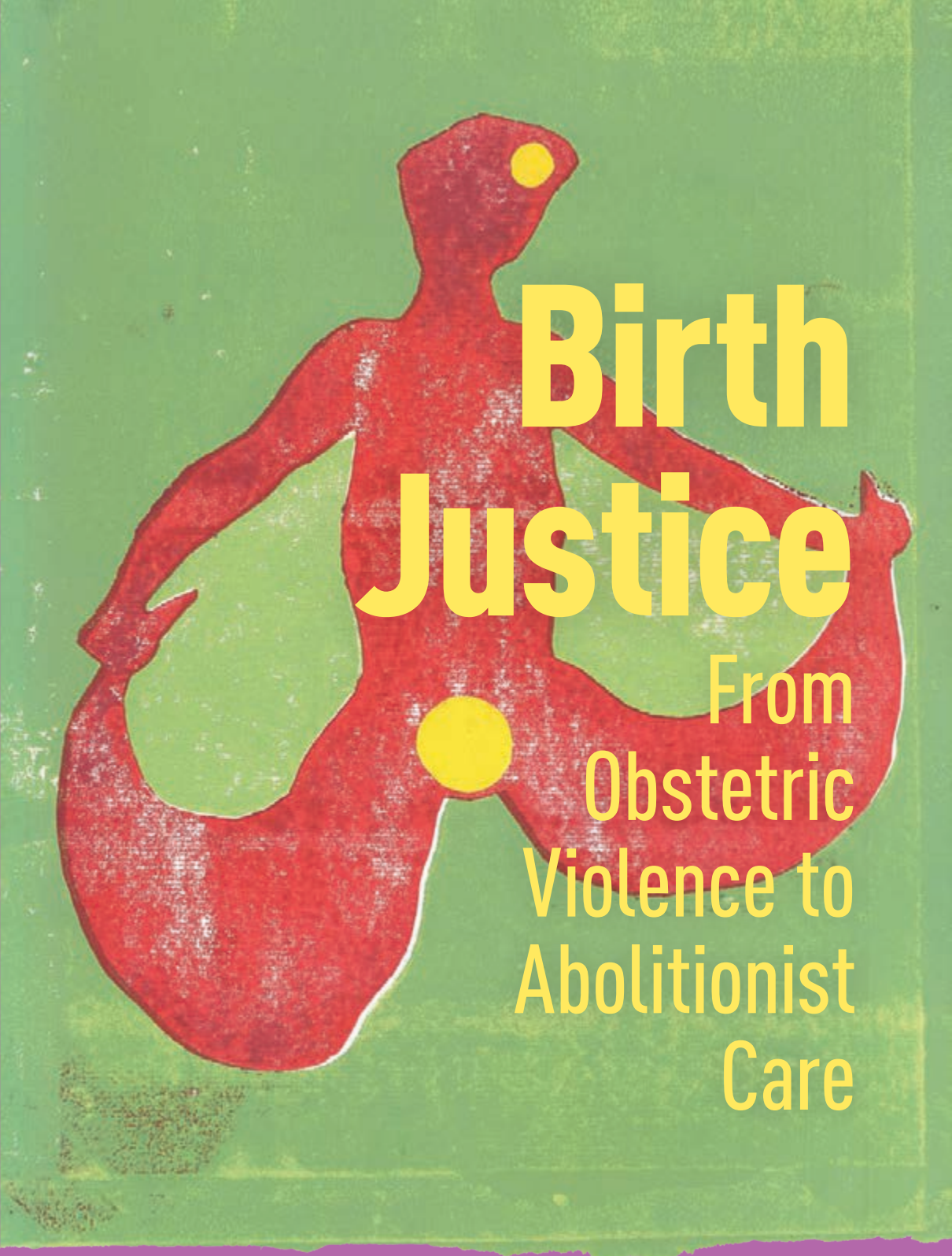

Birth Justice

From Obstetric Violence to Abolitionist Care

Amsterdam University Press

Rodante van der Waal

Birth Justice

This book provides startling new directions in midwifery and feminist scholarship and establishes Rodante van der Waal as a leading scholar in critical midwifery studies. Its central focus, obstetric violence—a current urgent concern in maternity care—is meticulously examined beyond the confines of the maternity sector and linked to the institutional violence inherent within the biopolitics of the modern state. Resistance to this violence is positioned not as an emancipatory struggle for legitimacy, but as a reimagination of reproduction and reproductive justice to-come, through the adoption of abolitionist radical care. Relationality—as a disruptive practice of care, and midwifery—by its commitment to relationality, are identified as philosophical and practical contributions to reproductive justice, while also destabilizing the grounds of midwifery idealism and essentialism. Rigorously argued, and drawing on a wealth of interdisciplinarities, the valuable and transformative perceptions contained in *Birth Justice* will speak strongly to academic readers, activists, care professionals, and health care policy makers. It is a call to arms, in the most profound sense—to the arms of care, of community, of justice.

Elizabeth Newnham
Associate Professor, Flinders University

Birth Justice is a must-read book that defies disciplinary boundaries, inspires the imagination, and nourishes resistant thinking. In this carefully curated collection of articles, intermezzo interludes, symposia, and reflections, Rodante van der Waal deftly weaves together theoretical, personal, narrative, and creative modes of inquiry. Beautifully and attentively written, the end-result is a vibrant philosophical meditation on birth, abolitionist care, and the work of gestational justice. Deeply thought-provoking, honest, and humane—this book is intellectual nourishment.

Dr Rachelle Chadwick
Senior Lecturer in Gender-based Violence, University of Bristol

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What if abolition isn't a shattering thing, not a crashing thing, not a wrecking ball event? What if abolition is something that sprouts out of the wet places in our eyes, the broken places in our skin, the waiting places in our palms, the tremble holding in my mouth when I turn to you? What if abolition is something that grows? What if abolishing the prison industrial complex is the fruit of our diligent gardening, building and deepening of a movement to respond to the violence of the state and the violence in our communities with sustainable, transformative love?

—Alexis Pauline Gumbs

The plan is to invent the means in a common experiment launched from any kitchen, any back porch, any basement, any hall, any park bench, any impoverished party, every night. This ongoing experiment with the informal, carried out by and on the means of social reproduction, as the to-come of the forms of life, is what we mean by planning; planning in the undercommons is not an activity, not fishing or dancing or teaching or loving, but the ceaseless experiment with the futurial presence of the forms of life that make such activities possible.

—Stefano Harney and Fred Moten

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Acknowledgements

Writing this book has been a collective project in many senses of the word. As is always the case, writing can only be done humbly in the hands of whole traditions of thought, in constant dialogue with writers, philosophers, and poets—I am indebted to all those thinkers who I was inspired by, whose thoughts I borrowed, whose thoughts I tweaked and used, and whose thoughts I attempted to honor and understand. But this study hides many more multitudes that have by now, crystallized onto the page, and whom I wish to thank deeply.

First and foremost, the 31 participants who have given me not only their time and their good conversation during interviews and focus groups, but also their ideas on the matter over a course of five years in more informal discussions and talks outside of this study. The most difficult challenge has been to represent and analyze the plurality and broad spectrum of so many hours of interview, and to not lose the difference between individuals in the group. I tried to keep the participants present not only in the empirical articles, but throughout the study, and in more creative pieces, where they pop up here and there to underscore that they are the true protagonists of this study—without their intelligence and resilience I would not have been able to write this book, and, maybe more importantly: I would not have found the strength and inspiration to continue to become a midwife. Without them knowing it, maybe, it was all these conversations, interviews, and focus groups on birth and midwifery that pulled me through the reality of the job in my first year after graduation. Mothers, midwives, doulas, and midwives in training who have been kind enough to participate, I deeply thank you for your time, your wisdom, and your continuous fight for birth justice.

Another assembly of people with heart for the cause that I cannot thank enough are the midwives, doulas, and academics with whom I founded the Critical Midwifery Studies Collective (CMS). We gathered as birth workers and mothers from all over the word to organize around issues such as coloniality, obstetric racism, and obstetric violence. Together, we hosted a summer school in 2022 which had the humanization of birth as its horizon. Without the brilliance of so many dedicated people, I would have never been able to relate to issues that I do not encounter in my own daily practice but deeply recognize as the interconnection of our struggle. CMS is where transnational solidarity and learning came alive for me. I would especially like to thank my fellow CMS midwives and friends—or *vroedvriendinnen*,

as Madyasa likes to say—Madyasa Vijber, my fellow midwife who reads the same books, has the same ideas, and reimagines the same kind of care, and who actually did in practice what I only wrote about, and Bahareh Goodarzi, Hannah de Klerk, Noëmie Wilemen, Priya Sharma, Anna Horn, Kaveri Mayra, Susana Ku, Fatimah Mohamied, and Jason Marcus, who carried CMS towards its launch with me during the summer school.

For me, as a lonesome thinker and individualized writer, it was not always easy to work together, think together, formulate together. But I was deeply convinced that a project like this, that aims to extend beyond the text into the world, and wishes to carry the world within itself, cannot be done in solitude and needs to be the collective it so desires. I am grateful that all my co-authors wanted to embark on writing, theorizing, analyzing, envisioning, and reimagining, together with me. They are true co-authors of this work: not only of the articles they co-formulated, but of its whole direction of thought, specifically, Kaveri Mayra and Anna Horn, with whom I discovered the world of abolition theory and activism. I wish to thank my co-authors Inge van Nistelrooij who is part of many of the articles; Rachelle Chadwick, whose work has been and still is extremely formative for me, it is an honor to be able to include you as a co-author; Bahareh Goodarzi, Alana Helberg Proctor and Madyasa Vijber, from whom I have learned so much on systemic and obstetric racism and whom I deeply admire for confronting and tackling these issues in the Netherlands; Bahar, thank you as well for being a guiding light in the world of academic midwifery and an example in your energy needed for change; Veronica Mitchell and Vivienne Bozaleck, with whom I wrote my first article in transnational solidarity: your perspective has shaped and grounded me throughout my study; Deborah Fox and Liz Newnham, again, two wonderful midwives from the other side of the world, Liz, your work and your friendship has meant a lot to me personally, professionally, and academically: thank you for your belief in me and your continuous support; and my fellow philosophers, Stella Villarmea, Aukje van Rooden, and Kim Schoof, the first of whom have been my philosophy teachers for years by now, and whose wisdom and clarity of thought I continue to admire. The latter is my dear friend Kim, who has become my close partner in this inspiring and sometimes difficult PhD project that we started together: thank you for being there with me till the finish line.

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alive and available, and the Abortion Network Amsterdam, which makes transnational solidarity a reality, each clinic visit in the Netherlands at a time of people who come from far across our borders. These practices have been the example for the conceptualization of 'abolitionist care' and I cannot thank you enough for what you do. You are the daily practice, the reimagination, the embodied and embedded thought, the reality of the work.

Apart from these multitudes of midwives, doulas, mothers, academics, activists, and practices that have shaped and continue to be present in this study, there are, of course, some individuals who have been willing to carry me, in all my idiosyncrasies, through this trajectory. First my supervisors, Inge van Nistelrooij and Stella Villarmea, whose expertise and breadth of knowledge I could not have done without, but who also took me under their wing, showed me the world of academia and the world of the philosophy of birth, and who were there for me in emotional, conflictual and difficult times—you made me understand the German expression for doctoral advisor: *Doktormütter*. I was very lucky to have you both as a polymaternal advisory team.

There were two other, more informal teachers, who were essential for the development of my thought. One was Sophie Lewis, whose online classes on a variety of repro studies-related topics I took and whose sharpness of thought and language continues to inspire my will for change and to provoke my theorizing. The other was Barbara Rothman, with whom I had the honor of spending the last months of writing in New York and who, at the last moment, although I knew her work since the beginning, made some important arguments crystal clear for me through wise conversation and relentless and warm curiosity.

And then, of course, my family and friends, whose solidarity, comrade- and friendship mean the world to me, even though I have been extremely busy and absent. I hope that they know by now that this is not due to any lack of love or admiration, but that I carry their thoughts and ideas with me in mine, and that I try to connect to their voices from wherever I am. Specifically, I would like to thank Dalin, you are the one who roots me, and the one who has been there for me always, ever since we met. Thank you for the depth of your friendship during this last decade and, I know, during the many yet to come. Hannah, my midwifery friend from the first hour, this has been yet another project we went through together—I cannot wait until you finish yours and to embark on many more life-altering steps together. Arthur and Jarmo, your ideas and practice and our countless conversations over the years have shaped me thoroughly and are among my most precious hours. Sebald, my brother, you are my sharpest reader and the one to whom the details

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Introduction

I aspire to experience as many births as were lived by the people
—Édouard Glissant

Abstract
This chapter is the introduction to the book *Birth Justice: From Obstetric Violence to Abolitionist Care*. In this introduction, I lay out the problematic of obstetric violence and give an overview of the relevant literature on the subject. I briefly introduce one of the main theses of the book, namely that obstetric violence is a problem of the dissolution of relationality needed for reproductive justice. Additionally, I provide some anarchafeminist methodological considerations and a chapter-by-chapter summary.

Keywords
Obstetric violence, abolitionist care, reproductive justice, relationality, care ethics, anarchafeminism.

A Quiet One

During the years when I was doing this study into violence in maternity care, my mother would always tell me that I was born without a single instance of violence. "And so was your brother," she would add. She then recounted how the midwife who was at my birth was barely noticeable and blended into our household, talking for hours with my father in the kitchen while my mother was sighing away her contractions. Usually, she continued the story by remembering how both the midwife and student midwife who were there at the birth of my brother also made themselves comfortable by talking to my father in the kitchen after having seen my mother only briefly in the living room, remarking *ah, ze is een stille* ("ah, she is a silent one")—interestingly, a

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characterization that I, now a midwife myself, have never heard to describe people in labor who use concentration and their solitude, rather than sound and the support of others, as ways to handle the pain.

In Dutch, *stille* is the word that is normally used for undercover cops at demonstrations who blend into the crowd and unexpectedly arrest protesters. And while this book precisely struggles against any overlap between reproduction and policing, the silent, undercover aspect of the characterization is poignant. Not only the midwives but my mother herself blended in with her second-floor Amsterdam apartment, with daily life, and, when it was my brother's turn, with caring for me. One could hear the neighbors waking up and going down the stairs, and, right above our heads, making breakfast and hastily going through their apartment to collect everything needed for the day. Nobody, except my parents and the midwife, and perhaps myself, knew that we were being born; nobody interfered or told my mother what to do, nobody noticed: an undercover birth, blended into the crowd, into the rhythm of daily life. Undercover—not to make arrests, but to create; not to subject or be subjected to discipline but to let birth develop autonomously, protected by invisibility. Not to support carcerality, but to subvert it: being free to move and labor in any position wanted. Not to control borders, but to transgress them; birthing life out of what was once thought to be an individual.

Of course, she had always said that the births of her children were tough: a force of nature, another power taking over her body until she thought she could not take it anymore, but she insisted that they were not violent. During the birth of my brother—I was 4 years old at the time—I took my job of drawing his birth card (a Dutch tradition that announces the birth of a new baby to friends and family) very seriously; the most important task ever given to me at that point in my life. There was concern over his condition which meant that my mother had to push before she felt the urge to, something she still regrets, but it was not violent. Compared to my own experiences at day care, I experienced the birth of my brother as far less disciplinary, less scary, freer.

In this book, the undercover, underground, undercommons aspect is conceptualized as that which has the potential to reimagine reproduction through practice and facilitate reproductive justice. In the three decades since my and my brother's birth, I have been the one hastily running up and down the stairs of the same house while studying philosophy and midwifery from my studio on the fourth floor. It was me chaotically collecting my things, mostly in the middle of the night without anybody noticing, to step into my car with my midwifery bags to support a birth somewhere in the neighborhood. Perhaps my image of birth when I was still a child is why

the first births that I saw were so unsettling. I now know how difficult it is to let birth unfold without trying to control it, to resist the urge of telling pregnant people what to do, and to instead encourage mothers to let go and do it by themselves; to, together, trust that they can. In many ways, this study grew out of the troubling discrepancy between my childhood memory of birth—from a time when more than 30 percent of Dutch mothers gave birth at home with their own midwife—and the feeling of discomfort I started to experience as a midwife 25 years later.[1]

As a midwifery student there was not much pause. I went from one birth to the next. And sometimes they were beautiful, like in my mother's stories, but often they were rough. Quite often they seemed brutal: the opposite of anything creative, transgressive, or humane. I saw mothers who came out of their labors traumatized. And in the lack of informed consent given by them, of communication with them, and love given to them during birth, I saw their dissociation unfold. Through the Dutch activist group for autonomy in pregnancy and birth de Geboortebeweging ("The Birth Movement") and the work of Dutch midwife Rebekka Visser, I quickly got to know the term obstetric violence, and it became a lens through which I could place many of the things I saw happening.[2] At the same time, the midwives who had the patience to let a birth happen by itself although they were physically exhausted from their 24-hour shifts, the doctors who were able to stay respectful while intervening in the process to make sure everything went well although they had other complicated births in their wards, and the mothers who were able to give birth themselves although they were completely overwhelmed by the extreme suddenness or the unbelievable slowness of the process—these midwives, doctors, and mothers started to feel like miracles, like the exception to the rule. Birth became that which filled me with anger and doubt, and that which I admired and loved most, including the actors involved: the mothers, the midwives, the maternity care nurses, the doctors. And of course, this love-hate relationship is precisely what propelled my fascination: the sense that there was love there that still needed to be liberated. Many birth workers deepened my conviction

1 For recent numbers on homebirth rates in the Netherlands, please see: https://www.perined.nl/onderwerpen/publicaties-perined/kerncijfers-2021.

2 For a current overview of obstetric violence in Europe, including the Netherlands, please see the forthcoming European Comission's report on obstetric violence: Patrizia Quattrocchi, *Obstetric Violence in the European Union: Situational Analysis and Policy Recommendations.* (Brussels: European Commission, 2024). For more information on the De Geboortebeweging in the Netherlands, please see: www.geboortebeweging.nl. For more information on the work of midwife Rebekka Visser, see: www.noorderzicht.nl.

that everyone can give birth without violence, and that, although it sits uncomfortably within most feminist, political, and activist programs, this is something worth fighting for—so that parents will be able to tell their children that they gave birth without a single instance of violence, as my mother likes to do. And so that they can recount that they were supported and in control, so that, as one of my midwifery mentors Froukje Jorissen puts it, they "can live on the power of that experience for years."[3]

At this moment in time, we are faced globally with mounting evidence of obstetric violence and racism, with a maternal and neonatal morbidity and mortality crisis for Black people and people of color, and with increasing criminalization of abortion which in turn increases maternal and infant deaths. During my years of empirical and theoretical study, I have come to conceptualize the cause of reproductive injustice as the institutionalized isolation of (potentially) pregnant people from both their community as well as their fertility or pregnancy, making them vulnerable to biopolitical policing and neo-eugenic control. It is the undercover aspect described above that I believe can be effectuated for the reimagination of reproduction *without* isolation, criminalization, and policing. Through empirical research which informed my turn to decolonial, feminist midwifery and Black radical theory, this study charts a path towards reproductive justice by way of "abolitionist care." Abolitionist care, in the case of reproduction, is a caring towards the abolition of authoritative institutions and restrictive laws and policies, in favor of community practices that truly are relational, free from violence, and that can as such reimagine and effectuate, through practice, what reproduction and reproductive justice are, so that we can live together *otherwise*.

To reimagine reproduction implies that there is something to be reimagined. Reproduction is not a mere biological event, but is formed by hegemonic discourses, socio-material structures, and ruling ideologies that are based on Enlightenment ideals of justice. Reproduction is formed by specific configurations of justice, even if these configurations are considered by critics to be unjust. The problem is not that reproduction is a sphere of society that has until now been left out of the configurations of justice, but rather that reproduction is disciplined through configurations of justice that are, in fact, not just for everyone. The way that reproduction is practiced today is strongly influenced by specific normative ideas on the "right" way to procreate, on the moral good in matters of kinship, and hence on justice in matters of reproduction. This means that it is not simply a matter of fighting

3 Rodante van der Waal, "Specter(s) of Care: A Symposium on Relationality, Midwifery, and Reproductive Justice to-Come," *Frontiers: A Journal of Women's Studies* 44, no. 2 (2023): 98–123.

for reproduction to be acknowledged as a realm in which the question of justice is at play. Were that the case the task would be easy: we would merely have to uncover the unjust practices and emancipatory change would be on its way. The task is rather to put other configurations of justice next to the oppressive hegemonic ones, which is what Black feminists from the United States have been doing very successfully since the 1990s.[4]

Now there are multiple contradictory convictions regarding what justice means in the case of reproduction. Some health care professionals think that obstetric violence is morally legitimate, for instance, or should not be seen as violence, since they see obstetric violence as the price to be paid for the protection of the life of the fetus. The same argument applies to abortion; for some, the criminalization of abortion is legitimate because justice in matters of reproduction for them means saving the embryo. These moral configurations of justice in juridical and caring practices around pregnancy and childbirth are still hegemonic. Just this year, the proposal to abolish the law in the Netherlands that anchors abortion legislation in the criminal code was rejected by a majority of the house of representatives, including the liberal party (VVD).[5] While abortion activists thought that it was enough to show the injustice of having abortion listed next to grave crimes such as murder and rape in the criminal code, the majority of representatives believed it to be better for abortion to remain an official injustice, just like murder, although abortion care is tolerated in the Netherlands until 24 weeks of pregnancy. Even in the self-proclaimed most tolerant country in Europe, the majority of representatives hence believe abortion to be a crime, albeit a tolerated one, and thus an example of injustice in matters of reproduction. The problem at hand is therefore not a simple fight for justice, but a clash of fundamentally conflicting ideas of what justice in reproduction entails—a fight for having reproductive freedom and self-determination reimagined as justice rather than injustice. A struggle wherein one viewpoint holds hegemonic power, while the other is still regarded as overly radical.

Reproductive justice, a term coined by Afro-American feminists in the 1990s,[6] should therefore not be understood as the articulation of something

4 For an overview and theorization of reproductive justice work of the last two decades, see: Loretta Ross, ed., *Radical Reproductive Justice: Foundations, Theory, Practice, Critique.* (New York: Feminist Press City University of New York, 2018).

5 NOS, "Nog onvoldoende steun voor schrappen abortus uit wetboek van strafrecht," May 23, 2024: https://nos.nl/artikel/2476329-nog-onvoldoende-politieke-steun-voor-schrappen-abortus-uit-strafrecht

6 The term was coined at a meeting by the Black feminist group *Women of African Descent for Reproductive Justice* in Chicago, IL in 1994. For more information, see: www.Sistersong.net.

fully new, but rather as a counter-normative claim; it is a struggle of liberation *against* the hegemonic conservative configuration of justice in matters of reproduction.[7] While courts still rule that justice in matters of reproduction means the prioritization of the life of the embryo above the rights of pregnant people, Black feminists' iteration of reproductive justice stands for radical bodily self-determination for the pregnant person: the right to have children, not have children, and raise children in safe and sustainable communities.[8] To sharpen the above distinction between these two iterations of justice when it comes to reproduction—roughly: a conservative and a liberatory one—I use Jacques Rancière's distinction between "police" and "politics" in my theoretical framework in the next chapter; a distinction which has recently been applied to care ethics by Sophie Bourgault.[9] With Rancière's help, I distinguish between a hegemonic "policing" configuration of reproductive justice, and a counter-normative "political" one.

Rancière uses the term "police" to indicate the social structure responsible for what he calls "the partition of the sensible."[10] The sensible for Rancière consists of the way in which it is commonly possible to perceive the world. As such, the police establishes the border between the perceivable and the unperceivable, the sayable and the unsayable. Some groups of people are heard, while others are not. Some are visible as humans, while others are not. For some, the violation of human rights is easily perceivable, while the dehumanization of others goes unnoticed. This distribution of the sensible is the partition of what is and what is not thinkable, whose voices are included and excluded, who can have a share in what is common to the community and who cannot, what seems to be just and unjust, whose knowledge is valid and whose is not. The participants in my empirical research stumbled on the conservative, patriarchal, and colonial configuration of justice in reproduction, that structures their current reality of reproduction. "Politics" is the term that Rancière uses to think the disruption of the current order of the sensible that is guarded by its hegemonic discourses, ideological presuppositions, socioeconomic relations, and political institutions—all of which are paradigmatically represented by his concept of "police." Politics

7 Daniel Loick, "Fugitive Freedom and Radical Care: Towards a Standpoint Theory of Normativity," *Philosophy and Social Criticism* 0 (2023).

8 See the articulation of reproductive justice in the statement of the Black feminist collective SisterSong here: https://www.sistersong.net/visioningnewfuturesforrj.

