (2021) method of peneaelogy regarding the penal system.

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