9 Jacques Rancière, *Dissensus: On Politics and Aesthestics*, trans. Steven Corcoran. (London: Continuum Books, 2010); Sophie Bourgault, "Jacques Rancière and Care Ethics: Four Lessons in (Feminist) Emancipation," *Philosophies* 7, no. 62 (2022).

10 Rancière, *Dissensus.*

can then be understood as a subversive disruption, and as a redistribution of the sensible. This means that, for the Black feminist iteration of reproductive justice to become reality, all domains of reproduction—all domains of the sensible when it comes to reproduction—must be reimagined, i.e., its ethics, its epistemics, its ontology, as well as its practice. I take up Rancière's politics as the counter-normative reimagination of reproduction and reproductive justice for those who were excluded from the distribution of the sensible imposed by the police, such as pregnant people, especially marginalized pregnant people, trans and non-binary pregnant people, Black pregnant people, and pregnant people of color. Reproductive politics, then, as a way to abolish reproductive policing and reimagine the sensible when it comes to reproduction, is the playing field of this collection.

This means that while I engage extensively with obstetric violence as a form of reproductive policing, my main interlocutors are thinkers, practitioners, and activists that do reproductive politics. This places my study in the field of critical feminist theory, rather than in public health or related fields that study the organization and practice of reproductive care. While I engage with the mounting evidence on obstetric violence and add some, the thinkers that I engage with, and differentiate myself from, are not the ones who deny or justify the existence of obstetric violence, obstetric racism, or the criminalization of abortion, but those that recognize the injustice in this and vow to resist it. The key intuition that underlies this study is that midwifery must always be politics rather than police, and the question that is central to the critiques, discussions, and polemics in this study, is the question of *how*. The reimagination of reproduction and reproductive justice is hence the main commitment of this study. And the hypothesis is that this reimagination is most promisingly done through abolitionist care, in relational practices and communities of radical care—something that attests to the insights of care ethics, in which practices of care are the sites of new configurations.

This collection consists of four parts, each consisting of three chapters. In part I, the empirical research sets the stage for the rest of the study. Here, the clashing configurations of justice, the related problem of consent, the appropriation of the laboring body, the influence of colonialism on current day obstetric practice, obstetric racism, and the important role obstetric violence plays in the training of students, come to the fore. In part II, these empirical findings are elaborated on through three critical historical studies in which obstetric violence is understood to be a problem of the undoing of two key relationship that are essential for the flourishing of the pregnant and maternal subject, and thus to reproductive justice:

the relationship between the person and their (capacity for) pregnancy, and the relationship between the (pregnant) person and their community of care. The appropriation and isolation of the maternal subject and the reproductive body are furthermore understood as the constitution of a "captive maternal"[11] in Western culture—that is isolated from the two key relationship of reproductive justice and thus forced to reproduce the world as it is—through a feminist interpretation of Solomon's judgment. The police configuration of justice in matters of reproduction is conceptualized as bio- and necropolitics, traced back to the early modern accusation of infanticide during the witch hunts at the time of primitive accumulation. The dissolution of reproductive relationality is subsequentially also located in postmodernity, namely in the 1960s, and the 2020s.

Part III deepens the understanding of obstetric violence, obstetric racism, and reproductive (in)justice through the lens of abolition. Starting again from empirical research, the activist resistance of mothers, doulas, midwives, and midwives in training is conceptualized as abolitionist care that reconstitutes relationality outside the institution, or sometimes outside-within, and aims to dismantle the obstetric institution that perpetuates violence. In the chapter 7, obstetric violence is then refracted as institutionalized violence primarily structured by obstetric racism. Because obstetric violence is institutional violence, and modern institutions are shaped by the colonialism, slavery, and racial capitalism that characterize modernity, institutional violence in institutions such as the police, the prison, or child protective services must be understood as always already racialized and racializing. And third, this abolitionist approach is theoretically further developed and differentiated from other, more socialist and communist feminist strategies that aim to reappropriate reproduction, differentiating an anarchafeminist approach to reproductive politics, namely abolitionist care.

In part IV, after having set the stage for reimagination within the practice of abolitionist care, the two key relationships of reproduction are once more, but now poetically, reimagined. The relationship between the maternal and their community of care is reimagined as the sociality of the "Whole Maternal" through a fictional symposium based on the data of my empirical research, and as the feminist usage of technology for reproductive justice through the relational practice of "somatophilic midwifery thinking." The relationship between the person and their capacity for pregnancy is reimagined through an engagement with the work of Clarice Lispector. To

11 Joy James, "The Womb of Western Theory: Time, Trauma, and the Captive Maternal," *Carceral Notebooks* 12 (2016).

come to a reimagination that amounts to reproductive justice for all, these key relationships are reimagined in favor of opacity, diversity, plurality, creolization, the abolition of the colonial subject through a radicalization of fecundity, and, consequently, a different configuration of life as "shared," all captured in the sociality of the Whole Maternal, that is, in Denise Ferreira da Silvia's terms, "difference," but without "separability."[12]

Since I enter the field of reproduction and reproductive justice through the case of obstetric violence, I will first give a general sketch of the landscape of international scholarly work on obstetric violence below (the specific context of obstetric violence in the Netherlands will be further elaborated upon in chapter 1). Then, I will shortly discuss my methodology, to end this introduction with a chapter-by-chapter summary. In the theoretical framework, "Reproductive Justice To-Come," this study is rooted in four central concepts that are congruent to five feminist fields of thought: 1) reproductive justice corresponding to Black feminist theory; 2) relationality corresponding to the field of midwifery; 3) reimagining reproduction corresponding to the field of critical feminist theory; and 4) abolitionist care corresponding to abolitionist theory and practice, and to care ethics.

Obstetric Violence

Obstetric violence is a term that many find provocative, radical, excessive; some even find it violent in itself.[13] Is forcing someone to give birth on their back really violence? Is it really violence to neglect someone's wishes during birth? Is performing an episiotomy with presumed consent really violence, even if the obstetrician was merely trying to save the fetus? While I entered this study with the research question "What *is* obstetric violence?" I quickly figured out that it is not up to me to decide what is violence and what is not, or whether or not it is the right term. Obstetric violence is the term that many victims of obstetric violence use, and my task, as a midwife, as well as an academic, is to take their words seriously. It is to try to understand the common structures, logics, and symptoms of what is

12 Denise Ferreira da Silva, "On Difference Without Separability," in *32nd Bienal de Sao Paulo. Incerteza Viva*, ed. Jochen Volz et al. (Sao Paulo: Bienal Sao Paulo, 2016), 57–65.

13 See, for instance: Maura Lappeman and Leslie Swartz, "How Gentle Must Violence Against Women Be in Order to Not Be Violent? Rethinking the Word 'Violence' in Obstetric Settings," *Violence Against Women* 27, no. 8 (2021): 987–1000. For a critical analysis of this critique, see: Rachelle Chadwick, "The Dangers of Minimizing Obstetric Violence," *Violence Against Women*, 29 no. 9 (2023): 1899–1908.

flagged as violence within these stories and experiences by different people, in different places. My job, in other words, is to understand what they are trying to say—precisely because it is a counter-hegemonic claim, and which most people instinctively dismiss. In this approach, I follow Joan Tronto's established notion that the assessment of care lies ultimately with the care receiver.[14] The evaluation of care by the care receiver determines, according to Tronto, whether the supposed care is indeed care. When supposed care is evaluated by the care receiver not as care, but as violence, it cannot be considered care.[15] When there are parents globally who experience their obstetric care as obstetric violence, this should be understood as an appeal to all those involved in reproduction and reproductive care to reconsider the way we facilitate safe pregnancy and birth, and to start looking for a practice that can truly be evaluated as care by all pregnant people—even if many other parents did receive the care they needed and wished for. As long as many experience their care as upsetting—36% in a rich country like the Netherlands—or as racism, violence, mistreatment, or abuse, the term obstetric violence should propel a call to action and reflection, rather than defensiveness. The question that guides this study is therefore what it is that people are trying to point out with their use of the term "obstetric violence," and where that specific form of violence comes from, how it functions, and what it perpetuates. And, importantly, how people are resisting this specific form of violence, and how to develop new forms of care that are not experienced as violence.

Mothers, feminists, midwives, doctors, academics, doulas, and others have been calling out violence in obstetrics for a long time. There are accounts from the nineteenth century in which midwives signal the rough treatment to which doctors subjected their laboring patients.[16] Violence in obstetrics was mentioned by a doctor in the renowned medical journal *The Lancet* as far back as 1827.[17] Public complaints of mothers themselves begin in the early twentieth century, culminating in written critiques from the 1950s onwards,

14 Joan Tronto, *Moral Boundaries: A Political Argument for an Ethic of Care* (New York: Routledge, 1993).

15 Tronto, *Moral Boundaries.*

16 See for instance Elizabeth Nihell, *A Treatise on the Art of Midwifery: Setting Forth Various Abuses Therein, Especially as to the Practice with Instruments; The Whole Serving to Put All Rational Inquirers in a Fair Way of Very Safely Forming Their Own Judgement Upon the Question* (London: Forgotten Books, 2018 [1760]).

17 James Blundell, "Lectures on the Theory and Practice of Midwifery. Delivered at Guy's Hospital by Dr James Blundell. Lecture 28: After-Management of Floodings, and on Transfusion," *Lancet* 8, no. 1 (1827): 673–681.

recognized by the World Health Organization as early as 1985.[18] In the Unites States in the 1940s, Margaret Mead in her classic *Male and Female* wrote for the first time about the isolation and appropriation of mothers in obstetrics:

> For months before the birth she has been preparing to leave her home and her husband, not for the home of her parents or her brother, as in many primitive societies, but for a strange, segregated spot, where she and many other women unknown to her will lie together, giving birth among strangers. When the baby is born, it is born against the force of gravity, on a delivery table designed not to let the child's own weight assist the birth, but rather to facilitate the ministrations of the obstetrician.[19]

In the 1970s, Doris Haire published a report on childbirth in the United States, mentioning various violent practices, such as routine unconsented episiotomies, and Suzanne Arms discusses the dehumanization of women in labor in the same decade.[20] In the 1970s, Adrienne Rich devoted a whole chapter in her canonical feminist book *Of Woman Born* to the history of "alienated labor" under patriarchy, in which she discusses multiple instances of violence in obstetrics, and recounts her personal experiences:

> The experience of lying half-awake in a barred crib, in a labor room with other women moaning in a drugged condition, wherein "no one comes" except to do a pelvic exam or give an injection, is a classic experience of alienated childbirth. The loneliness, the sense of abandonment, of being imprisoned, powerless, and depersonalized is the chief collective memory of women who have given birth in American hospitals.[21]

Despite the cultural differences, and of course the progress that sometimes comes with time, it is uncanny to note the similarities between Rich's experiences in the US in the 1960s and Anna Horn's account of "obstetric carcerality" 60 years later in the UK:

18 Barbara Rothman, *Recreating Motherhood* (New York: W. W. Norton & Company, 2000): 104; WHO, "Appropriate Technology for Birth," *Lancet* 24, no. 2 (1985): 436–437.

19 Margaret Mead, *Male and Female: A Study of the Sexes in a Changing World* (New York: Harper Collins, William Morrow and Company, 1949), 268.

20 Doris Haire, *The Cultural Warping of Childbirth* (International Childbirth Education Association, 1972); Suzanne Arms, *Immaculate Deception* (Boston: Houghton Mifflin, 1975); Adrienne Rich, *Of Woman Born. Motherhood as Experience and Institution* (New York: W.W. Norton & Company, 1986 [1976]): 180–182.

21 Rich, *Of Woman Born*, 177.

> Handcuffed by a cannula, strapped to a cardiotocograph that monitors my baby's heartbeat, I writhe with pain. The hospital bed physically and mentally shackles me. The aching pierces beyond the body like intense waves crashing through me. This was the prison in which I feared birthing my son.[22]

Notice the use of the metaphor of the prison appearing in both quotes, a way to understand obstetric violence which will come back extensively in this study, in which this specific form of institutional violence is understood as a form of policing and carcerality. One aspect of carcerality is the unconsented appropriation of the birthing body by medical staff that appears in both Rich's and Horn's quotes. According to Rich, the doctors, not the mothers, decided if someone was going to be put under during labor or have a natural birth, and what interventions would be done. The pelvic exams and injections that Rich described as being the only reason doctors came to visit the labor wards were done without consent. And although the decision whether to administer pain medication is mostly the choice of pregnant people these days, interventions done without consent remain a disturbing continuity: a recent study in the Netherlands shows that 42% of people who get an episiotomy and 47% who get injections during labor are not asked for consent, and 57% of those who refuse a cervical examination are overruled.[23] These interventions are still fully dependent upon the medical staff and the hospital, rather than on the needs and desires of pregnant people. Anna Seijmonsbergen-Schermers and Renate Schimmelink have proved that the rates of episiotomy vary too much to maintain that they are only done in order to save the life of the fetus (which is the only official indication for an episiotomy), ranging from 14% to 67% between hospitals and midwifery practices, and 8% to 48% between individual care workers.[24]

The conceptualization of obstetric violence as a form of policing and carcerality that circumscribes, separates, and isolates the mother both from

22 Anna Horn, "Birthing While Black," *Red Pepper*, accessed July 10, 2023, https://www.redpepper.org.uk/birthing-while-black-pregnancy-bodies-nhs-childbirth-maternity-medical-racism-carcerality/.

23 Marit S. G. van der Pijl et al., "Consent and Refusal of Procedures During Labour and Birth: A Survey Among 11 418 Women in the Netherlands," *BMJ Quality & Safety* 0 (2023): 1–12.

24 Anna Seijmonsbergen-Schermers et al., "Regional Variations in Childbirth Interventions and Their Correlations with Adverse Outcomes, Birthplace and Care Provider: A Nationwide Explorative Study," *PLOS ONE* 15, no. 3 (2020); Renate Simmelink, Etelka Moll, and Corine Verhoeven, "The influence of the attending midwife on the occurrence of episiotomy: A retrospective cohort study," *Midwifery* 125 (2023).

the fetus and from a relational form of care—a conceptualization that can be traced back to Rich—is most famously developed by Barbara Rothman in her books *In Labor: Women and Power in the Birthplace*[25] and *Recreating Motherhood.*[26] Rothman similarly theorizes the problem of violence in birth as caused by the appropriation of the birthing body, endowing the doctors with the active subject-position. The doctors are the agents in the event of childbirth, while mothers are reduced to the passive position of patients: "recipients of services rather than controllers of their own birthing."[27] Rothman historically locates the appropriation of the birthing body by obstetrics in the eradication of midwifery as a profession in the beginning and middle of the twentieth century.[28]

Obstetric mistreatment during pregnancy and childbirth does indeed have a history well into the twentieth century, the most famous examples being *Twilight Sleep*, a painkiller that was advocated for by suffragettes which inhibited people's memory during labor, making them forget the pain, but also causing severe headaches and self-mutilation, to prevent which they had to be tied to the bed during the high caused by the drug;[29] DES medication, a medicine against miscarriages that caused malformities in children assigned female at birth for several subsequent generations;[30] unconsented symphysiotomies (the splitting of the pubic bone) which occurred in Ireland until the 1980s;[31] and unconsented routine interventions, such as episiotomies;[32] and unconsented cesarean sections.[33] Dutch professor

25 Barbara Rothman, *In Labor: Women and Power in the Birthplace* (New York: W.W. Norton & Company, 1991 [1982]).

26 Barbara Rothman, *Recreating Motherhood* (New Jersey: Rutgers University Press, 1989).

27 Rothman, *Recreating Motherhood*, 104.

28 Ibid.

29 Lauren MacIvor Thompson, "The Politics of Female Pain: Women's Citizenship, Twilight Sleep and the Early Birth Control Movement," *Medical Humanities* 45 (2019): 67–74.

30 Susan Bell, *DES Daughters: Embodied Knowledge and the Transformation of Women's Health Politics* (Philadelphia: Temple University Press, 2009).

31 Homa Khaleeli, "Symphysiotomy – Ireland's Brutal Alternative to Cesareans," *The Guardian*, December 12, 2024, https://www.theguardian.com/lifeandstyle/2014/dec/12/symphysiotomy-irelands-brutal-alternative-to-caesareans.

32 S. Zaami, M. Stark, R. Beck, A. Malvasi, and E. Marinelli, "Does Episiotomy Always Equate Violence in Obstetrics? Routine and Selective Episiotomy in Obstetric Practice and Legal Questions," *European Review for Medical and Pharmacological Sciences* 23 (2019): 1847–1854.

33 There is a difference between court-ordered cesarean sections and unconsented or forced cesarean sections. In Europe, there is a case once every few years of a court ordered cesarean section, see the following article for the most recent case in the UK in 2022: Brian Farmer, "Pregnant Mentally Ill Woman Can Have C-Section Against Her Will, Judge Rules," *The Independent*, March 10, 2022, https://www.independent.co.uk/news/uk/crime/

Trudy Dehue presents an extensive history of pregnancy and abortion care in the Netherlands in her recent book *Ei, foetus, baby* ("Egg, Fetus, Baby"), describing shocking cases of violence across the last four centuries.[34] One of the gruesome practices that she recounts is that up until the early twentieth century, Catholic doctors were recommended by the church to do a cesarean section on a person in labor when they thought the fetus was dying, in order to baptize the fetus before its imminent death, often killing the mother as a result.[35] The death of the mother was not registered as iatrogenic, however, but as a "natural" postpartum death.[36]

Similarly, it took until the 1920s for Dutch gynecologists to stop using and recommending painful methods to empty the uterus after an infection caused by an abortion or miscarriage, by way of punishment.[37] A Flemish doctor described in the 1960s how everyone who had a miscarriage was still treated violently in the hospital, since the staff suspected everyone in that situation to have brought on the miscarriage themselves.[38] Furthermore, for most of the twentieth century in the Netherlands, people with an infected pregnancy were not relieved of their life-threatening pregnancy tissue, as that would amount to an abortion. Pregnant people hence paid with their lives for doctors' refusal to perform abortions.[39] Although this does not happen anymore in the Netherlands, life-saving abortions are still refused to pregnant people in other countries in the European Union and in the United States. In Poland, for instance, multiple women have died in the last two years due to obstetricians and gynecologists being either too afraid to perform an abortion under the new restrictive law (although the law in question does allow for abortion in life-threatening circumstances), or because they conscientiously objected.[40] While doctors

london-justice-court-of-protection-royal-courts-of-justice-high-court-b2033232.html. Unconsented cesarean sections in labor without a court order also happen. In the Netherlands, 13% of those who refused a cesarean section nonetheless had the procedure, which came down to 13 cases in a sample of approximately 11,418 people. In 17.8% of cases – 214 in total – consent was not sought. See: Van der Pijl et al., "Consent and Refusal of Procedures," 7.

34 Trudy Dehue, *Ei, foetus, baby: Een nieuwe geschiedenis van de zwangerschap* (Amsterdam: Atlas Contact, 2023).

35 Dehue, *Ei, foetus, baby*.

36 Ibid.

37 Ibid.

38 Ibid., 193.

39 Ibid.

40 Anna Pamula, "6 Stories Show the Human Toll of Poland's Strict Abortion Laws," *Time*, October 13, 2023, https://time.com/6320172/poland-abortion-laws-maternal-health-care/. See for the most recent case: Weronika Strzyzynska, "'All Pregnant Women Are in Danger': Protests in Poland after Expectant Mother Dies in Hospital," *The Guardian*, February 15, 2023, https://

cannot deny people the care they need in other life-threatening medical emergencies, it is due to the hegemonic configuration of justice in matters of reproduction—in which abortion is considered to be such a grave case of reproductive injustice that it is considered to be morally (and sometimes legally) worse than letting the pregnant person die—that Polish doctors are capable of refusing care.

It happens more often that doctors are more strict when it comes to abortion than is mandated even by highly restrictive abortion laws: recently there were cases in Texas where doctors refused to perform legal abortions,[41] and there was a tragic case in Romania, where Alexandra, a 25-year-old mother of 3 children, died in 2023 at 7 weeks of pregnancy due to infected pregnancy tissue that doctors refused to remove.[42] In European countries such as Germany, Croatia, Slovakia, Spain, and Italy, it is becoming increasingly difficult to get legal abortions due to the legalization of conscientious objection, as this practice creates so-called "abortion deserts"—in Italy, for instance, 71% of gynecologists are registered as conscientious objectors.[43] The policing of pregnant people in collaboration with doctors, the police and local courts, also regularly happens during childbirth. In 2019 in Spain, for instance, police showed up to the house of a woman in labor with a court order requested by doctors to have her admitted to the hospital because she was past 42 weeks' gestation.[44]

While midwifery and feminist scholars have been studying the medical confinement of pregnant people since the second feminist wave, the term

www.theguardian.com/global-development/2023/jun/14/all-pregnant-women-are-in-danger-protests-in-poland-after-expectant-mother-dies-in-hospital.

41 Poppy Noor, "Five Women Denied Abortion Care in Texas Sue State over Bans," *The Guardian*, March 7, 2023, https://www.theguardian.com/world/2023/mar/07/texas-abortion-women-lawsuit-ban.

42 IPPF, "Romania: IPPF EN Is Appalled by the Failures of the Romanian Healthcare System," October 31, 2023, https://europe.ippf.org/media-center/romania-ippf-en-appalled-failures-romanian-healthcare-system.

43 Tommaso Autorino, Francesco Mattioli, and Letizia Mencarini, "The Impact of Gynecologists' Conscientious Objection on Abortion Access," *Social Science Research* 87 (2020); Jessica Bateman, "How Conscientious Objection Laws Create Backdoor Abortion Bans in Europe," *New Lines Magazine*, May 31, 2023, https://newlinesmag.com/reportage/how-conscientious-objection-laws-create-backdoor-abortion-bans-in-europe/; Nicholas Casey, "In Spain, Abortions Are Legal, but Many Doctors Refuse to Perform Them," *New York Times*, September 21, 2021, https://www.nytimes.com/2021/09/21/world/europe/spain-abortion-doctors.html.

44 Stella Villarmea, "¿Cuándo pierde una mujer el derecho a decidir cuándo parir? [When Does a Woman Lose Her Right to Decide when to Birth?]," in *Amores y violencias: Género, Diversidad Sexual y Derecho* [*Loves and Violences: Gender, Sexual Diversities, and the Law*], ed. Defensoría de la Comunidad Universitaria de la Universidad de León (León: Eolas, 2021), 101–108.

"obstetric violence" did not appear until the early 2000s when it was used on a growing scale by activists in South America. Since then, the term has been what Rachelle Chadwick calls a "struggle concept," emerging from experiences of oppression and uniting activists globally.[45] Obstetric violence is also referred to as "obstetric mistreatment," or "disrespect and abuse," and sometimes positively phrased as a fight for "respectful maternity care."[46] By now, experiences of obstetric mistreatment have come to the fore in almost every country around the world, slowly leading to more and more international recognition, such as the 2019 United Nations' report from the Special Rapporteur on Violence against Women, which discusses obstetric violence in countries worldwide.[47] *The Lancet*'s midwifery series signaled disrespectful care and over-medicalization as the most important problems in obstetric care in the Global North, and midwifery-led care as the possible solution.[48] And in the EU there have been two reports conducted on obstetric violence, one by the European Commission, and one by the European Parliament.[49] In 2024, the Belgian Senate issued and accepted a report on obstetric violence; a first for Europe.[50]

In the Netherlands, the term "obstetric violence" nonetheless remains relatively unknown (the lack of engagement with the term and problem of obstetric violence in the Dutch context will be extensively discussed in chapter 1), but violence in obstetric and midwifery care has nonetheless been indicated. Lianne Holten and Esteriek de Miranda, for instance, have shown that the main reason for free-birthing (birthing without

45 Rachelle Chadwick, "Breaking the Frame: Obstetric Violence and Epistemic Rupture," *Agenda* (*Durban, South Africa*) 35, no. 3(2021): 104–115.

46 Gita Sen, Bhavya Reddy, and Aditi Iyer, "Beyond Measurement: the Drivers of Disrespect and Abuse in Obstetric Care," *Reproductive Health Matters* 26, no. 53 (2018): 6–18; Lynn P. Freedman et al., "Defining Disrespect and Abuse of Women in Childbirth: Research, Policy and Rights Agenda," *Bulletin World Health Organization* 92 (2014): 915–917.

47 Dubravka Šimonović, "A Human Rights-Based Approach to Mistreatment and Violence Against Women in Reproductive Health Services with a Focus on Childbirth and Obstetric Violence. Note by the Secretary-General," *Report of the Special Rapporteur on Violence against Women* (New York: United Nations, 2019), https://digitallibrary.un.org/record/3823698.

48 Richard Horton and Olaya Astudillo, "The Power of Midwifery," *The Lancet* 384.9948 (2014): 1075–1076; Lynn P. Freedman and Margaret E. Kruk, "Disrespect and Abuse of Women in Childbirth: Challenging the Global Quality and Accountability Agendas," *The Lancet* 384.9948 (2014): e42–e44.

49 Quattrocchi, *Obstetric Violence in the European Union.* The European Parliament's report is being drafted at this moment.

50 Belgische Senaat, Informatieverslag over lichamelijke zelfbeschikking en het tegengaan van obstetrisch geweld. January 15, 2024, https://www.senate.be/www/webdriver?MItabObj=pdf&MIcolObj=pdf&MInamObj=pdfid&MItypeObj=application/pdf&MIvalObj=117441406

medical assistance) in the Netherlands is traumatic experiences with obstetric care.[51] Yvonne Fontein Kuijpers has theorized disrespectful care as a conflict of values between mothers and birth workers.[52] Claire Stramrood and Martine Hollander pointed out that the main cause of the 9% trauma-rate and 1–3% PTSD rate after birth in the Netherlands is lack of support and communication from the obstetric staff, not the event of birth itself.[53] And Marianne Nieuwenhuijze articulated that shared decision-making and being able to choose one's position in labor greatly influence mothers' sense of control and subsequently their positive experience of birth.[54] Unfortunately, such shared decision-making and freedom of choice in labor is not very widespread. Marit van der Pijl has shown that informed consent for interventions is often not obtained. In almost half of the cases of episiotomies and postpartum synthetic oxytocin there was no informed consent.[55] 54% of parents in the Netherlands say that they experienced forms of disrespect and abuse, 20% of which were physical forms of violence.[56] Even when consent for interventions is asked and refused, refusal is overruled. This happens in 26% of refused episiotomies, and in 57% of refused vaginal examinations, 12% of refused cesarean sections, and 50% of cases of refused augmentation of labor with synthetic oxytocin.[57]

51 Lianne Holten and Esteriek de Miranda, "Women's Motivations for Having Unassisted Childbirth or High-Risk Homebirth: An Exploration of the Literature on 'Birthing Outside the System,'" *Midwifery* 38 (2016): 55–62.

52 Yvonne Fontein-Kuipers, Hanna den Hartog-van Veen H, Lydia Klop, and Lianne Zondag, "Conflicting Values Experienced by Dutch Midwives: Dilemmas of Loyalty, Responsibility and Selfhood," *Clinical Research in Obstetrics and Gynecology* 1, no. 1 (2018).

53 Claire A. I. Stramrood e tal., "Posttraumatic Stress Following Childbirth in Home-Like and Hospital Settings," *Journal of Psychosomatic Obstetrics & Gynecology* 32, no. 2 (2011): 88–97; Martine Hollander, F. van Hastenberg, Jeroen van Dillen, M.G. van Pampus, Esteriek de Miranda, Claire A.I. Stramrood, "Preventing Traumatic Childbirth Experiences: 2192 Women's Perceptions and Views," *Arch Womens Mental Health* 20 (2017): 515–523; Martine Hollander et al., "Women's Motivations for Choosing a High Risk Birth Setting against Medical Advice in the Netherlands: A Qualitative Analysis," *BMC Pregnancy Childbirth* 17, no. 423 (2017).

54 Marianne Nieuwenhuijze et al., "On Speaking Terms: A Delphi Study on Shared Decision-Making in Maternity Care," *BMC Pregnancy and Childbirth* 14, no. 1 (2014): 1–11; Marianne Nieuwenhuijze et al., "Influence on Birthing Positions Affects Women's Sense of Control in Second Stage of Labour," *Midwifery* 29, no. 11 (2013): e107–e114.

55 Van der Pijl et al., "Consent and Refusal of Procedures During Labour and Birth."

56 Marit van der Pijl et al., "Disrespect and Abuse During Labour and Birth amongst 12,239 Women in the Netherlands: A National Survey," *Reproductive Health* 19, no. 160 (2022): 6.

57 Van der Pijl et al., "Consent and Refusal of Procedures."

Theorizing Obstetric Violence

Prevalent examples of obstetric violence include forced interventions such as episiotomies, vaginal examinations, and cesarean sections, but also neglect, verbal abuse, and epistemic injustice. The first typology of obstetric violence was presented by Bowser and Hill in 2010. They categorized mistreatment during childbirth into 1) physical abuse, 2) non-consented care, 3) non-confidential care, 4) non-dignified care, 5) discrimination based on specific patient attributes, 6) abandonment of care, and 7) detention in facilities.[58] The second typology of obstetric violence was made by Bohren et al. five years later, and was presented through levels of domains, sub-domains, and specific indicators. The domains include 1) physical abuse, 2) sexual abuse, 3) verbal abuse, 4) stigma and discrimination, 5) failure to meet professional standards, 6) poor support between women and providers, and 7) health system conditions and constraints.[59]

In some countries, obstetric violence has been banned by the law, mostly as a form of over-medicalization, which has propelled the global usage and significance of the term.[60] In Venezuelan criminal law, for instance, obstetric violence is listed among 19 punishable acts of violence against women and is defined as:

> The appropriation of the body and reproductive processes of women by health personnel, which is expressed as dehumanized treatment, an abuse of medication, and to convert the natural processes into pathological ones, bringing with it loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting the quality of life of women.[61]

58 Diana Bowser and Kathleen Hill, *Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth: Report of a Landscape Analysis* (Washington DC: Harvard School of Public Health and University Research, 2010).

59 Meghan A. Bohren et al., "The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review," *PLoS Med* 12 (2015): 1–32; Rodante van der Waal and Kaveri Mayra, "Obstetric Violence," in *Gender-Based Violence: A Comprehensive Guide*, ed. Parveen Ali and Michaela M. Rogers (New York: Springer, 2023), 413–425.

60 Camilla Pickles, "'Obstetric Violence,' 'Mistreatment,' and 'Disrespect and Abuse:' Reflections on the Politics of Naming Violations During Facility-Based Childbirth. Hypathia 38 no. 3 (2023): 628-649.

61 Rogelio Pérez D'Gregorio, "Obstetric Violence, A New Legal Term Introduced in Venezuela," *International Journal of Gynaecology and Obstetrics The Official Organ of the International Federation of Gynaecology and Obstetrics* 111, no. 3 (2010): 201.

Similarly, over-medicalization has gradually been recognized as a key form of obstetric violence in many countries.[62] Raymond de Vries theorizes the intersection of over-medicalization and obstetric violence as stemming from a displaced sense of responsibility on the part of the obstetric institution and birth workers, which is exacerbated and reinforced by fear, resulting in the prioritization of the fetus over the mother.[63] Barbara Rothman has understood over-medicalization as a result of patriarchal, capitalist, and technological ideologies that cause artificial separation of mother and fetus during pregnancy and childbirth, leaving the mother cut off from her responsibility and experience as a mere container for the fetus, and the doctors as the "arbiters between the two parties in presumed conflict."[64] Elselijn Kingma underscores that this medical model of "fetal container" is a significant cause of obstetric violence.[65] These models of thought cause the mother to be reduced to a complicating rather than an enabling factor in childbirth.

Continuing this analysis, Michelle Sadler defines obstetric violence as a form of gender-based violence "deployed during childbirth against women, reflective of other forms of marginalization, contingent on their location within the larger political economy."[66] Sara Cohen Shabot further develops this notion of obstetric violence as a form of gender-based violence, namely as a form of gender policing to "make loud bodies 'feminine,'"[67] closely connected to the reproduction of gendered shame.[68] Furthering this analysis of obstetric violence as dependent on and reproducing the docile gendered body, Chadwick theorizes obstetric violence as a fleshy materiality, fundamentally dependent on specific power relations and socio-materialities.[69] As such, the birthing body is the site of gender oppression,

62 Michelle Sadler et al., "Moving beyond Disrespect and Abuse: Addressing the Structural Dimensions of Obstetric Violence," *Reproductive Health Matters* 24 (2016): 47–55.

63 Raymond de Vries, "Obstetric Ethics and the Invisible Mother," *Narrative Inquiry in Bioethics* 7, no. 3 (2017): 215–220; Rodante van der Waal and Inge van Nistelrooij, "Reimagining Relationality for Reproductive Care: Understanding Obstetric Violence as 'Separation'," *Nursing Ethics* 29, no. 5 (2021): 1186–1197.

64 Rothman, *Recreating Motherhood*, 110.

65 Elselijn Kingma, *Better Understanding the Metaphysics of Pregnancy: Organisms, Identity, Personhood & Persistence*. (Research proposal, University of Southampton, 2015).

66 Sadler et al., "Moving beyond Disrespect and Abuse."

67 Sara Cohen Shabot, "Making Loud Bodies 'Feminine': A Feminist-Phenomenological Analysis of Obstetric Violence," *Human Studies* 39, no. 2 (2016): 231–247.

68 Sara Cohen Shabot and Keshet Korem, "Domesticating Bodies: The Role of Shame in Obstetric Violence," *Hypatia* 33, no. 3 (2018).

69 Rachelle Chadwick, *Bodies that Birth: Vitalizing Birth Politics* (London: Routledge, 2018).

racial discrimination, the unjust global distribution of wealth, and colonialism, all coming together in the materiality of the gendered birthing body. Cohen Shabot and Chadwick both regard obstetric violence as gender-based violence in a discursive way: obstetric violence is a gendering practice that shapes birthing bodies and mothers. Obstetric violence should hence not only be understood as something that happens to the gendered body, but as a specific practice that genders, disciplines, and hence "polices" the always becoming body in a specific way. Chadwick and Cohen Shabot also both point out that this discursive aspect of obstetric violence can sometimes be "gentle violence,"[70] a normalized form of violence,[71] often incorporated and difficult to recognize. Dutch philosopher Elselijn Kingma has argued for the specific importance of autonomy and consent in maternity care, since maternity care involves socially sensitive body parts and is a medically unique situation in which one patient is harmed to benefit another, as in the case of an episiotomy. Kingma points out that in similar medical situations, such as organ donation, informed consent and refusal is an important and elaborate practice, while in maternity care, paradoxically, it has been proven that consent is denied or disregarded.[72]

Stella Villarmea argues that obstetric violence reveals that women are still not taken seriously as subjects in broader society as well as in philosophy. Obstetric violence shows that it still seems unnecessary to ask women for consent for intrusive interventions, and there is still no uproar when they are not.[73] For Villarmea, obstetric violence ultimately expresses that we have not fully subverted discrimination on the basis of having a uterus when it comes to women's subjecthood. While it was thought up until the first half of the twentieth century that having a uterus caused irrational behavior and hysteria, having a uterus today still means that one is not a subject in full rationality and capacity.[74] As Villarmea says: "When a uterus enters the room, reason goes out of the window."[75] Villarmea understands this normalization of obstetric violence and the fact that this type of violence

70 Chadwick, *Bodies that Birth*.

71 Sara Cohen Shabot, "Why 'Normal' Feels so Bad: Violence and Vaginal Examinations During Labour – A (Feminist) Phenomenology," *Feminist Theory* 22, no. 3, (2020): 443–463.

72 Elselijn Kingma, "Harming the One to Benefit the Other," *Bioethics* 35, no. 5 (2020): 456–464.

73 Stella Villarmea and Francisca Guillén, "Fully Entitled Subjects: Birth as a Philosophical Topic," *Ontology Studies* 11 (2011).

74 Stella Villarmea, "Reasoning from the Uterus: Casanova, Women's Agency, and Philosophy of Birth," *Hypatia: A Journal of Feminist Philosophy* 36, no. 1 (2021).

75 Stella Villarmea, "When a Uterus Enters the Room, Reason Goes Out the Window," in *Women's Birthing Bodies and the Law: Unauthorised Medical Examinations, Power and Vulnerability*, ed. Camilla Pickles and Jonathan Herring, (Oxford: Hart, 2020): 63–78.

is allowed to continue despite global awareness, as part of the gender-based exclusion of women from philosophy. Obstetric violence shows that the pregnant subject is negated as a subject in full rational and autonomous capacity, meaning that in Western culture, there is ultimately no such thing as a pregnant or laboring subject.[76] She therefore concludes that "if we want to change birth, we have to change the conversation."[77] Only if we include the topic of birth in philosophy, and thereby change the way we speak about birth, and the way we think about being human, will we be able to value embodied knowledge, and challenge assumptions about rationality, the subject, and our origin.[78]

Villarmea consequently understands obstetric violence as a particular form of gender-based epistemic injustice, since women's rationality is negated from the moment she is in labor. Sara Cohen Shabot also theorizes obstetric violence as epistemic injustice, identifying testimonial injustice as well as gaslighting as epistemic forms of obstetric violence.[79] Rachelle Chadwick additionally conceptualizes silencing as a form of epistemic injustice that characterizes obstetric violence.[80] Rianne van Hassel was the first to articulate four forms of epistemic injustice, characterizing obstetric violence in reproductive and obstetric care in the Netherlands: hermeneutic injustice, testimonial injustice, willful hermeneutic ignorance, and gaslighting.[81] I would like to point out—against, for instance, the Flemish Association of Gynecologists (VVOG), which recently declared that it forbids

76 Stella Villarmea and Brenda Kelly, "Barriers to Establishing Shared Decision-Making in Childbirth: Unveiling Epistemic Stereotypes about Women in Labour," *Journal of Evaluation in Clinical Practice* 26 (2020): 515–519.

77 Stella Villarmea, "A Philosophy of Birth: If You Want to Change the World, Change the Conversation," *Open Research Europe* 1, no. 65 (2021).

78 Stella Villarmea, "Rethinking the Origin: Birth and Human Value," in *Creating a Global Dialogue on Value Inquiry. Papers from the XXII World Congress of Philosophy*, ed. Jinfen Yan and David Schrader (Lewiston: Edwin Mellen Press, 2009); Stella Villarmea, Ibone Olza and Adela Recio, "On Obstetrical Controversies: Refocalization as Conceptual Innovation," in *Normativity and Praxis. Remarks on Controversies*, ed. Ángeles J. Perona (Milan: Mimesis International, 2015).

79 Sara Cohen Shabot, "Amigas, Sisters: We're Being Gaslighted," in *Childbirth, Vulnerability and Law*, ed. Camilla Pickles and Jonathan Herring (London: Routledge, 2020): 14–29; Sara Cohen Shabot, "'You Are Not Qualified – Leave It To Us': Obstetric Violence as Testimonial Injustice," *Human Studies* 44, no. 4 (2021): 635–653.

80 Rachelle Chadwick, "Practices of Silencing: Birth, Marginality and Epistemic Violence," in *Childbirth, Vulnerability and the Law*, ed. Camilla Pickles and Jonathan Herring (Routledge, New York, 2020), 30–48.

81 Rianne van Hassel, Rodante van der Waal, and Inge van Nistelrooij, "Mijn belichaamde kennis is van waarde. Een auto-etnografische, zorgethische analyse van epistemisch onrecht binnen de Nederlandse reproductieve zorg," *Tijdschrift voor genderstudies* (2022).

further use of the term and proposes that from now on "respectful maternity care" should be used, which is rather comical since it means the direct opposite[82]—that the usage of the term "obstetric violence" is itself a practice of epistemic justice, *contra* the normalization of violence against women, and the disbelief and denial that always follows their testimonies. Opposing the term, or refusing to use the term, is a continuation of hermeneutic epistemic injustice since it prevents the articulation mothers themselves give to their experiences. Refusing the term means not taking them seriously *again*.

The calling out of practices such as obstetric violence and obstetric racism can hence itself be considered political, exactly because it challenges the current partition of the sensible according to which medical institutions can claim a moral and epistemic authority. The fact that the term is provocative and many doctors react defensively to it suggests the subversive quality of the term, as it challenges the ethical and epistemic configuration of reproductive care. Rachelle Chadwick argues in defense of the term "obstetric violence" that it establishes an epistemic rupture, and that the concept itself can therefore be considered a form of struggle.[83] In a response to the accusation that its use is harmful to birth workers, Chadwick underscores the importance of the reference to "violence," exactly because it is antithetical to the mandate of care. In the obstetric partition of the sensible, in which the well-being of mother and child is imperative, it is indeed difficult to understand these practices as violence, as structural marginalization, oppression, exploitation, and extractivism is normalized. Politics, according to Rachelle Chadwick, thus begins with adopting a language of violence:

> By claiming a language of violence and naming unacceptable treatment during birth as such, feminist activists and scholars aim to make visible long-normalized, socially accepted, and often hidden modes of violation during reproductive events such as labor/birthing. [...] The language of obstetric violence is not meant to be comforting to health care practitioners

82 The VVOG published its statement on the term "obstetric violence" weeks after the report on obstetric violence was accepted by the Belgian Senate. It was months after a leading gynecologist wrote a satire on obstetric violence in their professional magazine to celebrate their jubilee. In the satire, Verhulst wrote about a doctor with an Arabic name who won the game for the best episiotomy by inventing a bomb that could be put under the perineum, exploding the pelvic floor without harming the baby. Note that this was months into the Gaza genocide and the framing of all Arabic Palestinian men as terrorists. There has been no apology nor any kind of uproar about the publication of a misogynous racist text like this by a doctor in a professional magazine for doctors. See: Guy Verhulst, "Senatus Populus Que Gynaecolorum," *Gunaïkeia* 28 no. 8 (2024).

83 Chadwick, "Breaking the Frame."

> but aims to generate discomfort in the hope of triggering critical and transformative reflections about normalized practices.[84]

A more elaborate discussion of the political, and hence abolitionist, implications of the usage of the term obstetric violence can be found in chapter 5.

Institutional Violence

The term "obstetric violence" makes it possible to demarcate, study, and resist a specific form of institutional violence that differs from other forms of patriarchal violence, such as domestic violence, or sexual violence.[85] Obstetric violence can be demarcated as a form of violence that happens within the institution of obstetrics, just as police violence happens within the institution of the police. As such, it is bound up with the modern constitution of the institution.[86] In this study, the concept of obstetric violence is taken up as an effective way to understand violence during birth both as gender-based violence but also as a specifically modern type of institutional violence. This two-sided approach differs from the theorization of obstetric violence as primarily gender-based, as the latter studies obstetric violence mostly based on cultural and structural domination and discrimination of gender, while I aim to connect gender-based obstetric violence to the biopolitics of the nation state. An institutional critique is important, as it is able to make visible the intersectional ways obstetric violence comes about in the institution. In many contexts, for instance, obstetric violence can take the form of neglect and a lack of accessible health care infrastructure, medication and personnel.[87] Conventional critiques in midwifery and feminist theory understand obstetric violence as a problem of over-medicalization and industrialization of health care, contributing to a harmful institution. Their focus on white and Western perspectives, however, leaves much unaccounted for. Reproductive and obstetric violence in the Global South and for people of color, for example, often manifests as the exact opposite of over-medicalization, even when obstetric care is provided by the same obstetric institution that does have a problem as regards the over-medicalization of white people.

84 Chadwick, "The Dangers of Minimizing Obstetric Violence," 1905.

85 Rodante van der Waal et al., "Obstetric Violence: An Intersectional Refraction Through Abolition Feminism," *Feminist Anthropology* 4 (2023): 91–114.

86 Ibid.

87 Chadwick, *Bodies that Birth*.

Since the institution of modern-day obstetrics is not free from a discriminatory and racist history and present-day racializing and exclusionary practices, the full extent of obstetric violence can only be grasped within an intersectional framework. The use of such a framework in this study distinguishes it from many theorizations of obstetric violence that examine the phenomenon within a problematic of gender-based violence and over-medicalization. Approaching obstetric violence from an intersectional perspective hence means that obstetric violence can never be separated from biopolitical racialization and racism as a consequence of slavery and colonialism. This will be further elaborated in the theoretical framework chapter, as well as in part one and part three of the book. The aim of an intersectional institutional analysis would be to understand the cause and function of obstetric violence in a racial capitalist (post)colonial society in the afterlife of slavery and how this violence is bound up with the biopolitics of the modern state.

In the growing body of work that engages in intersectional analyses, Rachelle Chadwick has made a valuable contribution. Her work analyzes socio-material "assemblages" of power relations and discursive practices, understanding obstetric violence as "an assemblage of disciplinary, bodily and material relations that are shaped by racialized, medicalized and classed norms about 'good patients,' 'good women' and 'good birthing bodies.'"[88] Researching obstetric violence within private and public hospitals in South Africa, Chadwick points out that the definition of violence as over-medicalization tends to problematize obstetric violence mostly when it happens to white middle- and upper-class people, while obstetric violence for marginalized and racialized communities often manifests as neglect and as a *lack* of access to high-quality care during childbirth.[89] As such, obstetric violence cuts across the ideological dichotomy of natural versus medical childbirth: denying a patient a cesarean section is obstetric violence just as much as forcing someone to have a cesarean is obstetric violence.[90] An intersectional perspective on obstetric violence has also been developed by Kaveri Mayra, whose research in India shows that intersections of oppression, such as lower levels of education, skin color, caste, religion, gender, socio-economic status, and other social determinants of health, increase people's vulnerability to obstetric violence, which is embedded

88 Ibid.

89 Ibid.

90 Kaveri Mayra, Rodante van der Waal, and Rachelle Chadwick, "Bodies that Birth and the Violence it Bears: In Conversation with Rachelle Chadwick," *Agenda* (*Durban, South Africa*) 35, no. 3 (2021): 130–135.

in India's postcolonial patriarchal context.[91] Obstetric violence can also be understood as consisting of forms of medical apartheid, such as a lack of access to good-quality obstetric care, differentiation in the quality of care based on race or class, or the use of marginalized, racialized people as experimental or practice subjects.[92]

Importantly, Dána-Ain Davis dissented from the term obstetric violence, observing that violence in obstetrics is not merely gender-based violence, but race-based as well.[93] She argues that in most cases concerning people of color, obstetric violence should rather be understood as obstetric racism. Davis conceptualizes obstetric racism as occurring at the intersection of medical racism and obstetric violence, arguing that it must be considered alongside obstetric violence as a distinct form of obstetric oppression. Drawing further on the work of abolitionist scholar and activist Ruth Wilson Gilmore's definition of racism as "the institutional and state-sanctioned practices that make particular groups of people vulnerable to harm and premature death,"[94] Davis makes clear that we can only understand Black women's experiences with violence in obstetrics through the lens of racism, otherwise we miss important dimensions of it or might not even recognize racist structures and practices as violence.[95] Davis differentiates seven dimensions of obstetric racism: 1) diagnostic lapses, 2) neglect, dismissiveness, or disrespect, 3) intentionally causing pain, 4) coercion, 5) ceremonies of degradation, 6) medical abuse, and 7) racial reconnaissance.[96] The last dimension has also been theorized as Sojourner Syndrome[97] and obstetric resistance,[98] which are understood to be Black people's additional labor to avoid or manage racism. Importantly, obstetric racism is iatrogenic not only because it includes emotional trauma, as in the case of obstetric

91 Kaveri Mayra, Zoe Matthews, and Sabu S. Padmadas, "Why Do Some Care Providers Disrespect and Abuse Women During Childbirth in India?" *Women Birth* 35, no. 1 (2021): e49–e59.

92 Harriet Washington, *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present* (New York: Harlem Moon, 2006).

93 Dána-Ain Davis, "Obstetric Racism: The Racial Politics of Pregnancy, Labor, and Birthing," *Medical Anthropology* 38, no. 7 (2019): 560–573.

94 Ruth Wilson Gilmore, *Golden Gulag: Prisons, Surplus, Crisis, and Opposition in Globalizing California* (Berkeley: University of California Press, 2007), 28.

95 Davis, "Obstetric Racism," 561.

96 Dána-Ain Davis, Cheyenne Varner, and LaConté J. Dill, "A Birth Story: How Cross-Disciplinary Collaboration Illuminates the Burdens of Racism During Birth," *Anthropology News*, August 27, 2021, https://www.anthropology-news.org/articles/a-birth-story/.

97 Leith Mullings, "Resistance and Resilience: The Sojourner Syndrome and the Social Context of Reproduction in Central Harlem." *Transforming Anthropology* 13, no. 2 (2005): 79–91.

98 Nefertiti OjiNjideka Hemphill et al., "Obstetric Experiences of Young Black Mothers: An Intersectional Perspective," *Social Science & Medicine* 317 (2023).

violence, but also because it is responsible for worse maternal and neonatal outcomes.[99]

The differences between obstetric violence and obstetric racism could also be understood as a matter of stratified reproduction. Stratified reproduction is a term that describes the unequal distribution of both social and biological reproduction across different populations and the value ascribed to the fertility and reproduction of some populations and not others, such as that IVF is easily accessible for some but very difficult to obtain for others.[100] Stratified reproduction entails the material obstacles and stigmas that marginalized people face regarding reproduction, which discourage them from having children, while other groups are facilitated and encouraged to reproduce. It can be understood as having emerged from eugenic ideologies and practices, which specifically targeted poor, colonized, and marginalized racialized groups.[101] While obstetric violence in the case of white people can be understood as resulting from over-medicalization that prioritizes safe passage of the baby, obstetric racism generally worsens neonatal outcomes, thereby falling indeed under "institutional and state-sanctioned practices that make particular groups of people vulnerable to harm and premature death." Obstetric racism originates from anti-Black violence in the transatlantic slave trade, having spread with the development of obstetrics globally to other places in the world. There also seems to be a racial stratification of obstetric violence itself that cannot be fully captured in a distinction with obstetric racism, such as an increased number of unconsented vaginal examinations happening to marginalized racialized people.[102] Furthermore, many studies of obstetric violence take place in low-resource African countries.[103] It is not the case, therefore, on a global level, that obstetric violence is conceptualized merely in relation to the over-medicalization of white people and thus that it is inherently exclusive as a concept. Obstetric violence entails the violent and disrespectful treatment of people in childbirth, in which people should always be understood as already racialized, while obstetric racism captures

99 K. Eliza Williamson, "The Iatrogenesis of Obstetric Racism in Brazil: Beyond the Body, beyond the Clinic," *Anthropology & Medicine* (2021).

100 Leith Mullings, "Households Headed by Women: The Politics of Race, Class, and Gender," in *Conceiving the New World Order: The Global Politics of Reproduction,* ed. Faye D. Ginsburg and Rayna Rapp (Los Angeles: University of California Press, 1995), 122–139.

101 Ann Stoler, "Making Empire Respectable: The Politics of Race and Sexual Morality in 20th-Century Colonial Cultures," *American Ethnologist* 16, no. 4 (1989): 634–660.

102 Van der Pijl et al., "Disrespect and Abuse."

103 Violet Perrotte, Arun Chaudhary, and Annekathryn Goodman, "'At Least Your Baby Is Healthy': Obstetric Violence or Disrespect and Abuse in Childbirth Occurrence Worldwide: A Literature Review," *Open Journal for Obstetrics and Gynecology* 10 (2020): 1544–1562.

the specific necropolitical treatment of people of color that is more strongly tied to stratified and uneven reproduction.[104]

This leaves us with three different but closely related forms of violence in obstetrics, alongside the more canonical conceptualization of obstetric violence as gender-based violence. There is (1) racially stratified obstetric violence, in which racialized people can be more prone to encounter forms of obstetric violence; (2) obstetric racism, in which obstetric violence and medical racism intersect, worsening maternal and neonatal outcomes; and (3) obstetric violence rooted in neglect or deprivation, to which people with lower social-economic status are more vulnerable.[105] All three forms are captured in obstetric violence as institutional violence, structured by obstetric racism. Arising in modernity, under the influence of colonialism, slavery, and eugenics, obstetric care should be understood as always already racialized and racializing; it always matters who is birthing. This study follows the abolitionist examples of feminists such as Angela Davis in combining these two critical trajectories, a method that makes it possible to link patriarchal domination over reproduction to practices of bio- and necropolitics, coloniality, eugenics, and capitalist accumulation. Abolition as a revolutionary movement originates from the fight for abolition of the institution of slavery. More recently, abolitionist have continued to make urgent calls for the abolition of harmful social and state institutions such as the police, prisons, and the family. In this book, I continue the critique of institutional violence and apply the abolitionist framework to the institution of obstetrics. The refraction of obstetric violence as always coming "after" race, so to speak, is discussed in chapters 3 and 5. Obstetric racism as a specific phenomenon is elaborated in chapter 2, and the relation between obstetric violence and obstetric racism is clarified further in chapters 2, 3, and 5.

Naturally, the tradition of any given research influences the questions posed and the analysis made. Since my analysis is grounded in abolition, feminism, Marxism, care ethics, and intersectionality, my critique is not so much focused on the influence of Christianity for instance,[106] but rather on the role of the state, capitalism, slavery, and colonialism. This does not mean that the church is not an important agent in the oppression of people with a uterus, but that other institutions play a critical, and much less researched,

104 Dána-Ain Davis, "Uneven Reproduction: Gender, Race, Class, and Birth Outcomes," *Feminist Anthropology* 4, no 2 (2023): 152–170.

105 Chadwick, *Bodies that Birth*; Kaveri Mayra, *'Women Are Supposed to Endure That!' A Critical Feminist Exploration of Obstetric Violence in Women's and Midwives' Birth Narratives in India* (PhD diss., University of Southampton, 2021).

106 Such as in: Dehue, *Ei, foetus, baby*.

role. Studying violence in obstetrics from the perspective I take makes it first and foremost a question of reproductive justice, always connected to the necro- and biopolitics of reproduction, the racialization of birth, eugenic ideology, and the colonial configurations of who is more and less human. This work hence continues the intersectional conceptualization of obstetric violence, through the abolitionist method of simultaneous critique and reimagination, working towards a reproductive justice to-come. In the next chapter, the theoretical framework of this study, I will elaborate further on the notion of reproductive justice to-come, as well as its central concepts: relationality, reproductive justice, feminism, and abolitionist care.

A Note on Method and Positionality

Once I started to uncover this subject, a mind already full of stories and experiences of birth became even more densely populated. Most of my study was carried out in the challenging rhythm of doing a PhD by day and midwifing by night, each thought interrupted and confronted by the unfolding of another birth, which always seemed to challenge any hypothesis I might have, while theory mostly seemed to fall short in real life, where care workers turned out to be respectful *and* violent, humane *and* paternalistic, professionals controlling women *and* people who give their life to the facilitation of reproductive health. I was entangled in a constant imaginary conversation with all those other midwives, supervisors, mothers, gynecologists, and, later, my own students. Inevitably, as a practicing midwife I became the contradiction that I, as a student, found so difficult to grasp: the sense of responsibility pushed me to commit more acts of what I would classify as obstetric violence than I ever expected, while at the same time I would go along further with the wishes, fears, hopes, and despairs of pregnant people than I ever thought I could. This study is not an accusation, although it might read that way to a lot of care workers. Instead, I aim to make explicit, interpret, critique, and learn from all the people and births that populate my mind, as well as my own practice, collected in their contradictions and entanglements, stitched together in critique, hoping to repurpose this tapestry of a world of birth for one that radiates reproductive justice.

Ursula Le Guin wrote in her book *The Carrier Bag Theory of Fiction* that she aimed to write in a feminine manner.[107] She aimed to go beyond the

107 Ursula K. Le Guin and Donna Jeanne Haraway, *The Carrier Bag Theory of Fiction* (London: Ignota Books, 2019 [1986]).

singular narrative where the protagonist hunts the mammoth, to capture the story of the women collecting scraps of food, nuts, berries, and herbs for healing in their carrier bags. Abortion, pregnancy, and birth are, just as the care they evoke, not one story, but the collection of a multiplicity of perspectives, of different thoughts, perhaps guided by the same intuition, perhaps arguing towards the same thing, but remaining evasive, collecting arguments, addendums, revisions. In my bag, in which a world of birth lives, there are midwives who, when giving birth themselves refused to enter the room of the hospital as long as there were scissors present that could be used to make a cut, and who switched between midwifery practitioners during the course of their own homebirths because they were not taken seriously by their own midwives. There are people who birthed alone in silence, and there are those who are supported by their whole families. There are births where I arrived just in time to see the baby born as they unfolded in less than an hour, and the births that took days. There are stories of forced cesarean sections and free-birthers, abortions and miscarriages, of parents who were scared to death, plagued by pain and exhaustion, and of others who would do it again tomorrow. Édouard Glissant wrote, "I aspire to experience as many births as were lived by the people,"[108] and that captures what my aspiration was for years. In the spread-out carrier bag, presented as a tapestry that is this book, all these different births and actors come to the fore, sometimes in direct quotations, sometimes in a fictional symposium, and sometimes sublimated in more abstract theoretical arguments. Rather than a singular systematic argument, the critique and the reimagination, the empirical research and the theory, the fiction and the facts should all be collected together, as a quilt for reproductive futures, as something that can be ripped to pieces again to reorder all present contradictions for a justice to-come, or as a piece of cloth that can be put in one's pocket as one runs down the stairs, gets in one's car, and drives to the births one is called to.

I will restrict this section to some general notes on the methodology of the study as a whole, since each chapter comes with its own extensive methodology, and my own positionality is discussed many times throughout the collection, but there are three general methodological premises that it is helpful to make explicit here. The first is a methodological differentiation that is understood as one between Marxism and anarchism. Where Marxism "has tended to be a theoretical or analytical discourse about revolutionary strategy," anarchism "has tended to be an ethical discourse

108 Édouard Glissant, *Poetic Intention*, trans. Nathanaël (New York: Nightboat Books, 2010), 15.

about revolutionary practice."[109] Anarchism is a project that "sets out to begin creating the institutions of a new society 'within the shell of the old,' to expose, subvert, and undermine structures of domination but always, while doing so, proceeding in a democratic fashion, a manner which itself demonstrates those structures as unnecessary."[110] Rather than a systematic Marxist discussion of the economy surrounding care and reproduction, however important such an analysis is—take for instance Adler-Bolton and Vierkant's *Health Communism* or Lewis's *Full Surrogacy Now*—this study is a collection of articles that falls more within the scope of an anarchafeminist project, producing an ethical discourse about revolutionary practices. Inspired by the empirical data which laid bare an implicit anarchafeminist vision and practice of care on the part of the participants, this study consists of different methodologies that are tied together in an ethical discussion of practices, trying to subvert the conservative partition of the sensible when it comes to justice in reproduction, through the constitution of a "new society 'within the shell of the old' to expose, subvert, and undermine structures of domination."[111] Even the articles that are not directly about practices, but critique the current crisis of care, are informed by the standpoint of the practice and knowledge of activists, doulas, midwives, and mothers committed to reproductive justice, and by extensive empirical research and practical engagement in birth and abortion work and activism. As such, this study is part of the feminist scholarly field of care ethics, in which normativity is situated in practices of care themselves.

Due to its emphasis on the particularity of specific practices and their implicit normative elements, the empirical and conceptual facets of care ethics research are constructed in an ongoing dialectic: empirical research into lived experience and practices and the socio-political contexts of moral problems feeds back into the theoretical framework, in order to contribute to the ongoing discussion of this interdisciplinary field of inquiry.[112] In this study, 31 participants were included as participants in the empirical part of the study: 10 mothers, 11 midwives, 5 doulas, and 5 midwives in training. My aim was to study what the participants are already thinking and doing, how they themselves are already living and making ethical decisions in their transformative practices, and push that a bit further

109 David Graeber, *Fragments of an Anarchist Anthropology* (Chicago: Prickly Paradigm Press, 2004), 6.

110 Ibid., 7.

111 Ibid.; Chiara Bottici, *Anarchafeminism*. (London: Bloomsbury Academic, 2022).

112 Carlo Leget, Inge van Nistelrooij, and Merel Visse, "Beyond Demarcation: Care Ethics as an Interdisciplinary Field of Inquiry," *Nursing Ethics* (2017).

theoretically. The second premise is hence to "reject self-consciously any trace of vanguardism"[113]—that is, any trace of presumed leadership:

> One observes what people do, and then tries to tease out the hidden symbolic, moral or pragmatic logics that underlie their action; one tries to get at the way people's habits and actions make sense in ways that they are not themselves completely aware of. One obvious role for a radical intellectual is to do precisely that: to look at those who are creating viable alternatives, try to figure out what might be the larger implications of what they are (already) doing, and then offer those ideas back, not as prescriptions, but as contributions, possibilities, and as gifts.[114]

The presumption is hence that the relational communities in which reproductive justice is possible already exist. Transformative practices and revolutionary acts should not only be judged by their ability to be there for all people or transform the whole system, since this would frame counter-normative practices or counter-communities as deficient merely due to their necessarily smaller scale. When letting go of this demand for scale—"the moment we stop insisting on viewing all forms of action only by their function in reproducing larger, total, forms of inequality of power"—it becomes possible to see that "anarchist social relations and non-alienated forms of action are all around us."[115] It might be more fruitful to root our inquiries in these practices rather than to dismiss them. In this study, I depart, for instance, from the common Dutch homebirth practice of which my mother's birth was an example. But also, relational care in which medical technology is used to facilitate the parent's self-determination would be an alternative practice where reproductive justice already exists and is worthwhile studying.

The third assumption is that reimagination is something that primarily happens in practices, be they practices of care or art. Theory has to be actively open to radical and fundamental reimagination, capable of asserting "that institutions like the state, capitalism, racism, and male dominance are not inevitable; that it would be possible to have a world in which these things would not exist and that we'd be all better off as a result."[116] Since we have no proof that this is indeed the case, this initial assumption functions as a belief and a moral imperative. A commitment to reimagination when

113 Graeber, *Fragments*, 12.
114 Ibid.
115 Ibid.
116 Ibid., 10.

theorizing practices is therefore "the political principle" of abolitionist and anarchist theory and of this study.[117] In this collection of articles, both practices of care (see chapters 6, 7, and 9), as well as literary practices (see chapters 4, 11, and 12) will be the locus of reimagination. This is hence a study of how people already engage in critique, mutual aid, undercommoning, self-determination and self-organization, and how these self-organized practices of radical care reimagine otherworlds of reproduction.

Chapter-by-chapter Summary

Starting with an empirical analysis of obstetric violence and obstetric racism in the Netherlands (part I), I then move on to a critical and historical analysis of the current crisis of reproductive injustice and the historical configuration of the dissolution of relationality that is essential to reproductive justice (part II), to then engage with theories and practices of abolition (part III), and finally to a reimagination of the relationships that are constitutive of a reproductive justice to-come (part IV). The first half is thus an assessment and critique of the current situation and the second half is dedicated to transformation and reimagination. Practice and theory are carefully interwoven throughout the whole study, and the empirical data will come back throughout the book: part III and IV both have an extensive empirical chapter, in addition to part I which is fully empirical. Additionally, in order for each part to depart from a specific cultural scene or societal perspective that stimulates perception and reimagination, I open each part with an intermezzo, to set the stage, if you will. These intermezzi can be understood as small examples, scenes, or case studies that introduce the reader to each part of the book. The first intermezzo is a report from a people's tribunal on birth justice; the second is the abortion scene in Céline Sciamma's *Portrait de la jeune fille en feu*; the third is the story of one of the participants that can be considered paradigmatic for this study; and the fourth is the artist Asia Bordowa's *Boring Future of Abortion* and Natalie Lennart's *Birth Undisturbed* series.

Most chapters were written together with other academics and midwives, which is why I proceed in the plural "we" below, unless I am the sole author of the chapter. The chapters can be read in the order of the book, or out of order, since the chapters are based on individual articles.

117 Ibid., 11; Bottici, *Anarchafeminism;* Chiara Bottici, *Feminist Mythology* (New York: Bloomsbury Academic, 2021).

Part I. Obstetric Violence and Obstetric Racism in the Netherlands

The collection opens with three empirical studies into obstetric violence and obstetric racism in the Netherlands. It starts with a people's tribunal on obstetric violence and obstetric racism, and the whole first part can be read as testimonies in a people's tribunal on obstetric violence and obstetric racism in the Netherlands. Chapter 1, "Shroud-Waving Self-Determination: A Qualitative Analysis of the Moral and Epistemic Dimensions of Obstetric Violence in the Netherlands," is an analysis of how obstetric violence manifests in reproductive care and how it corresponds with different configurations of reproductive justice. The objective of this chapter is to gain insight into the forms and normalization of obstetric violence by focusing on the moral and epistemic injustices that both facilitate obstetric violence and make it look acceptable. First, we discuss the forms of obstetric violence most commonly mentioned by the participants, which were unconsented vaginal examinations, episiotomies, and pelvic floor support. Second, we demonstrate two major themes that concern practices related to moral and epistemic injustice: 1) "playing the dead baby card," with the subthemes "shroud waving," "hidden agenda," and "normalizing obstetric violence"; and 2) "troubling consent," with subthemes "not being asked for consent," "saying 'yes,'" "saying 'no,'" and "giving up resistance."

Chapter 2, "Obstetric Racism as Necropolitical Disinvestment of Care: How Uneven Reproduction is Effectuated in the Netherlands through Linguistic Racism, Exoticization, and Stereotypes," discusses obstetric racism in the Netherlands. While the participants were not asked specifically about obstetric racism in the interviews, many participants raised the topic by themselves, which underscores that obstetric violence and obstetric racism are not only intimately connected, but also that obstetric violence cannot be theorized distinctly from obstetric racism. In this chapter, we analyze their insights on obstetric racism in relation to obstetric violence and Davis's concept of uneven reproduction and obstetric racism. We conceptualize how Davis's concepts of uneven reproduction and obstetric racism are linked in the Netherlands through the usage of linguistic racism, othering, and racial stereotypes. Through interpreting uneven reproduction as consisting of a bio- and necropolitics that optimizes certain life through investments and negates "other" life through disinvestments, we link the concept of uneven reproduction to daily practices of obstetric racism within the obstetric institution. These practices demonstrate a similar logic of selection and deselection, investment and disinvestment, manifesting as linguistic racism, othering, exoticization, and the racial stereotyping

of Black women as "natural" birthers, and other marginalized racialized women as "bad" birthers.

Chapter 3, "Obstetric Violence within students' Rite of Passage: The Reproduction of the Obstetric Subject and its Racialized (M)other," focuses on the impact of obstetric violence and obstetric racism in students' education and training, elaborating on the hypothesis that obstetric violence is an essential part of the formative years of students, with obstetric violence being deeply embedded in students' internships. Bringing the philosophical work of Achille Mbembe and Denise Ferreira da Silva into dialogue with a comparative analysis between medical students' education in South Africa and the Netherlands, we argue that the modern obstetric subject (doctor or midwife) representing the obstetric institution appropriates the maternal body as outer-determined, in order to constitute itself in terms of self-determination and universal reason. We conclude that this appropriation is one of the root causes for the persistence of obstetric violence.

Part II. The Dissolution of Reproductive Relationality

The three chapters of the second part theorize the development of the current patriarchal and racializing configurations of justice in reproduction. First we examine patriarchal authority on justice, second, the period of the witch hunts and primitive accumulation, and third, postmodernity. In all three historical moments, the specific dissolution of reproductive relationality is brought to the fore. The chapters also show a counter-community at work, in which a counter-normative conception of reproductive justice exists, either via the construction of a feminist mythology, or through the autonomous practice of midwifery, or through reimagination. The second part opens with the abortion scene in Sciamma's *Portrait de la jeune fille en feu*, where an illegal abortion is performed in France in the second half of the eighteenth century. In the chapters, racialization is consistently addressed as essential to the understanding of moral judgments on reproduction. It is important to note that the three studies of historical moments have been chosen on the basis of the empirical data; they are therefore not a comprehensive account of the development of our moral and epistemological conception of reproduction through time.

First, we go back to the Old Testament to study the push towards the institutionalized patriarchal rendering of justice in matters of reproduction, which inhibits the administration of justice within the community itself and care for the event of childbirth. In this fourth chapter, "How to Liberate the Captive Maternal: Hacking the Origin Story of Reproductive Justice," the

appropriation of reproductive justice as culminating in a "captive maternal" is traced back to the story about the wisdom of King Solomon in the Old Testament. We identify the story of Solomon's judgment—one that has been critiqued by feminists often from the perspective of epistemology, but never from the perspective of reproduction studies—as an origin story that constitutes the authority of the patriarchal institution to administer reproductive justice. Solomon's judgment is analyzed in order to make its underlying logic explicit as a code that can be identified throughout (pre- and post-)modernity, consisting of two moments of infanticide and maternal separation which establish the patriarchal authority of the institution over reproduction, and eugenically constitute the child, i.e., the future subject. A deconstruction of the story is proposed, to liberate the captive maternal and reimagine reproductive justice.

Then I turn to the European witch hunts to study the form of obstetric violence that is commonly known as "playing the dead baby card," in which the risk to the baby's life is exaggerated in order to make the mother comply with hospital policy. In chapter 5, "The 'Dead Baby Card' and the Early Modern Accusation of Infanticide: Situating Obstetric Violence in the Bio- and Necropolitics of Reproduction," also addresses the central hypothesis that this collection continuously works through, namely that reproductive violence is, at its core, the institutionalized dissolution of the relationships that constitute pregnancy and fertility for the sake of reproductive discipline and control. I discuss how women were given the status of citizens in many places in Europe in the name of justice, namely, in order to be tried for infanticide. I draw on Silvia Federici's work to show how the primitive accumulation of women's bodies and of reproduction was carried out by means of the documentation of pregnancies and the prosecution of those who miscarried, a key step in the subsequent policing and appropriation of reproduction in modernity. This has been intimately tied to conceptions of justice, as much of it was done through courts and trials, that is, in the name of justice. It is argued that a predominantly racialized, instrumentalized, and individualized conception of pregnancy and reproductive care is responsible for a severance of relationalities that make up the maternal and reproductive subject, namely 1) the relationship between the person and their child or reproductive capabilities, and 2) the relationship between the pregnant person and their community of care. This double dissolution of relationships is traced back to the time of primitive accumulation during the witch hunts in early modernity.

Chapter 6, "Reimagining Relationality for Reproductive Care: Understanding Obstetric Violence as "Separation,'" rehearses the hypothesis

that reproductive and obstetric violence fundamentally come down to a dissolution of relationality, but now in postmodernity from the 1960s up to the 2020s. It traces this dissolution in two discursive domains, namely, the juridical-political and the ethical-existential. Consequently, a plea is made for a radical reimagination of maternal relationality, envisioning what care ethical midwifery, including abortion care, could be, a topic picked up in parts III and IV of this book.

Part III. Abolitionist Care

Part III develops an abolitionist perspective based on the empirical study, specifically on interviewees' own analyses of the causes of obstetric violence and, most importantly, their counterstrategies and forms of resistance to it. It opens with an intermezzo on an exemplary case of one of the participants, who organized her own care outside of the institution. Chapter 7, "The Undercommons of Childbirth and Its Abolitionist Ethic of Care: A Study into Obstetric Violence among Mothers, Midwives (in Training), and Doulas," continues the analysis of obstetric violence and racism through a standpoint epistemology of the midwives in training, practicing midwives, doulas, and mothers. Through a dialogue with both the participants and critical theory, especially with care ethics and Black Studies, two main themes are established: 1) "institutionalized separation" with the subthemes expropriation," "carcerality," and "violence," and 2) "undercommoning childbirth," with the subthemes "fugitive planning," "anarchic relationality," and "abolition." Institutionalized separation is again understood to be the separation of the pregnant person from a partner, from a community of care, and from their midwives, with a consequent experience of isolation. The second main theme concerns the strategy to resist of the participants affected by obstetric violence (including professionals): "undercommoning childbirth." Undercommoning is theorized as the formation of an underground commons of knowledge, mutual aid, and radical abolitionist care. The aim of the second theme is to reconstitute or "heal" the relationality that was broken through institutionalized obstetric violence and to resolve the experience of isolation.

In chapter 8, "Obstetric Violence: An Intersectional Refraction through Abolition Feminism," the consequences of understanding obstetric violence in the light of the obstetric institution and obstetric racism are elaborated further. This essay takes up the theorization of the empirical findings of chapter 7, exploring how reproductive justice activism often takes the form of self-organized alternative care practices, coinciding with efforts

to abolish the institution that delivers inadequate and violent forms of reproductive care. Through auto-ethnographic work from four different scholars and birth workers from four different continents, obstetric violence and obstetric racism are explicitly thought through in relation to each other. Through the lens of abolition feminism, the concept of obstetric violence is refracted by centering anti-Black obstetric racism as the anchor point of obstetric violence, where the afterlife of slavery, racial capitalism, and the consequences of patriarchal biopolitics come together. It is argued that abolition provides a unique approach to tackling obstetric violence, as it not only aims to challenge and dismantle violent institutions, but specifically focuses on the capacity of Black, indigenous, and independent doula and midwifery practices to be the basis of building a life-affirming world of care.

Chapter 9, "Undercommoning Anthrogenesis: Abolitionist Care for Reproductive Justice," zooms in on a comparison of different abolitionist strategies when it comes to the reimagination of reproduction for a reproductive justice to-come. I focus on two influential approaches in contemporary debates about reimagining sexual reproduction: 1) a grand-scale approach, whose focus is primarily on fundamentally restructuring and redistributing the institutionalized commons of reproductive care; 2) an undercommoning, abolitionist approach that aims to abolish public institutions by way of transnational coalitions of small-scale mutual aid and radical care practices constituting otherworlds of reproductive justice. The account of the second strategy highlights two abortion and birth networks in the Netherlands that provide transnational and fugitive care for reproduction (the Abortion Network Amsterdam and a loose collaborative network of midwives), and it is this strategy that is explored as basis of a promising feminist future for reproductive justice.

Part IV. Reimagining Reproduction

This collection closes with three chapters on the reimagination of reproductive justice on multiple levels: the practical, the political, and the aesthetic. The intermezzo opens with the work of two artists, Bordowa and Lennart, who reimagine the future of abortions as "boring," and the future of birth as "undisturbed." Chapter 10, "Specter(s) of Care: A Symposium on Midwifery, Relationality, and Reproductive Justice To-Come," does this by fictionally staging a counter-community, based on the empirical data provided by the participants of the study. It is a symposium of mothers and midwives, which echoes Plato's symposium about love. This fictional symposium between the mothers, midwives, and doulas is an attempt to reconceive the

relationality between the pregnant person and their community of care. Following Édouard Glissant, the notion of reproductive justice "to-come" is elaborated more explicitly: through a combination of hauntology and decolonial empirical methodology, a specter of care comes to the fore in the figure of Phaenarete, the mother of Socrates who was a midwife, to make the notion of the to-come tangible as the direction of the reimagination of reproductive justice, invoking a practice and poetics of opacity, receptivity, and creolization. In the symposium, the relationship between the possibly pregnant person and their community of care is reimagined as the "Whole Maternal," which would include all variations of (poly)maternalism, as well as their midwives—a variation of Glissant's concept of the "Whole World."

To find a fruitful way to reimagine a relationality of care in which technology is used to achieve reproductive justice, chapter 11, "Somatophilic Reproductive Justice: On Technology, Feminist Biological Materialism, and Midwifery Thinking," discusses the specific type of epistemology that independent midwifery practices rely upon. This is a different form of rationality than positivist rationality used in institutional health care, but also different from the more techno-affirmative strands of some second-wave feminism. Midwifery negotiates technology from a perspective that prioritizes experiential, embodied, and tacit knowledge. Midwifery's epistemological standpoint is that of a somatophilic rationality of thinking *with* the body, guarding women and birthing people's reproductive autonomy through a specific *technē* that uses both technology and nature. A certain tendency in midwifery, however, is developing towards an anti-technological essentialism. This essay brings Shulamith Firestone's efforts to eliminate biological sex with the help of technology into dialogue with midwifery's somatophilic epistemic standpoint, in order to reimagine a feminist relational engagement with nature that can achieve reproductive justice in the form of "midwifery thinking," derivable from Firestone's and midwifery's shared biological materialism.

The final chapter, "'When the Egg Breaks, the Chicken Bleeds': Unsettling Coloniality through Fertility in Lispector's *The Passion According to G.H.* and *The Chronicles*," concerns the reimagination of the relationship between the person and their capacity for pregnancy. This not to come to a configuration of the current postcolonial subject in such a way that she can be pregnant, but rather to affirm pregnancy, birth, and fertility as always already transgressive of the current subject. Fertility is effectuated to carry the project of abolition to its furthest consequence, namely to also include the abolition of the current hegemonic subject, in favor of the reimagination of the human *otherwise*. Putting the work of Clarice

Lispector in dialogue with the work of Glissant and Denise Ferreira da Silva, we elaborate Lispector's crucial contribution to the reconfiguration of the relationship between the subject and the world, which can be understood as an attempt to "unsettle the coloniality of being"[118] through fertility. In a study of her novel, *The Passion According to G.H.*, supported by fragments from her *Chronicles*, we show how fertility is an essential link between subjectivity and coloniality, and how Lispector reimagines fertility as a possibility of being deeply affected by the world, and even for the colonial subject to perish. Consequently, we argue that Lispector's work must not primarily be understood as ontological or in search of pre-discursivity, but as concerned with the political question of dismantling the colonial subject and its world in order to open up the potential of living *otherwise*, worthy of the name of "reproductive justice."

The reimagination of the relationality of reproduction so that it can facilitate reproductive justice comes down to a "Wole Maternal," in which all versions of the (poly)maternal can flourish, a "midwifery thinking," and a radical affirmation of fertility in such a way that it dissolves the Western subject and another relationship is established between the human and the world.

118 Sylvia Wynter, "Unsettling the Coloniality of Being/Power/Truth/Freedom: Towards the Human, after Man, Its Overrepresentation–An Argument," *CR: The New Centennial Review* 3, no. 3 (2003): 257–337.

Theoretical Framework: Reproductive Justice to-Come

Abstract

This chapter formulates the theoretical framework for the book *Birth Justice: From Obstetric Violence to Abolitionist Care*. I highlight four themes that correspond to four theoretical, and sometimes practical, fields. First, "reproductive justice," and Black feminism. Second, "relationality," and midwifery. Third, "reimagining reproduction," and feminist theory. And fourth, "abolitionist care," and the field of care ethics and abolitionist theory and activism. Consequently, a differentiation between two forms of justice in reproduction comes to the fore: a hegemonic, conservative conception of justice in reproduction that leads to the policing and controlling of reproduction by the dissolution of relationality, and a liberatory conception of reproductive justice that facilitates reproductive autonomy, through the healing of relationality through what I term "abolitionist care."

Keywords

Abolitionist care, relationality, care ethics, Jacques Rancière, reproductive violence.

It was perfectly normal in Amsterdam in the 1990s to give birth at home accompanied by a small community midwifery practice. While the homebirth rates today are only a third of what they were then, autonomous midwifery care is still strong in the Netherlands, facilitating both home and hospital births for non-medical labor, depending on what the mother wants. However, Dutch obstetric and midwifery care is not devoid of obstetric violence, obstetric racism, and overall reproductive injustice. The combination of facilitating relatively good care in some areas when it comes to women's autonomy and self-determination, while having the same problems with obstetric violence

Waal, van der, R., *Birth Justice. From Obstetric Violence to Abolitionist Care*. Amsterdam: Amsterdam University Press 2025
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and racism as in many other parts of the world, makes the Netherlands an interesting location to study both the problem of obstetric violence as well as forms of resistance and alternative non-violent practices of care.

Maternity care in the Netherlands is paradoxically defined both by structures of violence and racism that we see globally and by its reliance on independent midwifery care at a time when in most countries autonomous midwifery care had been dismantled for decades. This provides the Netherlands with a strong infrastructure to facilitate alternative ways of care that are fully covered by health insurance and integrated into the organization of care, but it also forces us to come to terms with the fact that autonomous midwifery care does not in fact protect pregnant people against obstetric violence and racism, as is often assumed when birth workers internationally hold up Dutch maternity care as the "mecca for mothers and midwives."[1] The Dutch landscape therefore proves to be very rich for the study of obstetric violence: there are obstetricians, gynecologists, big university hospitals, small community midwifery practices, caseload midwifery practices, big midwifery practices, midwives and doctors who are alternative and progressive, midwives and doctors who are conservative, midwives and doctors who speak out, and midwives and doctors who conform. All these practices are covered by insurance. There are also independent direct-entry midwifery academies and there is a growing group of doulas providing support to pregnant people when it comes to their rights, as well as an extensive activist movement consisting of mothers, midwives, doulas, and doctors focused on rights and autonomy in pregnancy, called de Geboortebeweging (The Birth Movement). The Netherlands is therefore a good place in which to answer the principal question of this collection: how can we move from obstetric violence and obstetric racism to a way of caring for reproduction that can ensure reproductive justice to-come?

During the course of the research, I differentiated four theoretical concepts, each roughly corresponding to fields of study and/or practice, that are central to answering this question. Below, I discuss these concepts and corresponding fields that make up the theoretical framework in which this study can be situated. These are: 1) *reproductive justice* corresponding to Black feminist theory, 2) *relationality* corresponding to midwifery studies, 3) *reimagining reproduction* corresponding to feminist theory on reproduction, 4) *abolitionist care* corresponding to care ethics and abolition. At the end of this chapter, it should be clear why I believe that the most promising approach to how we can move from obstetric violence to reproductive justice lies in the relational practice of "abolitionist care" in which reproduction can be reimagined.

1 Barbara Rothman, CUNY-symposium on midwifery, New York, December 8 2023.

Reproductive Justice

Reproductive justice is a term that was coined by Black feminists in the US in 1994.[2] It was a response to the one-dimensional focus of white second-wave feminism which was primarily fighting for the right to abortion. With a history of forced abortions and hysterectomies, Black and indigenous people were, however, struggling as much for the right to have children as the right not to have them. Reproductive justice hence puts abortion, childbirth, *and* motherhood center stage, stands for activist leadership of indigenous people, people of color, and Black people, and is committed to be a grassroots movement sprung from marginalized communities.

Loretta Ross defines reproductive justice as "the complete physical, mental, spiritual, political, social, and economic well-being of women and girls, based on the full achievement and protection of women's human rights."[3] The Black feminist collective SisterSong also explicitly adds the right to bodily autonomy as a fourth principle.[4] And, the term 'Birthing Justice' was already used in the 1990s to underscore the importance of reproductive justice within the practice of giving birth.[5] Reproductive justice means, in short, that fertility and reproduction are safe capabilities, emotionally, and physically, for everybody.

In the 1980s, Angela Davis dedicated a chapter in her pathbreaking *Women, Race, and Class* to "Racism, Birth Control and Reproductive Rights," in which she gives an intersectional critique of the birth control movement that "has seldom succeeded in uniting women of different social backgrounds, and rarely have the movements' leaders popularized the concerns of working-class women."[6] According to Davis, the birth control movement was sometimes "blatantly racist," such as when it advocated the involuntary sterilization of people of color. This feminist movement was not able to resist the influence of eugenic ideologies on reproduction and walked a thin line between demanding the right for abortion and advocating eugenic policies for marginalized people, sometimes resulting in forced abortions, sterilization, and contraception: "What was demanded

2 See: www.Sistersong.com.

3 Loretta Ross, "What is Reproductive Justice," in *The Reproductive Justice Briefing Book: A Primer on Reproductive Justice and Social Change* (SisterSong Women of Color Reproductive Health Collective and The Pro-Choice Public Education Project, 2007), 4.

4 See: www.sistersong.com

5 Julia Chinyere Oparah and Alicia D. Bonaparte, *Birthing Justice, Black Women, Pregnancy, and Childbirth* (New York: Routledge, 2016).

6 Angela Y. Davis, *Women, Race, Class* (New York: Vintage, 1981), 343.

as a right for the privileged came to be interpreted as a 'duty' for the poor."[7] Davis points out how the birth control movement participated in presenting abortions as the solution for structural social problems such as poverty, lack of social housing, or underpaid jobs, instead of aiming to tackle the problem of poverty itself: what if poverty was the reason that people who wanted children actually could not have them?[8]

Shortly afterwards, Hortense Spillers identified the forced separation between enslaved women and their children—termed "natal alienation" in her famous essay *Mama's Baby, Papa's Maybe*—which can be read as one of the principal reproductive injustices of slavery. For Spillers, robbing Black women of their motherhood by violently severing the relationship between mother and child was part of an "ungendering" of Black women.[9] This forced separation is not a thing of the past. Even today, Black people suffer more neonatal mortality, more preterm birth, and higher morbidity rates than white people and most other people of color globally. I conceptualize natal alienation as described by Spillers as part of the dissolution of one of the key relationships of reproductive justice, which I develop further in the next section, "Relationality."

In the 1990s, this genealogy was further developed by Dorothy Roberts' *Killing the Black Body*, a classic study of the history of reproductive control of Black women in the US. Roberts shows how enslaved women were used to reproduce enslaved children, while after the abolition of slavery, they were pushed by state policies to use long-term contraceptives or be sterilized in order to have fewer children.[10] In formerly colonized countries, sterilization and contraception were either implemented through economic incentives or enforced—most infamously, the drug Depo Provera which was tested on Black women in the US without their consent and was forced on many others, for instance working class Black women in South Africa.[11] Exposing this trajectory—from the prevention of enslaved women's reproduction when it was cheaper to buy enslaved people, to the stimulation of enslaved women's reproduction after the closing of the transatlantic slave trade, to their forced sterilization after slavery was abolished—Roberts puts racial justice at the heart of the struggle for reproductive justice. She shows how,

7 Ibid., 358.

8 Ibid., 355.

9 Hortense Spillers, "Mama's Baby, Papa's Maybe: An American Grammar Book," *Diacritics* 17, no. 2 (1987): 72.

10 Dorothy Roberts, *Killing the Black Body. Race, Reproduction, and the Meaning of Liberty* (New York: Pantheon Books, 1997).

11 Harriet Washington, *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present* (New York: Harlem Moon, 2006).

influenced by the eugenic ideology of feminists like Margaret Sanger, white feminists' fight for abortion and contraception continued to control the fertility of women of color, rather than enhance their reproductive freedom. As such, Roberts was amongst the first to broadly document what I refer to in this study (in chapters 2, 3, 5 and 8) as the bio- and necropolitics of reproduction, in which some life is actively stimulated to reproduce, while the reproduction of other life is made so difficult that it often amounts to a "killing," in Roberts' terms, of that current or potential life.

In 2023, Dána-Ain Davis conceptualized the difference in investments and disinvestments that are made in the reproduction of different people as "uneven reproduction," resulting in different maternal and neonatal mortality and morbidity rates.[12] She expands both Leith Mullings' application of the Marxist concept of "uneven development" to social reproduction and builds further on Shellee Colen's conceptualization of "stratified reproduction." They were one of the first to describe the different reproductive outcomes between groups. Uneven development is a Trotskyist term describing the different levels and ways of development of capitalism in different places, and their dependency on one another, thereby centering transnational relations and permitting the understanding of capitalism as developing in a dialectic of center and periphery, and the enclosure of colonized lands to accelerate capitalist development in the center. Uneven development has come to indicate this dependency, where investment in some means disinvestment in others, since investment depends upon expropriated resources. With the lens of uneven reproduction, Davis aims to theorize how this logic of investment and disinvestment is globally effectuated as well in the case of reproduction through uneven policy, practices, and programs. As such, Davis expands the concept of stratified reproduction, which centers on the intersectional difference in reproductive labor and the experience and social value thereof, and lays bare the global policies that are behind these differences.[13] In chapter 2, the concept of uneven reproduction is elaborated further to include the specific bio- and necropolitics of obstetric violence in the institution. To achieve reproductive justice for all, a thorough analysis of, and subversion of, these inequalities is essential.

A clear example of the bio- and necropolitics of uneven reproduction is Françoise Vergès's study into the 1970s campaign against the legalization of abortion in France. This campaign coincided with a wave of forced abortions

12 Dána-Ain Davis, "Uneven Reproduction: Gender, Race, Class, and Birth Outcomes," *Feminist Anthropology* 4, no 2 (2023): 152–170.

13 Davis, "Uneven Reproduction."

and hysterectomies performed on women on the island of La Réunion, which is a French *département*, by French doctors. While abortions were encouraged for Black people in La Réunion, even performed without their consent and knowledge, abortions were demonized when it came to white women in France.[14] Abortion was illegal and a moral scandal for some, but was performed by obstetricians without consent on others, in the same country and during the same era. Chapters 2 and 3 further elaborate on the bio- and necropolitics of reproduction in daily practices of obstetric racism in the obstetric institution. The intersectional conceptualization of reproduction by feminists such as Davis, Roberts, and Vergès is central to understanding reproductive injustice, and what reproductive *justice* stands for.

In contrast to the white feminist conceptualization of reproductive freedom, which organized mainly around choice, reproductive justice emphasizes intersectional and racial justice, focusing on the dismantling of the dialectic of racialized investment and disinvestment strategies and the bio- and necropolitics of reproduction, towards the equal ability of all people to reproduce or not reproduce. The lesson that racial justice is essential to any conception of reproductive justice has still not been learned by white feminism, which claims to fight and stand for reproductive autonomy and freedom but too often remains silent when it comes to marginalized communities. It remains as vital as ever to have a transnational and intersectional understanding of reproduction, and account for the influence of racism and colonialism on conceptions of reproductive rights, freedom, health, and autonomy. Especially during a time in which the current Black maternal mortality crisis is costing Black women their lives in the wealthiest nations on earth, and the severe reproductive injustice which Palestinians in Gaza suffer is not considered a moral scandal even though it has been designated by the International Court of Justice (ICJ) to be potentially genocidal. At this moment, the miscarriage rate in Gaza has increased by 300%, women are giving birth without care and medicine, are having cesarean sections without anesthesia, and have no menstrual hygiene products, while even before the current war, the difference in neonatal and maternal mortality and morbidity rates between Palestinians and Israelis was indicative of severe reproductive injustice, and such severely uneven reproduction that it has been termed "reproductive genocide."[15]

14 Francoise Vergès, *The Wombs of Women. Race, Capital, Feminism* (London: Duke University Press, 2020).

15 "The Palestinian Feminist Collective Condemns Reproductive Genocide in Gaza," February, 2024, Palestinian Feminist Collective, https://palestinianfeministcollective.org/

Reproductive injustice can be considered a "glue," or *point de capiton*, that holds multiple systems of oppression together, and ensures, indeed quite literally, their reproduction, which is what makes reproduction an essential focus for study, as well as change.[16] The anthropologist Sheila Kitzinger sees the way we treat birth as an indicator of what is valued in a society and what not: "In any society, the way a woman gives birth and the kind of care given to her and the baby points as sharply as an arrowhead to the key values of the culture."[17] The prosecuted Hungarian gynecologist, homebirth midwife, and reproductive rights activist Ágnes Geréb famously argued that "the freedom of a country can be measured by the freedom of birth."[18] Injustices in reproduction regarding discrimination on the basis of race, gender, class, and (dis)ability, expose how structures of oppression are organized in society as a whole. It is because of these current and historical configurations of stratified and uneven reproduction, that the demands of reproductive justice are defined broadly as the right to have children, to not have children, and to raise children in safety and dignity.[19] As such, it also consists of a struggle for housing, land back, economic, and environmental justice rather than merely the right to choose, as it entails the right to raise children in a dignified environment, indeed it consists of revolution more generally. The struggle for reproductive justice hence managed to shift the focus from a fight for freedom of choice towards a social movement that has a broader intersectional approach to justice.[20] To achieve reproductive justice, a more radical social and ideological transformation is needed than merely making a medical procedure, like abortion for instance, accessible or ceasing to force people to have one. Rothman already remarked in the 1980s when reflecting on the results of the feminist fight for reproductive care that "a clinic appointment for an abortion is not the revolution. It is not even a woman-centered approach to reproduction."[21]

the-pfc-condemns-reproductive-genocide-in-gaza/. For more information please see the open letter I wrote together with other repro-academics, workers, and activists, "Resistance is Fertile: No Reproductive Justice without Freedom for Palestine," https://docs.google.com/forms/d/1OtOXdpOqvEKR660euKdFMDfdFunKohHYI8i0KyQLWFo/edit#responses.

16 Patricia Hill Collins, "On Violence, Intersectionality and Transversal Politics," *Ethnic and Racial Studies* 40, no. 9 (2017): 1466.

17 Sheila Kitzinger, *Women as Mothers: How They See Themselves in Different Cultures* (New York: Vintage Books, 1980).

18 Toni Harman and Alex Wakeford, *Freedom for Birth* (Alto Films, 2012).

19 Loretta Ross and Rickie Solinger, *Reproductive Justice: An Introduction* (Oakland: University of California Press, 2017).

20 Kimala Price, "What is Reproductive Justice?" How Women of Color Activists Are Redefining the Pro-Choice Paradigm," *Meridians* 10, no. 2 (2010): 42–65.

21 Rothman, *Recreating Motherhood*.

Ross and Solinger differentiate between reproductive health, reproductive rights, and reproductive justice. In this differentiation, reproductive justice is mainly focused on political influence, societal awareness, and activist organizing. Consequently, the objective and strategy of reproductive justice could be understood as the obtainment and protection of (human) rights. While affirming the commitment to reproductive justice, I propose to venture beyond this somewhat liberal rights-based framework. In this study, I do not differentiate between reproductive health, rights, and justice, but rather understand reproductive justice as the presence of a relational network of care in which reproductive health, autonomy, freedom, and reimagination can be equally and optimally facilitated for everyone. Understanding reproductive justice not as a liberal emancipatory demand for rights, but rather as a struggle between different configurations of justice in matters of reproduction, where some are hegemonic and oppressive—what I described before as police—and others are liberatory and subversive—attesting to reproductive politics. On the basis of this understanding, I develop a practice-based understanding of the concept of reproductive justice, not to be achieved through a struggle for rights, but through relational abolitionist care through which reproduction can be reimagined. This strategy is developed through the remaining three concepts that are central to this study, which are themselves grounded in an engagement with the fields of midwifery studies, feminist theory, and abolitionist theory. In what follows, I will elaborate the concepts of relationality, reimagination of reproduction, and abolitionist care.

Relationality

Relationality is essential for all principles of reproductive justice: the right to have children, the right to not have children, the right to raise these children in safe and sustainable communities, and the right to bodily autonomy.[22] In order to have children, a relational community of care is needed; in order not to have children, access to contraceptive and abortion care has to be relationally facilitated; in order to raise children in safe environments, communities and collective responsibility is vital; in order to practice bodily self-determination, one needs others for access to knowledge, medicine, and care. Many scholars have argued that the

22 See for more information on the future of reproductive justice envisioned by SisterSong: https://www.sistersong.net/visioningnewfuturesforrj.

emergence of the individual Enlightenment subject characteristic of modernity dissolves relationality in most areas of our life. Ruth Wilson Gilmore, for instance, understands capitalist oppression as the division of relations and the subsequent individuation and separation of groups.[23] Fred Moten and Stefano Harney understand modernity as the dismantling of "a sociality not based on the individual."[24] And Silvia Federici shows how it was specifically the appropriation of women's bodies and knowledge on reproduction that dissolved relational communities of care.[25] In line with these thinkers, I understand relationship not as a relationship between individuals, but as a sharedness "not derivative of the individual."[26]

The lack of relationality when it comes to reproductive care has been extensively criticized by midwives and feminist scholars of pregnancy and birth. In the 1970s, Nancy Stoller Shaw discussed the lack of relationality in her book *Forced Labor: Maternity Care in the United States*,[27] when she described a typical birth as one in which the mother is "separated, as a person, as effectively as she can be from the part of her that is giving birth."[28] Fifty years later, it is proven that a lack of relationality and continuity of care indeed leads to the alienation of the mother from her own labor, to obstetric violence and obstetric racism, and consequently to trauma.[29] In this study, the dissolution of relationality in reproduction is considered to be the core of obstetric and reproductive violence. Obstetric violence undoes the, what I term, two key relationships of reproductive justice, or "reproductive relationality," thereby separating the pregnant person from their (capacity for) pregnancy, and hence their (potential) child, as well as their community of care:

23 Ruth Wilson Gilmore, *Golden Gulag. Prisons, Surplus, Crisis, and Opposition in Globalizing California.* (Berkeley: University of California Press, 2007).

24 Stefano Harney and Fred Moten, *All Incomplete* (New York: Autonomedia, 2021), 123.

25 Silvia Federici, *Caliban and the Witch: Women, the Body, and Primitive Accumulation* (New York: Autonomedia, 2004).

26 Harney and Moten, *All Incomplete*, 123.

27 Nancy Stoller Shaw, *Forced Labor: Maternity Care in the United States* (New York: Pergamon Press, 1974).

28 Shaw, *Forced Labor*, 84; Rothman, *Recreating Motherhood*.

29 Claire A. I. Stramrood et al., "Posttraumatic Stress following Childbirth in Home-Like and Hospital Settings," *Journal of Psychosomatic Obstetrics & Gynecology* 32, no. 2 (2011): 88–97; Martine Hollander, F. van Hastenberg, Jeroen van Dillen, M. G. van Pampus, Esteriek de Miranda, Claire A. I. Stramrood, "Preventing Traumatic Childbirth Experiences: 2192 Women's Perceptions and Views," *Arch Womens Mental Health* 20 (2017): 515–523; Sergio Martinez-Vázquez et al., "Factors Associated with Postpartum Post-Traumatic Stress Disorder (PTSD) Following Obstetric Violence: A Cross-Sectional Study," *Journal of Personalized Medicine* 11, no. 5 (2021): 338.

1) the relationship between the person and their (capacity for) pregnancy, including the one between mother and child, or pregnant person and embryo, or woman and fertility. Obstetric violence seperates a mother from her child through, for instance, taking away her responsibility for the child, inhibiting felt connection, and dissociation from her body. But this first relationship also includes the way one thinks about abortion, deals with contraception, miscarriage, and reproductive technology, a future child, or a current pregnancy. When it is not possible to develop a relationship with one's own fertility in freedom and without stigma, such as in the case of forced contraception, the criminalization of abortion, and obstetric violence, this is an expropriation, or dismantling of the relationship between oneself and one's fertility. The relationality of the potentially pregnant person and (the potential fruits of) their fertility has thus an epistemic, ethical, as well as an existential dimension.

2) The relationship between the (potentially pregnant) person and their community of care, which includes partner(s), friend(s), family, doulas, midwives, doctors, etc. Obstetric violence isolates the pregnant person through a separation from a community of care. This second relationality is of essential importance when people need an abortion, birth care, and contraceptives, but also to access knowledge, cultural scripts, ideas, in order to be able to develop their own ethical and existential ideas regarding their fertility. It is this relationship in which the reproductive justice and freedom of the community is facilitated and protected, hence including activist movements and networks. In the case of obstetric and reproductive violence, this relationship can also be considered expropriated or dismantled, leaving the (potentially) pregnant person isolated and therefore prone to control and policing.

In the case of obstetric and reproductive violence, both the first relationship between the person and their child or fertility, as well as the second, between the person and their community of care, are expropriated. All chapters in this collection deal with the dissolution, the expropriation, as well as the healing and reimagination of both of these relationships. Part III of this study is specifically dedicated to the reimagination of reproduction through a reimagination of relationality. Below, I elaborate on the insights of midwifery in the problem of the dissolution and expropriation of relationality in reproduction.

Midwifery is a practice, an activist movement, a strain of thought about reproduction, and an academic field. Traditionally, it is the profession

involved in maternity care that has relationality at its core—"midwife" literally meaning "being-with women."[30] The potential of relational midwifery for better sexual, reproductive, maternal, and neonatal health outcomes, as well as for resisting obstetric violence and obstetric racism, is consistently proven by midwifery scholars. Research, including a Cochrane systematic literature review, has shown that long-term relational involvement of a small group of midwives during pregnancy and childbirth contributes to an increase in trust, empowerment, and personalized care, and a decrease of pain, distress, trauma, over-medicalization, unnecessary interventions, need for epidurals, instrumental deliveries, fetal and neonatal losses, pre-term birth, and low birth-weight babies.[31] The Cochrane review from 2016 also explicitly concluded that all pregnant people should be offered midwife-led continuity models of care, since relationality and continuity of care is lacking in obstetric-led approaches.[32]

Midwifery scholarship has developed an extensive critique of the obstetric institution and industrialized birth by arguing that the violence and mistreatment of pregnant people results from the dissolution of relationality. In the Global North, the focus is mostly on the over-medicalization, institutionalization, and industrialization of maternity care, while midwives in the Global South have been raising awareness of the lack of care and medicine, the neo-colonization of birth, and the fight to preserve or restore indigenous and traditional midwifery.[33] Barbara Rothman, one of the frontrunners of this midwifery-centered critique of obstetrics, states in her 1989 book *Recreating Motherhood* that "patriarchy has blinded us to the relationship that is pregnancy. It is as if looking at pregnancy with men's eyes we see, well—nothing."[34] As a result, mothers are "cut off from their

30 Barbara Rothman, *A Bun in the Oven: How the Food and the Birth Movement Resist Industrialization* (New York: NYU Press, 2016).

31 Noelyn Perriman, Deborah Lee Davis, and Sally Ferguson, "What Women Value in the Midwifery Continuity of Care Model: A Systematic Review with Meta-Synthesis," *Midwifery* (2018); Sandall, Jane, Marie Hatem, Declan Devane, Hora Soltani, and Simon Gates, "Discussions of Findings from a Cochrane Review of Midwife-Led versus Other Models of Care for Childbearing Women: Continuity, Normality and Safety," *Midwifery* 25, no 1 (2009): 8–13; Jane Sandall et al., "Midwife-Led Continuity Models versus other Models of Care for Childbearing Women," *Cochrane Database of Systematic Reviews* (2016); Daphne McRae et al., "Reduced Prevalence of Small-for-Gestational-Age and Preterm Birth for Women of Low Socioeconomic Position: A Population-Based Cohort Study Comparing Antenatal Midwifery and Physician Models of Care," *BMJ Open* 8, no. 10 (2018).

32 Sandall et al, "Midwife-Led Continuity Models."

33 For a recent case, see for instance: Ava Sasani, "'Medical Colonialism': Midwives Sue Hawaii over Law Regulating Native Birth Workers," *The Guardian*, February 24, 2024, https://www.theguardian.com/us-news/2024/feb/27/hawaii-midwives-lawsuit-birth-regulation-indigenous.

34 Rothman, *Recreating Motherhood*, 53.

bodies, their children, the fathers of those children, and other mothers,"[35] a claim that captures the two moments of separation I describe above. As is the case for the whole movement of autonomous midwifery,[36] Rothman's project is to "put together what patriarchy, technology, and capitalism have taken apart."[37] It is in line with this aim that this study, and most radical midwifery scholarship, must be understood. Mavis Kirkham, for instance, devoted an edited collection to the mother-midwife relationship in which various midwifery scholars theorize the mother-midwife relationship as the foundation which allows the mother to be a moral and epistemic agent, capable of birth. The one-to-one mother-midwife relationship is thus seen as an antidote—a solution to institutionalized violence, over-medicalization, and disrespect.[38]

Rothman argues that the need to separate babies from their mothers stems from the 1960s, when it became clear that the placenta can pass elements that are harmful for the fetus, constructing the uterus as a dangerous, rather than safe, place. With the need to protect babies from their mothers, the disciplining of the mother intensified and fetal monitoring began.[39] While the ideological dissolution of relationality in pregnancy can be traced to early modernity, and even to the Old Testament, as I discuss in chapters 4 and 5, mother and child had to be treated as a unit in obstetrics until the advancement of technology allowed for the separate monitoring of the fetus:

> The alienation of the woman from the birth, and more fundamentally from the body, is, I believe, the most important and consistent theme in modern obstetrics. The perception of the fetus as a person separate from the mother draws its roots from patriarchal ideology, and can be documented at least as far back as the early use of the microscope to see the homunculus. But until recently, the effects of this ideology on the management of pregnancy could only be indirect. For all practical purposes, the mother and the fetus had to be treated as one unit while the fetus lay hidden inside the mother.[40]

35 Ibid., 55.

36 Autonomous midwifery is midwifery that operates outside of, although often in collaboration with, the obstetric institution. In the Netherlands, there is still a strong organization of autonomous midwifery care, which is different than in most other European and Western countries.

37 Ibid., 55.

38 Mavis Kirkham, ed., *The Midwife-Mother Relationship* (London: Palgrave, 2010).

39 Rothman, *Recreating Motherhood*, 60–61.

40 Ibid., 105.

The evolution of medical technology played a crucial role in taking the separation of mother and child to its current extent, during the end of the twentieth century. The question of separation due to technology, as well as the potential benefits of technology for healing relationality, will be further discussed in chapter 6.

In the 1990s, Sheila Kitzinger theorized how homebirth, an essential aspect of the autonomous midwifery practice, resists the dissolution of relationality between the mother and her community of care. During a homebirth, the midwife is a guest in the home of the mother, rather than the other way around, making it possible for the mother to determine her own rhythm of labor and constitute a relationship with the midwife on her own terms. A year before I was born myself, Kitzinger wrote in her book *Homebirth:* "All that is needed for the majority of labors to go well is a healthy pregnant woman who has loving support in labor, [of someone] who is self-confident, and attends with infinite patience."[41] Indeed, much like the support of the midwives who were at my mother's labors. Midwifery scholars have been consistently proving that homebirth produces better outcomes for low-risk births than birth in birth centers and hospitals, in terms of morbidity, unnecessary interventions, and emotional and psychological wellbeing—and they are cheaper.[42] The home is a place that can facilitate the relationality of pregnancy and birth, resulting in a mother that can birth her baby by herself.[43] Rothman also characterizes homebirth as one of the major strengths of the birth movement, although homebirth was made practically and legally impossible in many places. According to Rothman, homebirth functions as *pièce de résistance* when it comes to the industrialization of society.[44] The autonomous midwifery movement kept on valuing birth as more than a mere medical process, practicing it as an existential, social, and relational event that is best carried out in an intimate environment. Homebirth is not only a form of resistance against the medical dominance over birth, but also a crucial part of the continuous reimagination

41 Sheila Kitzinger, *Homebirth: The Essential Guide to Giving Birth Outside the Hospital* (New York: Dorling Kindersly, 1991).

42 Eileen K. Hutton, et al., "Perinatal or Neonatal Mortality among Women who Intend at the Onset of Labour to Give Birth at Home Compared to Women Who at the Onset of Labour Intend to Give Birth in Hospital: A Systematic Review and Meta-Analysis. *The Lancet* 14 (2019): 59-70. For the Dutch context, see: Veronique Huijbregts, "Het Geboortecentrum: Een prima plek voor vrouwen die kiezen om niet thuis te bevallen," *ZonMW* (2009), https://www.tno.nl/media/7289/het_geboortecentrum_factsheet.pdf.

43 Kitzinger, *Homebirth*.

44 Rothman, *A Bun in the Oven*.

of birth in a different way. Melissa Cheyney theorizes how midwives use rituals in homebirth to subvert the medical protocols that construct birth as a non-relational pathological situation that has to be managed by doctors. Midwives actively reconstitute priorly expropriated relationality and reestablish birth as "connection, celebration, power, transformation, and mothers and babies as inseparable units."[45] This is in stark contrast to the practice of obstetrics that Jo Murphy Lawless critiques in *Reading Birth and Death: A History of Obstetric Thinking*.[46] Lawless lays bare a fundamental belief on the part of obstetrics in the incompetence of laboring people. She characterizes obstetrics as follows: "If I were to extract only two words whereby to classify the concerns of contemporary obstetric practice, they would include not birth, but risk and death."[47] She brings to the fore how this belief about risk and death, in combination with institutional norms that demand compliance, make it impossible for women to birth in relational autonomy and competent self-determination.

In her 2018 book *Towards the Humanization of Birth*, Elizabeth Newnham further adds to the critique of obstetrics as an expropriation of relationships and a dismissal of the agency of mothers. She emphasizes that it makes more sense for midwives who work in obstetric units to have a good relationship with their fellow midwives, the nurses, and the obstetricians, than to have a relationship of solidarity or advocacy with the mothers, which can put the midwives' relationship with the hospital at risk. Newnham concludes that the relationality between the mother and their community of care is inhibited by the relationship that the clinical midwife has with the hospital. She analyzes how the institution of obstetrics undoes the relationship between mother and midwife, resulting in a situation in which the pregnant person can only be an additional guest, rather than a true subject with whom birth workers are in an equal relationship. The same goes for the relationship between mother and child. Newnham argues that the rhythm of the institution is so invasive that it is difficult to establish one's own rhythm of birth with one's child. Obstetric care hence undoes both key relationships described above—the one between mother and child, and the one between the mother and her community of care.[48] All this is not to deny that the speed of the

45 Melissa Cheyney, "Reinscribing the Birthing Body: Homebirth as Ritual Performance," *Medical Anthropology Quarterly* 25, no. 4 (2021): 520.

46 Jo Murphy Lawless, *Reading Birth and Death: A History of Obstetric Thinking* (Bloomington: Indiana University Press, 1998), 229.

47 Ibid.

48 Elizabeth Newnham, Lois McKellar, and Jan Pincombe, *Towards the Humanisation of Birth. A Study of Epidural Analgesia & Hospital Birth Culture* (Cham: Palgrave Macmillan, 2018).

hospital is oftentimes lifesaving, of course, but we must consider how we can make sure that this speedy care only rushes in when needed.

In the Netherlands, relational community midwifery also has the task of risk assessment, that is, the determination of whether a pregnancy is low-risk or high-risk, which in turn determines whether a birth can be accompanied at home or must be referred to the hospital. This means that most people start their maternity care with community, independent midwives and stay with them as long as the pregnancy and birth remain low risk. When it comes to risk assessment, the work of Dutch midwife and academic Bahareh Goodarzi has shown that midwives are well-equipped to determine risk in childbirth, since midwives have a relationship with the people they care for and think from a physiological rather than a pathological perspective.[49] As Goodarzi argues, risk is best assessed by professionals who are less trained to focus on disease but are able to see that the spectrum of what can be considered "normal" is very broad in childbirth, and, importantly, by people who are culturally attuned to the pregnant people they care for, and who humanely and continuously support them throughout pregnancy and childbirth.[50] In the Netherlands, midwives traditionally defend their role in childbirth as gatekeepers who determine when exactly a childbirth becomes a high-risk medical event, hence only permitting the intrusion of the obstetric rhythm if needed.[51] It remains important to stress once more that pregnancy and birth can be considered low-risk unless there is reason to believe otherwise. Most of the job of the midwife and the obstetrician is thus not to "cure" a condition, but to patiently be with someone throughout their pregnancy and childbirth and detect when there is an indication that a pathology is developing. The overestimation of risk can lead to over-medicalization and obstetric violence, and occurs more in the hospital than at home, and can be considered iatrogenic.[52] As an illustration, in the Netherlands at this moment, 28% of pregnant people's labor is induced, and 8% have a planned

49 Bahar ehGoodarzi et al., "Models of Risk Selection in Maternal and Newborn Care: Exploring the Organization of Tasks and Responsibilities of Primary Care Midwives and Obstetricians in Risk Selection across The Netherlands," *International Journal of Environmental Research and Public Health* 9, no. 3 (2022); Bahareh Goodarzi et al., "Towards a Better Understanding of Risk Selection in Maternal and Newborn Care: A Systematic Scoping Review," *PLOS ONE* 15, no. 6 (2020).

50 Bahareh Goodarzi, *Putting Risk in Its Place: The Complexity of Risk Selection in Maternal and Newborn Care*, (PhD diss., AmsterdamUMC, 2023).

51 Bahareh Goodarzi et al., "Risk and the Politics of Boundary Work: Preserving Autonomous Midwifery in the Netherlands," *Health, Risk & Society* 20, no. 7–8 (2018): 379–407.

52 Goodarzi, *Putting Risk in its Place*; Ivan Illich, *Medical Nemesis. The Expropriation of Health* (New York: Pantheon books, 1976).

cesarean section, meaning that 36% of labors no longer start spontaneously, which can be considered a form of risk-averse over-medicalization that has potentially iatrogenic physical consequences.[53] The lack of a culturally attuned, relational, community-based assessment of risk can furthermore result in racist policy recommendations. The recommendation in the British NICE guidelines, which are used internationally, to induce all people of color at 39 weeks, is an example of policy that has no eye for a personalized assessment of risk, nor for the social construction of race, nor for the role racism plays in the worse outcomes for people of color at late-term pregnancy. The recommendation was reversed after much protest.[54] Risk assessment that resists both over- and under-medicalization must thus be considered a central part of relationality in reproduction.

Relationality in midwifery also extends from the home to the community. Midwifery community practices can be culturally centered, and offer group care, community events, or mother groups. Black relational community midwifery practices are known to reduce maternal and neonatal mortality rates for Black people better than the obstetric institution. Through relational and culturally centered care in their communities, Black midwives are able to reduce preterm birth and low birthweights as well as raise maternal and neonatal mortality rates.[55] Culturally concordant relational midwifery reduces stress symptoms caused by racism by avoiding racist aggressions,

53 Hajo Wildschut and Anna van Seijmonsbergen-Schermers, "In blijde verwachting…hoezo? Over medicalisering en bevallingservaringen in de geboortezorg," *Cahiers Geschiedenis van de Geneeskunde en Gezondheidszorg* (2023, *forthcoming*); Anna Seijmonsbergen-Schermers et al., "Regional Variations in Childbirth Interventions in the Netherlands: A Nationwide Explorative Study," *BMC Pregnancy and Childbirth* 18, no. 1 (2018); Anna Seijmonsbergen-Schermers et al., "Variations in Use of Childbirth Interventions in 13 High-Income Countries: A Nultinational Cross-Sectional Study," *PLOS Med* 17, no. 5 (2020).

54 Goodarzi, *Putting Risk in its Place*; For the guideline, see: National Institute for Health and Care Excellence (NICE), "Inducing Labour," last modified November 4, 2021, https://www.nice.org.uk/guidance/ng207/resources/inducing-labour-pdf-66143719773637.

55 Alicia Suarez, "Black Midwifery in the United States: Past, Present and Future," *Sociology Compass* 14 (2020); Jennie Joseph and Stephan Brown, *The JJ Way: Community-Based Maternity Center. Final Evaluation Report* (Orlando: Visionay Vanguard Group, 2017); Jennifer Almanza et al., "The Impact of Culturally-Centered Care on Peripartum Experiences of Autonomy and Respect in Community Birth Centers: A Comparative Study," *Maternal Child Health Journal* (2021); Leseliey Welch et al., "We Are Not Asking Permission to Save Our Own Lives: Black-Led Birth Centers to Address Health Inequities," *The Journal of Perinatal & Neonatal Nursing* 36 (2022); Keisha Goode and Arielle Bernardin, "Birthing #blackboyjoy: Black Midwives Caring for Black Mothers of Black Boys During Pregnancy and Childbirth," *Maternal Child Health Journal* 26 (2022); Ruha Benjamin, *Viral Justice: How We Grow the World We Want* (Princeton: Princeton University Press, 2022), chapter 5.

and instead actively offering a safe environment to birth.[56] Dána-Ain Davis theorizes how midwifery and doula work can be considered a form of mutual aid that extends beyond pregnancy and childbirth, as for instance in the case of doulas distributing food in so-called "food deserts" during the Covid-19 pandemic.[57] Becky Reed's recent book on a famous independent midwifery practice in London, the Albany practice, also attests to community midwifery being both an example for improving physical and emotional outcomes in birth and uplifting neighborhoods through relational community care. At the same time, the state prosecution and closure of the Albany practice, despite much community protest, also testifies to the violence with which these alternative practices are confronted.[58] And in 2015, Sheena Byrom and Soo Downe have freed "the roar behind the silence" of midwives struggling with impossible workloads, exposing midwives' frustration over being unable to provide relational care, often resulting in complicity to obstetric violence, moral stress, and compassion fatigue.[59] Their work has reinvigorated midwifery activism by advocating for the humanization of childbirth through the reconstitution of birth as a relational and communal event.

Key to all these relational practices is that they allow for the mother to be taken seriously, as philosopher Stella Villarmea says, in "full rationality and capacity."[60] As such, they counter the epistemic injustice in which pregnant people are continuously ignored, neglected, over-medicalized, and violated. The core of what can be characterized as "midwifery thinking'" is that pregnant people *know* how to birth, something that anthropologists and sociologists of midwifery have been defining as central to midwifery philosophy from the 1990s until the present.[61] As such, midwifery is about being in relation with pregnant people becoming parents. As Rothman

56 Dána-Ain Davis, *Reproductive Injustice, Racism, Pregnancy and Premature Birth* (New York: NYU Press, 2019); Sarah Forrester et al., "Racial Differences in Weathering and Its Associations with Psychosocial Stress: The CARDIA Study," *SSM – Population Health* 7 (2019).

57 Dána-Ain Davis, "The Labor(s) of Birth Work: Doula Work as Mutual Aid," (Keynote lecture, Critical Midwifery Studies Summer School, 2022). Available on www.criticalmidwiferystudies.com.

58 Becky Reed, *Closure: How the Flagship Albany Midwifery Practice, at the Heart of Its South London Community, Was Demonized and Dismantled* (London: Pinter and Martin, 2023).

59 Sheena Byrom and Soo Downe, *The Roar behind the Silence: Why Kindness, Compassion and Respect Matter in Maternity Care* (London: Pinter and Martin, 2015).

60 Stella Villarmea, "When a Uterus Enters the Room, Reason Goes Out the Window," in *Women's Birthing Bodies and the Law: Unauthorised Medical Examinations, Power and Vulnerability*, ed. Camilla Pickles and Jonathan Herring (Oxford: Hart, 2020).

61 Inge van Nistelrooij, "Humanizing Birth from a Care Ethics Perspective" (Keynote lecture, Critical Midwifery Studies Summer School, 2022); Rodante van der Waal et al., "Somatophilic Reproductive Justice: On Technology, Feminist Biological Materialism, and Midwifery Thinking," *Technophany* (2024). Available on www.criticalmidwiferystudies.com.

writes: "It's not just the making of babies, but the making of mothers that midwives see as the miracle of birth."[62] Rothman's other famous quote is on the wall of the midwifery academy in Amsterdam where I did my training: "Midwives know that birth is about making mothers. Strong, competent, capable mothers who trust themselves and know their inner strength."[63] In this study, midwifery is hence not only treated as a practice, but taken up as a relational, ethical, and epistemic perspective that emerges from a practice, as a promising way of thinking and working towards reproductive justice.

The configurations of relationality in the practice of midwifery do not exist without problems, however. Too often, midwifery is grounded on exclusive identities, such as essentialist ideas about womanhood and sex,[64] or implicit assumptions of whiteness and coloniality. Much of the theorizing of relationality in midwifery comes from the second feminist wave and is influenced by essentialist ideas on woman- and motherhood, as well as written by white women who lacked awareness of racism as well as Black and indigenous theorizing on reproduction. An important part of this book is therefore dedicated to critiquing and reimagining the ethical and epistemic relationality of midwifery, rather than taking it for granted. Far from being primarily theoretical, this reimagination is rooted in practices of care and responsibility. Must the relationality between a potentially pregnant person and someone who cares for them consist of a one-to-one relationship between mother and midwife, as midwifery often makes it out to be, or should we understand it as a sociality or a community not reducible to individuals? After all, with the birth of a child, a whole social network of relations shifts: uncles and aunts, too, are born when a child is born. Additionally, every birth is part of a new generation and therefore contributes to the shifting of a whole society; with the birth of a child a new citizen is born, which is relevant for the whole community.[65] According to Hannah Arendt, every child is the promise of a new beginning to a community, a sentiment which is captured according to her in the sentence

62 Rothman, *A Bun in the Oven*.

63 Ibid., and personal correspondence.

64 See for instance: Karleen D. Gribble et al., "Effective Communication about Pregnancy, Birth, Lactation, Breastfeeding and Newborn Care: The Importance of Sexed Language," *Frontiers in Global Women's Health* 3 (2022).

65 Inge van Nistelrooij, *Het zelf als moeder: De Dialogical Self Theory vanuit zwangerschap, zorgpraktijken en baarzaam-zijn* (Inaugural address, Nijmegen: Radboud Universiteit, 2022); Inge van Nistelrooij, "The Fluidity of Becoming: The Maternal Body in Feminist Views of Care, Worship and Theology," in: *Care Ethics, Religion and Spiritual Traditions*, ed. Inge van Nistelrooij, Maureen Sander-Staudt, and Maurice Hamington (Leuven: Peeters, 2022); Christina Schües, *Philosophie des Geborenseins* (Munich: Verlag Karl Aber, 2016).

that underscores this relationality from Händel's *Messiah*: "For unto us a child is born."[66] The medicalization and individualization of care hides these relational and societal aspects of birth, but midwifery can hide these broader community aspects as well by making itself, or the one-to-one mother-midwife relationship, all too important.

Does midwifery understand what relationality is when mother and midwife have different cultural backgrounds? How to think of a caring sociality in an increasingly globalizing world where communities are less and less defined by one shared tradition or religion? And what about gender? Reading midwifery theory, one gets the impression that birth happens, or should happen, exclusively within the body and community of women. But must the relationality of pregnancy and midwifery only consist of women? What about (trans) men and non-binary pregnant people and birth workers? An essentializing tendency is reemerging in midwifery that leans towards the exclusive usage of sexed language, contributing to the exclusion of trans people and those beyond the gender binary.[67] And what does a relationship with a potential child look like if one decides to have an abortion? Currently, dogmatic critiques of medicalization also foster an increasing anti-abortion sentiment amongst midwives, who see abortion also as a form of medicalization. How to build community with people who want medicalized births? Who want a caesarean section without a medical reason? In the light of obstetric and reproductive violence that undoes the relationship between the potentially pregnant person and both their community of care and their potential child, the question is how we can restore relationality to be able to have glorious abortions and safe and loving births. One of the main questions is therefore: amidst a system characterized by obstetric and reproductive violence, what kind of relational practice can effectuate true reproductive justice?

These questions are tentatively answered in the reimagination of both key relationships in Part IV of the book. In answering these questions, I rely both on the thoughts and reflections of Dutch independent community midwives who form a central part of my empirical study, and on Critical Midwifery Studies, a new strand of midwifery thought that I co-developed and established while doing this research.[68] Critical Midwifery Studies understands midwifery to be a marginalized epistemic standpoint through

66 Hannah Arendt, *The Human Condition* (Chicago: The University of Chicago Press, 1998).

67 Gribble, "Effective Communication."

68 Critical Midwifery Studies (CMS) Collective Writing Group, "A Call for Critical Midwifery Studies: Confronting Systemic Injustice in Sexual, Reproductive, Maternal, and Newborn Care," *Birth* 49 (2022): 355–359.

which we can "study upwards" the intersections of oppression present in reproductive care.[69] While it acknowledges the potential of midwifery for reproductive justice, it believes that midwifery can only truly realize this potential if it incorporates critical theory, such as intersectional feminism, Black radical theory, gender studies, and decolonial theory, into its thought on relationality, abortion, respectful care, and community care.[70] This book contributes to the further development of Critical Midwifery Studies by taking these critical theories as its main interlocutors.

Reimagining Reproduction

From early modernity through to the present, people with the capacity for pregnancy have been policed through carceral institutions in the name of justice.[71] Exerting control on both midwives and mothers through accusations of witchcraft was one of the many ways to gain control over reproduction. Silvia Federici shows how pregnant people and midwives were regulated and controlled by local courts in early modern Europe.[72] And Annie Menzel reveals how Black midwives were controlled, disciplined, and policed in post-slavery United States through changing demands on what is supposed to be in their midwifery bag.[73] Surveillance of midwives through inspections of their midwifery bag was one of many methods in a targeted campaign that made midwives out to be ignorant and dangerous and through which they were put out of practice.

Practices that we now consider unjust, such as economic incentives for sterilization and abortion, were normalized on the basis of an appeal to justice; a normative ideology was constituted around how human reproduction should be, successfully shaping how we reproduce. Take for instance the criminalization of abortion—recently, a mother in the UK was sentenced to 3 to 28 months in prison for carrying out an abortion by herself—,[74] and

69 Ibid.

70 Ibid.

71 Federici, *Caliban and the Witch*; Trudy Dehue, *Ei, foetus, baby. Een nieuwe geschiedenis van de zwangerschap* (Amsterdam: Atlas Contact, 2023).

72 Federici, *Caliban and the Witch.*

73 Annie Menzel, "The Midwife's Bag, or, the Objects of Black Infant Mortality Prevention," *Signs* 46, no. 2 (2021): 283–309.

74 Tobi Thomas, "Outrage at Jail Sentence for Woman Who Took Abortion Pills Later Than UK Limit," *The Guardian*, June 12, 2023, https://www.theguardian.com/world/2023/jun/12/woman-in-uk-jailed-for-28-months-over-taking-abortion-pills-after-legal-time-limit.

forced or coerced contraception for vulnerable' people, or the deaths and forced pregnancies that are the result of the many conscientious objectors among catholic doctors in Europe. There are also practices that we now recognize as unjust but that were considered just until relatively recently, such as the separating of indigenous children from their families in Canada and displacing them to boarding schools in murderous circumstances,[75] the forced labor of women who became pregnant out of wedlock in the Magdalen laundries run by the Catholic church in Ireland,[76] and the forced sterilization that Dutch trans people underwent up to 2014 in order to receive gender affirmative surgery,[77] the reason why there have been only few transmasculine births in the Netherlands.

The critique and reimagination of reproduction are therefore intimate concerns of feminist thought and practice. Midwives and wise women have always been involved in the regulation of conception, and in the nineteenth and twentieth century, suffragettes fought not only to gain the right to vote, but also to be in charge of their own fertility. Ever since the development of contraceptive technologies, feminists have been committed to adjusting the nature of reproduction and steering it towards more desirable paths. Women such as Margaret Sanger from the US, Marie Stopes from the UK, and Guadalupe Arizpe de la Vega from Mexico are only some of the pioneers of feminist configurations of reproduction in the first half of the twentieth century. These configurations, however, also consisted of eugenic arguments on the benefits of contraception as a way to enhance the human race. One of many examples is Stopes' "ProRace" contraceptive cervical cap which she sold in her clinics, and which aimed to be a source of "light in our racial darkness."[78] The focus on the improvement of the "human race" as the goal of public health policies was a central tenet of eugenic and Malthusian thought and fully relied on a normative conception of reproduction, and hence on a moral claim on the good in matters of reproduction. Similarly, in Mexico, the promotion of

75 Ian Austen, "'Horrible History': Mass Grave of Indigenous Children Reported in Canada," *New York Times*, September 5, 2022, https://www.nytimes.com/2021/05/28/world/canada/kamloops-mass-grave-residential-schools.html.

76 Government of Ireland, *Report of the Inter-Departmental Committee to Establish the Facts of State Involvement with the Magdalen Laundries*, February 5, 2013, https://www.gov.ie/en/collection/a69a14-report-of-the-inter-departmental-committee-to-establish-the-facts-of/?referrer=http://www.justice.ie/en/jelr/pages/magdalenrpt2013.

77 Kyle Knight, "Netherlands Apologizes for Transgender Sterilizations: Government Offers Compensation for Unwanted Surgeries," *Human Rights Watch*, December 1, 2020, https://www.hrw.org/news/2020/12/01/netherlands-apologizes-transgender-sterilizations.

78 Nora Heidorn, "Touching Matters of Care (Birth Rites Collection, 2022)," last accessed March 18, 2024, www.Noraheidorn.com/Touching-Matters-of-Care.

family planning went hand in hand with the reproduction of ideas of Mexican lower-class women as hypersexual and fertile.[79] The first hormonal birth control pill was tested without consent on lower-class Puerto Rican women through a US program in which Sanger was involved.[80] And, as we saw above, the birth control movement combined advocacy for abortions with practices of forced sterilization of, and experimentation on, lower-class people and people of color.

Even feminist moral claims for reproductive rights hence often continued a eugenic normative configuration of reproduction, like those of Sanger, Stopes, and De la Vega. Within the feminist movement there is thus an important differentiation to be made between views on reproduction that are congruent with capitalist racialized and (post)colonial society, and visions for reproductive justice which disrupt these structures. In this collection, there is a continuous differentiation at play between conservative normative claims on reproduction, which implicitly continues a configuration of justice made by patriarchal (post-)colonial society that has strong normative conceptions and rules about reproduction, and a disruptive feminist reimagination of reproduction, based on a counter-normative claim on justice. To sharpen these different configurations of reproduction, I again use Rancière's differentiation of "police" and "politics" that I already shortly touched upon in the introduction.

According to Rancière, "the police" designates that power which administers a particular hegemonic ethical, epistemic, and ontological ordering that categorizes the sensible world around us, determines "what is visible and what not, […] what can be heard and what cannot."[81] This partition of the sensible guards the borders of the ethical and the epistemic throughout society, particularly by means of social and carceral institutions.[82] The "logic of the police" thus establishes and enforces an order, which is always based on an—ethical, epistemic, ontological—exclusion.[83] To disrupt the order of the police would mean to have those who are not part of the order appear and speak. This disruption is what Rancière terms "politics." For Rancière, politics is the intervention in a social order premised on an exclusion.

79 Lina-Maria Murillo, "Espanta Cigüeñas: Race and Abortion in the US-Mexico Borderlands," *Signs: Journal of Women in Culture and Society* 48, no. 4 (2023): 795–823.

80 Dorothy Roberts, "Margaret Sanger and the Racial Origins of the Birth Control Movement," in *Racially Writing the Republic: Racists, Race Rebels, and Transformations of American Identity*, ed. Bruce Baum and Duchess Harris (Durham: Duke University Press, 2006).

81 Jacques Rancière, *Dissensus: On Politics and Aesthestics*, trans. Steven Corcoran (London: Continuum Books, 2010), 36.

82 Ibid.

83 Ibid., 53.

While Rancière has a broad definition of police, encompassing but far exceeding the actual institution of the police, he has a demanding definition of politics. Politics, in Rancière's definition, is only that which truly disrupts "the partition of the sensible," i.e., that which challenges and subverts the ethico-onto-epistemic police order. While the activism of Sanger, however ambitious, still perpetuates a form of reproductive policing, and the same goes for essentialist midwifery ideas, the Black feminist project of reproductive justice can truly be seen as politics. "Politics" excludes traditional forms of liberal democratic governance. Instead, Rancière reserves the domain of the political for subversive or revolutionary practices, which, in letting those who were previously silenced be heard, are truly disruptive of the way the sensible is distributed. It is by virtue of such interventions into the epistemic, ethical, and ontological fabric of society that political acts are capable of "suspending all logics of legitimate domination."[84] Which is why, following Rancière, the exercise of reimagination in this book is conducted both through the practice of care as well as through literary praxis.

The efforts of second-wave white feminists to make contraception and birth control accessible were aligned with "policing" in that they relied on and perpetuated a stratified eugenic conception of reproduction. Although the movement resulted in increased self-determination, it did so within the logic of eugenics and the classed and racialized conceptions of humanity at the time. As Rothman points out, this continued until the end of the twentieth century:

> Sanger made her alliances with the eugenics movement and with the population-control movement. The contemporary feminist reproductive-rights movement does the same: making uneasy alliances with the new eugenics movement which looks at embryos and fetuses as products suitable for quality-control testing, and with the population-control movement with its often classist and racist agenda. At the clinical level, the focus is on the fetus; at the policy level the focus is on the population. The woman is lost.[85]

But there have also been many feminist approaches which have continuously expanded our understanding of reproductive justice and can be considered political. Marxist feminists, for instance, uncovered the realm of social reproduction where unpaid care work is done to maintain the labor force

84 Ibid., 33.

85 Rothman, *Recreating Motherhood*, 75.

needed in a capitalist society. As a result, their configuration of reproduction and reproductive justice was, in contrast to that of Sanger and Stopes, related to the social order as a whole. Within this realm of feminist theory, the most important thinkers for my reimagination of reproduction include Silvia Federici, Barbara Rothman, Shulamith Firestone, Sophie Lewis, and Joy James; those who have further developed Marxist theory to include the realm of social reproduction, but who have also conceptualized the biological processes of pregnancy and birth itself as essential pillars of capitalist society. My theoretical engagement with feminist theory in this collection of chapters is a continuation of these authors' work on sexual and biological reproduction, in which Marxist analysis of primitive accumulation, wage-labor, and the relations of production is extended to the realm of sexual reproduction, with (in my case) a focus on the obstetric institution, even though it is, sometimes, a critique on and differentiation from their thought. Below, I will discuss in what sense these thinkers are specifically political, i.e., subversive of the current practice and understanding of reproduction, and which aspects of their work I take further and leave behind. I have grouped these thinkers in three directions, according to their different political strategies of reimagination: first, Federici and Rothman, who focus on the reappropriation of reproduction as a relational and community practice; second, Firestone and Lewis, who are more interested in biology itself as the locus of the problem and do not shy away from technology in fixing the oppressive sides inherent in nature, and third James, who uses fugitivity as a strategy of abolition.

Silvia Federici develops a Marxist feminist understanding of reproduction. In her pathbreaking book *Caliban and the Witch: Women, the Body, and Primitive Accumulation*,[86] she shows how the bodies of people with the capacity for pregnancy have been appropriated by the state on the grounds of justice since early modernity. And, additionally, how the appropriation of women who often had a key role in the community was essential in the dismantling of the commons. Federici provides insight into the role of local courts in the trial of women on the basis of what was considered to be injustice in matters of reproduction, such as abortion, or "infanticide," as it was referred to at the time. During early modernity, in many places in Europe, abortion became a *crimen exceptum*, the highest crime, and it was the crime that was most often followed by a conviction. Also, a difference was rarely made between miscarriage, abortion, stillbirth, or infanticide. She argues that the disciplining of women as a matter of justice to be determined by a court

86 Federici, *Caliban and the Witch*.

was key to the birth of modern society and capitalism—thus identifying the first "police" configuration of modernity of what justice is in matters of reproduction. According to Federici, capitalism rests on the dismantling of the commons by targeting women, and thus on the capture and isolation of people with reproductive capacity, in order to control both reproduction and the community, attesting to the dissolution of what I called the two key relationships of reproductive justice. What we must do, therefore, is reinstall those relationships, those reproductive commons of care.

Mariarosa Della Costa and Silvia Federici aimed to overthrow capitalism through overthrowing the police configuration of reproduction in their Wages for Housework campaign in the 1970s.[87] The campaign did what it said: it demanded wages for housework. But not, as is often thought, merely because they wanted a kind of basic income or monetary recognition for the housework that they did, or because they demanded the acknowledgement that raising kids and cleaning the house was real work. Instead, they sought to show that the capitalist system cannot in fact afford to pay wages for housework. The goal was never to get wages, but to show that wages for housework could never be paid in a capitalist society. We can understand the political explosiveness here as a gesture capable of "suspending all logics of legitimate domination": when those who are excluded from the current order of society demand justice, this demand indeed puts the society itself at stake in a revolutionary manner. It reveals that society rests on the fundamental injustices that women suffer, and that justice would mean the fundamental reorganization of society. The call for reproductive justice in the case of the Wages for Housework movement is thus not an appeal to justice within the hegemonic framework, i.e., recognition in terms of wages or rights, but an attempt to unsettle the social order and its understanding of reproduction. For Federici, the feminist reimagination of reproduction and the hegemonic conception of reproduction within capitalist society are hence mutually exclusive. And this is what makes her demands, and her specific reimagination of reproduction, politically radical. Rather than aiming to reform a fundamentally exclusionary society, the point was to abolish the order of society by making one's own necessary exclusion from that order visible through the lens of reproduction.

In her book *Recreating Motherhood*, Rothman insightfully shows how the sensible in case of reproduction is distributed and policed in the case of reproduction according to the three hegemonic ideologies of capitalism,

87 Luise Toupin, *Wages for Housework. A History of an International Feminist Movement: 1972-1977* (London: Pluto Press, 2018).

patriarchy, and technology. These three ideologies exclude the pregnant person from the partition of the sensible in the case of reproduction. The property logic of capitalism determines that the product of pregnancy is owned by the one who owns the seed, not the one who does the reproductive labor. In patriarchy, it is the patrilineal lineage carried by the seed that gives legitimacy to the child. To protect this lineage, a child needed (and sometimes still needs) to be born in wedlock with the name of the father, so that it stands under paternal supervision—extending the patriarchal claim from the individual father to society, with the fatherland laying claim to the child that grows out of the paternal seed.[88] This has resulted in reproductive technology that is profit-driven, and supported by a conception of pregnancy that underscores the prioritization of "seed" as the foundation of the baby, rather than the fleshly labor of pregnancy—it was long thought that sperm grows into a baby, and that the pregnancy was only needed to provide the nutrients to grow a tiny baby already present in the sperm. The combination of these three ideologies result in what Rothman calls the "containment view" of pregnancy where the pregnant person functions as the mere container for the child.

When it became clear that the DNA of both parents is responsible for the DNA of the child, so not only the sperm but also the egg, the containment hypothesis changed only partially. Rothman argues that in Western thought the egg is treated the same way as sperm; together, they form the seed that grows into the baby, but the labor of pregnancy itself remains devalued. Even when it became clear that the placenta can pass substances that can have good or bad influence on fetal development, the containment view of the seed for which the mother is merely a container remained mostly intact. The main change was that the container in which the seed grows became constructed as hostile and potentially polluted, thus justifying even more reproductive control, rather than finally picturing the mother as being a co-constitutive agent. Again, we see how the containment view also undoes both key relationships fundamental to reproductive justice.[89]

To reimagine reproduction, we must resist this view, built on all three ideologies that police the sensible in the case of reproduction, by reconstituting the relationality that pregnancy consists of, as well as the relationship with a community of care, embodied in Rothman's thought by the midwife. The reappropriation of these relationships would challenge the hegemonic configuration of reproduction that turns the bodies of people with the

88 Rothman, *Recreating Motherhood*, 45.

89 Ibid.

capacity for pregnancy into extractivist sites. The healing of these two relationships is political in the sense that it would disrupt the patriarchal, capitalist, and technological ideologies that currently polices the ontological understanding and practical reality of pregnancy. Within analytic philosophy, for instance, Elselijn Kingma has theorized this "fetal container model" further, pointing out that this "containment view" is hegemonic in contemporary discourse.[90] Kingma reimagines reproduction in such a way that the fetus could be considered part of the mother. According to this "parthood view," the labor of pregnancy is considered as fundamentally co-constitutive and part of the developing fetus. Kingma's reimaging of the hegemonic metaphysics of pregnancy is a political intervention, since the view in which the baby is considered part of the mother challenges our conception of pregnancy at an ontological level, posing a problem to our understanding of humans as individuals. Political reimagination can also be done through practice, for instance by organizing a homebirth which reconstitutes both relationships as well, as Rothman herself did in the 1970s in New York. The organization of a homebirth shows how political the reassertion of relationality and relational autonomy was: the only doctor willing to support Rothman was one of the former abortionists in the underground collective The Janes. For Rothman, reclaiming the relationality of reproduction is a political act that resists capitalist and patriarchal ideology and prefigures a "reproductive communism" where reproductive labor is reorganized relationally and communally: "from each according to her ability, to each according to her need."[91]

Shulamith Firestone was among those who took up this Marxist feminist effort, specifically in relation to biology.[92] Firestone makes the case that pregnant people have been oppressed due to their reproductive capacity, and that it is time to take pregnancy into their own hands. She argues that it is the biology of sexual reproduction itself that must be considered oppressive, not only our political, ethical, and ontological configuration of

90 Elselijn Kingma, *Better Understanding the Metaphysics of Pregnancy: Organisms, Identity, Personhood & Persistence*. (Research proposal, University of Southampton, 2015); Elselijn Kingma, "Were you a part of your mother?" *Mind* 128, no. 511 (2019): 609–646; Elselijn Kingma, "Lady Parts: The Metaphysics of Pregnancy," *Royal Institute of Philosophy Supplements* 82 (2018): 165–187; Elselijn Kingma. "Biological Individuality, Pregnancy, and (Mammalian) Reproduction," *Philosophy of Science* 87, no. 5 (2020): 1037–1048. Anne Sophie Meincke proposes a third option, the Process View, which argues that pregnant organisms are neither one nor two: Anne Sophie Meincke, "One or Two? A Process View of Pregnancy," *Philos Stud* 179 (2022): 1495–1521.

91 Ibid.

92 Shulamith Firestone, *The Dialectic of Sex. The Case for a Feminist Revolution* (New York: Verso, 2015 [1970]).

it. Pregnancy is to be understood as an injustice for those burdened with it due to their vulnerability to medical complications, the toll it takes on the body and mind, and the dependencies it involves—a lens she coins "biological materialism." In a reworking of the classic Marxist argument, Firestone conceptualizes potentially pregnant people as the proletariat of sexual reproduction. Consequently, she understands pregnant people as revolutionary subjects when it comes to reproduction. Firestone thus urges us to take up the challenge of reappropriating not only the means of production, as in orthodox Marxism, but the means of reproduction as well, and, crucially, not only in terms of social reproduction, but also of sexual reproduction, and hence as the physical biological labor of pregnancy itself. Due to the fact that, for Firestone, the root of injustice lies in the biological reality of pregnancy, she poses the infamous solution of taking pregnancy out of the body, in favor of ectogenesis, as such effectively abolishing sexual difference. This is again a radical political reimagination of reproduction, as it disrupts the hegemonic partition of the sensible by centering those who were not taken into account.

However, it could be argued that due to a lack of focus on relationality, Firestone's approach is not able to resist and subvert the capitalist logic of commodification, the patriarchal logic of the seed, or the technological negation of the mother identified by Rothman. Hence, the political strategy here is a different one than those advocated by Rothman and Federici. Where Federici and Rothman resist the logic of separation, commodification, individualization, technology, and patriarchy, Firestone repurposes these logics to such an extent that they are no longer tools of oppression but are reclaimed for liberation. She pushes the devaluation of pregnancy and the prioritization of the seed so far—to ectogenesis, for instance—that it becomes liberatory. In contradiction to Rothman's political reimagination, which rests on a reconstitution of the relationships that are continuously expropriated, Firestone takes that expropriation even further, so that reproduction is no longer dependent on the labor of pregnancy. The political strategy is thus fundamentally different from the more relational focus of Federici or Rothman.

Indebted to Firestone, Sophie Lewis's gestational communism also centers the dispossessed class of sexual reproductive subjects in her work—surrogates, mothers, and abortion-seeking pregnant people—, while arguing for utopic communist reproductive futures that are envisioned and governed by gestators themselves.[93] Following Federici, Lewis highlights

93 Sophie Lewis, *Full Surrogacy Now. Feminism against Family* (New York: Verso, 2019).

the impossibility of sustaining capitalism without free sexual and social reproductive labor, and conceives a technologically facilitated liberation that would fundamentally transform biological reproduction, as Firestone advocates. However, for Lewis, gestational communism does not grow out of a revaluing of relationality and community as the core of pregnancy, birth, and reproductive care, as with Federici, but it is developed through Firestone's more traditional Marxist idea, namely that the worker, who does the devalued labor required for (re)production, takes charge of pregnancy, and hence of the means of reproduction. Rather than divest from the project of modernity, as Federici does, Lewis repurposes the possibilities, structures, and ideas of modernity, following Firestone and the current movement of xenofeminism, who embrace enlightenment ideas and the emancipatory potential of technology. Where Rothman and Federici reconstitute expropriated relationality, Firestone and Lewis provocatively repurpose and radicalize possibilities that are present within current structures that might intuitively seem oppressive, in order to liberate those currently oppressed by them. This results in a fundamentally different view on medicalization from that of Federici and Rothman when it comes to reproduction. In chapter 6, these views are juxtaposed and brought together.

Another feminist philosopher who is concerned with reproduction in the realm of the political, but has a different strategy again, is the abolitionist Joy James. James terms those who are structurally coerced into doing sexual and social reproductive work "captive maternals."[94] As caretakers, captive maternals contribute to what James calls the "womb of Western theory," which she understands not only as the material reproduction of the world as we know it, but also as the theoretical discursive reproduction of that world—this is similar to Rancière's ethical, epistemic, and ontological "partition of the sensible." Captive maternals hence are part of society, engulfed in it, and essential to its reproduction, not as autonomous subjects but as "captives," left to do the necessary free labor that is needed to reproduce the world as it is. Captive maternals are ensnared within the Western world, but as excluded and silenced, echoing Rancière's understanding of the appropriation and exclusion of people in the realm of the police order. What would then be political, according to James, is not to disrupt the order of the police by exposing the exclusions on which that order depends, such as in the case of Federici, or by taking over the means of biological reproduction from biology, as Lewis and Firestone propose. Instead, James argues, inspired

94 Joy James, "The Womb of Western Theory Time, Trauma, and the Captive Maternal," *Carceral Notebooks* 12 (2016).

by the Black radical tradition of the maroons, the political thing to do would be to flee captivity. In James's work, the captive maternal develops from being a caretaker within the Western womb, to eventually being a fugitive from that order, building an otherworld elsewhere. Eventually, one would need to militantly defend those otherworlds of care against the police order.[95] James's theory thus has a different strategy when it comes to understanding what politics is; of what it means to disrupt the police. Rather than showing how some are excluded from the hegemonic police order and pushing the system to its own impossibility, as Federici does, or taking over the means of reproduction, as Firestone and Lewis want, James proposes a *flight* from the current distribution of the sensible *and* the militant defense of another world. Rothman's reimagination through a reconstitution of relationality via autonomous midwifery perhaps comes closest to James's fugitive abolitionist approach; both signal the need to heal relationality through alternative practice, and then also militantly defend it. If we think back to the relational autonomy facilitated by autonomous midwifery care in which my mother birthed me in the 1990s, and the situation we are in today, it is not only the former but definitely also the latter that we must urgently learn to do better.

When it comes to the domain of police, the question is how certain narratives, logics, and codes have normalized reproductive and obstetric violence so deeply that we have come to apprehend them as just. When it comes to reproductive politics, there is a tradition of feminist thinkers who staged political interventions in the police configuration of reproductive justice by radically reimagining reproduction *otherwise*. Federici emphasizes the reconstitution of community and the reproductive commons, which I configure in my study as the relationship between the person with the capacity for pregnancy and their community of care. For Rothman, the political reimagination consists of a reappropriation of the relationship between what I have termed the person and their (capacity for) pregnancy. The political intervention of Firestone is her theory of biological materialism and the consequent demand for feminism to treat biology as a problem in need of a revolutionary solution. I build further on her biological materialism from a midwifery perspective in chapter 6. Lewis's call for the abolition of all normative, disciplinary, and

95 In *Revolutionary Love*, Joy James lays out the four stages of revolutionary love of the captive maternal: 1) conflicted caretaker, 2) movement builders, 3) maroon communities, 4) militant war resisters. See: Joy James, *In Pursuit of Revolutionary Love: Precarity, Power, Communities* (London: Divided Publishing, 2023), 16.

institutionalized policing is a reproductive politics that searches for being human *otherwise* though producing human otheriwse. And, following James, I understand the political reimagination of reproduction as an act of flight, where the reimagination of reproduction is carried out directly in alternative practices of care that are expressive of reproductive justice. As I elaborate further below, part III of this study, "Abolitionist Care," is dedicated to such forms of political reimagination of reproduction and is elaborated on further below.

Abolitionist Care

Reproductive justice is an aim, an ethical principle, which makes it possible to critically analyze the current reproductive care crisis. However, it does not yet provide us with a developed theory of how exactly we are to achieve reproductive justice when institutionalized health care is not facilitating it. While, for instance, a concept such as transformative justice (or that of healing justice) does provide a clear alternative to the carcerality of institutions such as the police, the justice system, and the prison, reproductive justice is still developing a political strategy or care practice that offers an alternative to the obstetric configuration of reproduction. What makes a concept such as transformative justice so compelling, for instance, is that it is anchored in practices of justice such as relational community care and accountability that provide a clear alternative to carceral justice. It is transformative because justice is no longer understood as punishment but reconfigured as "healing" through the dismantling of root causes that lead to injustice in the first place.[96] The transformative aspect thus lays in building new social relations that are resistant to dominant societal structures. If transformative justice is the alternative to carceral justice, then reproductive justice should provide the alternative to reproductive control and appropriation.[97] But reproductive justice is still understood more broadly as a set of principles rather than as an alternative practice or political strategy, although the participants in many alternative care practices, such a doula or midwifery practices, would understand themselves as striving towards reproductive justice.

96 Mariame Kaba, *We Do This 'Til We Free Us: Abolitionist Organizing and Transforming Justice*. (Chicago: Haymarket Books: 2021).

97 This is also what Dean Spade understands to be the value of mutual aid. Dean Spade, "Solidarity not Charity: Mutual Aid for Mobilization and Survival," *Social Text* 38 (2020).

The four principles of reproductive justice—the right to have children, to not have children, to raise children in safe and sustainable environments, and to bodily autonomy—are captured in many practices in which reimagination of reproduction, reproductive care, and reproductive meaning making can take shape. But how to understand what specific practice unites the practices that strive towards reproductive justice? While the concept of reproductive justice can be understood as a counter-normative political claim that disrupts and resists the obstetric partition of the sensible, it needs to be accompanied by an alternative relational practice of care in which reproductive justice is realized *as presence*. When it comes to reproductive justice, it is the care of reproduction that is the central praxis which must be liberated from the institution, whether around the labor of pregnancy and childrearing or the medical provision of contraception, fertility treatments, abortion, and birth.[98] While an alternative practice of accountability, for instance, constitutes the core of transformative justice, *the core of* reproductive justice must ultimately be realized as an *alternative practice of care*. In Rancièrian terms, *the political intervention that can abolish the policing of reproduction is a practice of care*. In case of reproduction, the abolition of the police must be realized through care. Drawing on both abolition theory and care ethics, I will theorize "abolitionist care" as the practice of reproductive justice.

Abolitionist theory and activism originated in the fight against chattel slavery in the nineteenth century and evolved further in the fight to dismantle the ongoing logic of slavery in contemporary institutions, such as the prison industrial complex, the police, and child protective services.[99] As slavery was being transposed into the prison industrial complex, and its logics incorporated in the US legal system and the police, abolition as a political struggle became relevant again.[100] Abolitionist scholars such as Black feminists Angela Davis, Harsha Walia, Ruth Wilson Gilmore, Mariame Kaba, and Dorothy Roberts have since shown how modern institutions, especially carceral ones, are formed by the logics of slavery and colonialism that capture, extract, expropriate, appropriate, and circumscribe. Abolition understands institutionalized violence as inherent to institutions, whose emergence is deeply intertwined with oppressive structures such as

98 This does not mean, of course, that accountability has no place in transformative practices of reproduction, but it is not the main organizing principle, as it is in the case of transformative justice.

99 Angela Y. Davis et al., *Abolition. Feminism. Now* (Chicago: Haymarket Books, 2022).

100 Ibid.

capitalism, colonialism, and patriarchy. Therefore, rather than arguing for the reform of such institutions, the aim of abolitionist theory and activism is to dismantle "death-making" institutions—an analysis that resonates with Mbembe's concept of necropolitics—and build "life-affirming" ones instead.[101]

As is the case with other institutions, the history of modern obstetrics can be traced back to colonialism and the slave plantations in North and South America. Deirdre Cooper Owens shows in her book *Medical Bondage* that the obstetric institution has its origins on slave plantations in the US where planters and doctors started collaborating to enhance the reproductive health of enslaved people in order to increase their reproduction after the closing of the transatlantic slave trade.[102] Sim's speculum is the most famous example of an instrument developed on enslaved people without anesthesia that has come to define the profession of obstetrics and gynecology.[103] The knowledge of Black midwives was structurally appropriated by doctors on plantations, eventually fully expropriating them from reproductive care in the twentieth century. As we have already seen above, the contraceptive pill, too, knows a racist history that is fundamentally shaped by the afterlife of slavery. While we can repurpose medical technology, such as specula and contraceptives, it is important to consider whether this is truly possible within institutions that can genealogically be traced back to plantations, and whose current practices are still responsible for racially stratifying reproduction, as in the case of forced contraception in the case for lower-class people, disabled people, or people of color. To give an example from my own daily practice, it is not rare for me as a midwife in Amsterdam to have someone who is determined to be "vulnerable" by doctors in the hospital transferred back to our midwifery practice a couple of days after childbirth with a contraceptive device implanted in their arm without really knowing what it is, or what it is for, and without remembering having given consent.

Recently, Michelle Goodwin published *Policing the Womb*, a study on obstetric and reproductive violence in the US, covering abortion, birth, and pregnancy.[104] As a scholar of law, Goodwin looks at how the obstetric institution plays an essential part in the carceral policing enforced by the state, and makes the case that obstetricians in the US are complicit in the

101 Kaba, *We Do This 'Til We Free Us.*

102 Deirdre Cooper Owens, *Medical Bondage: Race, Gender, and the Origins of American Gynecology* (Athens: University of Georgia Press, 2018).

103 Ibid.

104 Michelle Goodwin, *Policing the Womb. Invisible Women and the Criminalization of Motherhood* (New York: Cambridge University Press, 2020).

criminalization of abortion. The trend of the obstetric institution's complicity in carceral institutions is a global phenomenon. There have been cases in Brazil where obstetricians call the police when they suspect an abortion; in the UK they bring cases to judges for court-ordered caesarean sections; in Spain they call the police to have someone taken from their home to have an induction; and in the Netherlands they alert social services when a mother does not comply with obstetric policy.[105] K. Eliza Williamson analyzes this phenomenon in the Brazilian context, arguing that "what may at first appear as two very separate institutions—public healthcare and the military police—converged in the hospital waiting area, highlighting the necropolitics of the Brazilian state."[106] Goodwin argues that the obstetric institution must therefore be regarded not only as a welfare institution, but also as a carceral one, involved in the disciplining and categorization of reproduction. She highlights that the obstetric institution plays an essential role in the carceral control of reproduction, in complicity with the police and the legal system. Institutions that are traditionally understood as social or welfare institutions, Goodwin argues, can be regarded as an extended arm of the carceral system.[107]

While abolition in the US is mostly centered around a critique and dismantling of carceral institutions such as the police and the prison—or, in the case of Europe, around the abolition of the border regime—abolitionist theory is developing a critique of social or welfare institutions as well.[108] Activists and theorists point out that these institutions both contribute to the prison industrial complex, but that they also have their own inherent carceral logic. Well-known examples of abolitionist theory in this regard are Dorothy Roberts's critique of child protective services and her plea for its abolition, and Liat Ben-Moshe's abolitionist application of anti-psychiatry

105 Human Rights Watch, "Brazil: Revoke Regulation Curtailing Abortion Acces," last modified September 21, 2020, https://www.hrw.org/news/2020/09/21/brazil-revoke-regulation-curtailing-abortion-access; Birthrights, "Human Rights Concerns as Court Permits Caesarean on Woman currently with Mental Capacity," last modified September 4, 2019, https://birthrights.org.uk/2019/09/04/human-rights-concerns-as-court-permits-caesarean-on-woman-currently-with-mental-capacity/; Stella Villarmea, "¿Cuándo pierde una mujer el derecho a decidir cuándo parir? [When Does a Woman Lose Her Right to Decide When to Birth?]," in *Amores y violencias: Género, Diversidad Sexual y Derecho* [*Loves and Violences: Gender, Sexual Diversities, and the Law*], ed. Defensoría de la Comunidad Universitaria de la Universidad de León (León: Eolas, 2021), 101-108.

106 K. Eliza Williamson, "The Iatrogenesis of Obstetric Racism in Brazil: Beyond the Body, beyond the Clinic," *Anthropology & Medicine* (2021), 8.

107 Goodwin, *Policing the Womb.*

108 Dorothy Roberts, *Torn Apart: How the Child Welfare System Destroys Black Families – and How Abolition Can Build a Safer World* (New York: Basic Books, 2022).

and deinstitutionalization of mental and physical disabilities.[109] Rancière's broad definition of policing can help us to understand how carcerality is not only effectuated by carceral institutions such as the police, the court, or the prison system, but is made up of the whole ethical, epistemic, and ontological ordering of society that determines who is more and who is less human. Marquis Bey gives us a similarly broad understanding of carcerality that extends beyond institutions typically understood as carceral. According to Bey, a carceral system is one that is:

> penchant to proliferate capture and expropriation along racist and sexist axes [...] via assumed ownership over racialized and/or non-masculinely-gendered subjects, circumscription [...], regulation of movement and inhabitation of private space, and extraction of surplus goods and resources (be it labor, sex, sexual labor, time, etc.)[110]

I continue this form of abolitionist critique by examining the carcerality and policing inherent in the institution of obstetrics. In other words, I am not focusing on how the obstetric institution contributes to traditional carceral institutions such as the police and the justice system, but rather on the ways in which obstetrics enforces its own hegemonic "partition of the sensible" when it comes to reproduction, and how it justifies this policing with a specific ethical, epistemic, and ontological configuration of reproduction. As such, I understand obstetric violence as a form of carcerality present in the obstetric institution that borders, circumscribes, confines, captures, and isolates: A carcerality that springs from the societal, moral, epistemic, and ontological ordering and policing of reproduction, which is distinct from, but connected to, the complicity with carceral institutions described by Goodwin. In my understanding, it is the carcerality and policing inherent in the obstetric institution which differentiates obstetric violence from more general reproductive violence, such as the criminalization of abortion.

Although, in the words of Ruth Wilson Gilmore, the aim of abolition is to "abolish one thing, namely everything,"[111] abolitionist movements

109 Liat Ben-Moshe, *Decarcerating Disability. Deinstitutionalization and Prison Abolition* (Minnesota: University of Minnesota Press, 2020).

110 Marquis Bey, *Anarcho-Blackness, Notes Towards a Black Anarchism* (Chico: AK Press, 2020), 94.

111 Ruth Wilson Gilmore and and Léopold Lamber, "Making Abolition Geography in California's Central Valley," *The Funambulist* December 20, 2018, https://thefunambulist.net/magazine/21-space-activism/interview-making-abolition-geography-california-central-valley-ruth-wilson-gilmore

often focus their attention on one specific institution, in order to critique the specific violence which that institution produces, exposing how that institution intersects with others, and, most importantly, what alternatives to such institutions we can come up with. Recalling Joy James's theory of the flight of the captive maternal as a political act, abolition can be understood as a flight from a specific form of captivity. Fred Moten and Stefano Harney understand fugitivity in their works *The Undercommons* and *All Incomplete* as a liberatory approach in which certain social practices are disentangled from their appropriation by an institution and practiced elsewhere.[112] In their case, they aim to fugitively liberate the practice of study from the university. They call the alternative relations that arise rom such flight an "undercommons," a sociality centered around autonomous communal, i.e., not institutional, practices. Importantly for this study, Moten and Harney's undercommons consists of "a sociality not based on the individual,"[113] or, in Denise Ferreira da Silva's words, that exists as "difference without separability."[114]

The undercommons of reproduction functions in this study as the political strategy and philosophical vantage point for abolishing the obstetric partition of the sensible through a radical reimagination and reconstitution of relationality. The hypothesis is that it is through the reconstitution of those excluded *as* relationality, *as* undividable sociality, that the hegemonic ethical, epistemic, and ontological configuration of reproduction can be abolished, in order to reach reproductive justice within and through a fugitive relationality. If the carceral logic of the obstetric institution undoes relationalities in order to isolate and capture the maternal, the political act that will resist and subvert this order consists of the fugitive healing and reconstitution of relationality through care. Ruth Wilson Gilmore says that "abolition is a form of presence, not absence," meaning that institutions can be abolished through building alternative social relations which are able to resist institutionalized forms of violence.[115] As discussed, transformative justice is, for instance, put in place of carceral justice, community care for disabled people is put in place of institutionalization, and the anti-psychiatry movement has successfully abolished various forms of oppressive institutionalized

112 Stefano Harney and Fred Moten, *The Undercommons: Fugitive Planning and Black Study* (New York: Autonomedia, 2013); Harney and Moten, *All Incomplete*.

113 Harney and Moten, *All Incomplete*, 123.

114 Denise Ferreira da Silva, "On Difference without Separability," in *32nd Bienal de Sao Paulo. Incerteza Viva*, ed. Jochen Volz et al. (Sao Paulo: Bienal Sao Paulo, 2016), 57–65.

115 Wilson Gilmore and Lamber, "Making Abolition Geography."

psychiatric care.[116] Instead of dismantling something and replacing it with nothing, the dismantling takes place via a (re)constitution of relationality. In transformative justice practices, for instance, the community is relationally present in practicing accountability together, while the carceral justice system consists mainly of relational absence. In the same manner, independent midwifery can be understood as a relational alternative for obstetrics. Where obstetrics separates, individualizes, and isolates, midwifery consists of healing these dissoluted relationalities, mainly by just "being-with."

Joan Tronto highlighted five phases of care: recognizing the need for care, taking responsibility to meet that need, the actual physical work of providing care, the evaluation of that care by the care receiver, and the democratic/societal organization of care. It is these five phases that are the key to the realization of reproductive justice.[117] Below, I will relate abolitionist practice to the specific configuration of care in the field of care ethics, asking how we should understand care from an abolitionist point of view. Joan Tronto's and Berenice Fisher's canonical definition of care is as follows:

> Everything that we do to maintain, continue, and repair our "world" so that we can live in it as well as possible. That world includes our bodies, ourselves, and our environment, all of which we seek to interweave in a complex, life-sustaining web.[118]

This definition of care has been slightly edited by Puig de la Bellacasa to broaden "our world" and "disrupt the subjective-collective behind the 'we:'"

> Care is everything that *is* done (rather than everything that "we" do) to maintain, continue, and repair "the world" so that *all* (rather than "we") can live in it as well as possible. That world includes … *all* that we seek to interweave in a complex, life-sustaining web (modified from Tronto).[119]

Although the world and the subject are already transgressed here, Inge van Nistelrooij amended this definition further to incorporate a future presence by including the not-yet, that which is still becoming and still unknown:

116 Ben-Moshe, *Decarcerating Disability*.

117 Joan Tronto, *Moral Boundaries: A Political Argument for an Ethic of Care* (New York: Routledge, 1993); Joan Tronto, *Caring Democracy. Markets, Equality, and Justice* (New York: NYU Press, 2013).

118 Tronto, *Moral Boundaries*, 103.

119 Maria Puig de la Bellacasa, *Matters of Care: Speculative Ethics in More Than Human Worlds* (London: University of Minnesota Press, 2017), 161.

> Care is everything that is done to maintain, continue, *letting become* and repair "the world" so that all can live in it as well as possible. That world includes all … that *seeks to be interwoven* in a complex, life-sustaining web (modified from Tronto and Puig de la Bellacasa)[120]

But how would we define care oriented toward abolition rather than "repair"? How do we define care oriented not toward maintaining "our" world, but toward a different one? How do we define care that does not aim to continue and be interwoven in this world, but, in the words of Marquis Bey, to flee from it, toward an otherworld?[121] What if care is to be revolutionary rather than sustaining? Transformative rather than reparative? What would care look like if it were used to bring us, in the words of Denise Ferreira da Silva, to the "end of the world as we know it?"[122] What if care were "politics" rather than "police"? How to define care that is not aimed at repair or reform, but at abolition? How can we think of care when we know that most care in this world is characterized by the policing we aim to abolish? Abolitionist care can be understood as a form of politics that aims to refuse, flee from, and abolish the police order of "our world" so that we can build another one through care. Building on Tronto, de la Bellacasa, and van Nistelrooij, "abolitionist care" could be defined as follows:

> *Abolitionist care* is everything that is done *to dismantle and flee from* "the world" *by fostering and defending otherworlds in which all already* live as well as possible. *These otherworlds* include all that seek to be interwoven in a complex, life-sustaining web *of difference without separation, committed to a justice to-come.*

Midwifery as a distinct profession, political-epistemic standpoint, and a way of "being-with" reproduction has been resisting the industrialization and institutionalization of childbirth, and is therefore promising for an abolitionist project. Traditional midwives and birth attendants were at the forefront of opposition to the expropriation of birth by obstetrics and have consequently offered a tireless and consistent critique of the specific violence and injustice that the obstetric institution produces. At the same time, they have been adamant in liberating birth from the institution and

120 Van Nistelrooij, "The Fluidity of Becoming."

121 Marquis Bey, *Them Goon Rules: Fugitive Essays on Radical Black Feminism* (Tucson: University of Arizona Press, 2019).

122 Silva, "On Difference without Separability."

taking its practice somewhere else to restitute birth to pregnant people. This does, indeed, amount to wat could be called abolitionist care. Whereas communal practices of accountability are an alternative to carceral justice, communal grassroots practices of care can be understood as an alternative to obstetric violence and racism.

To understand abolitionist care as the exemplary practice of reproductive justice not only provides for a clear practical strategy, but also changes the conception of the term "justice" into "reproductive justice"; not constituted by four abstract principles, but emerging from practices of care—hence underscoring that the reimagination of the good in matters of reproduction is something done through practice. That justice is not an abstract principle to live towards, but rather something which emerges from concrete practices is the core of the feminist field of care ethics. The notion of different normative configurations of justice has been a core feminist insight in the field of care ethics since the groundbreaking work of Carol Gilligan.[123] Gilligan conducted extensive empirical research into the reasons behind women's decisions to have an abortion and showed that their judgments are not so much based on general principles, but on specific situations and circumstances. She developed an alternative to principle-based ethics, namely a relation-based conception of justice, determined on the basis of context, practice, material dependencies, and affected relationalities, which developed into a separate field of ethics, namely "care ethics." The implication of care ethics is not that it becomes impossible to say anything general about justice, but that instead, a new normative relation to justice is constituted, which is not dependent on abstract principles, but on a materially situated practice of good care.[124] When faced with moral dilemmas, rather than adhering to general principles we should be guided by the care needs of those affected in the specific situation. It is thus the *practice* of care that develops an understanding of the "good" and is expressive of that understanding. As such, care, rather than universal rights or principles, becomes the leading normative standpoint to depart from, and the standpoint of care is always situated. Margaret Urban Walker understands this as a collaborative-expressive model of morality, in which morality is expressed within situated relational practices of responsibility.[125] Following from epistemic standpoint theory, care ethics

123 Carol Gilligan, *In a Different Voice: Psychological Theory and Women's Development* (Cambridge: Harvard University Press: 1982).

124 Tronto, *Moral Boundaries.*

125 Margaret Urban Walker, *Moral Understandings: A Feminist Study in Ethics* (2nd ed.; Oxford: Oxford University Press, 2007).

has developed a *normative* standpoint theory, in which moral understandings are configured by socially located material practices and can differ within and between groups.[126]

Daniel Loick argues that this not only implies that normativity, similarly to knowledge, is socially situated and structured by context, but, as in epistemic standpoint theory, that some people can have a *better* normative understanding of what the good is, due to their social position in the world, just as they can have a better epistemic understanding of certain phenomena.[127] When it comes to misogyny, for instance, we could argue that women not only know better what misogyny is and how it works, but that they probably also have a better normative standpoint and ethical judgment when it comes to fighting misogyny and safeguarding women from gender-based violence. Similarly, the mother, from her epistemic and normative standpoint, is better able to articulate a broader normative standpoint regarding reproductive justice than the doctor. This is where, in Loick's terms, a "counter-normativity" develops within the ethical practice of a "counter-community" that is able to confront hegemonic normative conceptions.[128] In contrast to the hegemonic understanding, these counter-normativities have the potential to create a more adequate moral understanding of what reproductive justice is, as they not only resist oppression within current society, but are able to go beyond it, thereby anticipating a different and more just world. Loick terms this the "superiority of the subjugated," a superiority that applies to both the epistemic and the ethical dimensions.[129] It is thus not only the case that mothers and doctors have a conflicting but equally valid normative conception of what justice is when it comes to reproduction, but it can be argued that people with the capacity for pregnancy potentially (just as with epistemic standpoint theory, this is a potential that has to be developed) have a better— that is, relational and contextual—moral understanding of reproductive justice, exactly because they know what it means to be captured, violated, and criminalized.

Justice, in care ethics, is therefore always that which is immanently with us in practice. At the same time, it remains crucial to acknowledge that the bio- and necropolitics of reproduction are still causing grave reproductive injustice in the form of obstetric violence and racism, uneven reproduction,

126 Daniel Loick, "Fugitive Freedom and Radical Care: Towards a Standpoint Theory of Normativity," *Philosophy and Social Criticism* 0 (2023).

127 Ibid.

128 Daniel Loick, "The Ethical Life of Counter-Communities," *Critical Times* 4, no. 1 (2021): 1–28.

129 Ibid., 15.

and racially stratified reproduction. Therefore, reproductive justice is marked by a "non-contemporaneity,"[130] as it always consists of a multiplicity of existing practices in the present, and in the past, such as the reproductive justice that was granted to my mother during her reproductive life, as well as the always not yet, since "justice" must be understood as an "indivisable" concept, which either exists for all or not at all. There is no freedom until we are all free, and there is no reproductive justice until it is justice for us all.[131] This paradoxical tension between the absence and presence of justice has been captured by Jacques Derrida in his notion of "justice to-come." According to Derrida, justice is both that which must not wait and that which we never cease to strive towards:

> it is [...] because of this always excessive haste of interpretation getting ahead of itself, because of this structural urgency and precipitation of justice that the latter has no horizon of expectation (regulative or messianic). But for this very reason, it *may* have an *avenir*, a "to-come," which I rigorously distinguish from the future that can always reproduce the present. Justice remains, is yet, to come, *à venir*, it has an, it is an *à venir*, the very dimension of events irreducibly to come [...] "Perhaps," one must always say perhaps for justice.[132]

The "perhaps" is what makes us humble in the light of justice, or, more precisely, in the light of claiming justice. While feminists such as Sanger must have been convinced of their dedication to justice, we can now see how her practice not only failed to reach reproductive justice, but how her conception of reproductive justice itself was flawed. The constant working and failing is what is captured by a justice *to-come.* It underscores once more that ideas of justice should not primarily be universalized, but that universal ideas of justice should guide normative decisions in situated, caring, relational, practices. Abolitionist care is the haste of interpretation of justice, it is the practice that cannot and will not wait, and that ensures the to-come of reproductive justice; it carries the presence of justice in the direct care that it provides, while working towards a world in which there is reproductive justice for all, all the while acknowledging that it is

130 Jacques Derrida, *Specters of Marx: The State of the Debt, the Work of Mourning and the New International* (New York: Routledge, 2006).

131 Audre Lorde, *Sister Outsider: Essays and Speeches* (Berkeley: Crossing Press, 1984).

132 Jacques Derrida, "Force of Law: The Mystical Foundation of Authority," in: *Deconstruction and the Possibility of Justice*, ed. Drucilla Cornell, Michel Rosenfeld, and David Gray Carlson (New York: Routledge, 1992), 27.

always to-come. It aims to change the ethics, epistemology, and ontology of reproduction through a counter-community of care that is expressive as well as protective of its own counter-normative conception of reproductive justice, which reconstitutes the relationship between the person and their (capacity for) pregnancy, and the relationship between the person and their community of care. Abolitionist care would mean to transgress the borders of the current partition of the sensible in reproduction, to dismantle the world and the subject as we know it, and undercommon reproduction *otherwise* for a reproductive justice to-come.

PART I

Obstetric Violence and Obstetric Racism in the Netherlands

Intermezzo. A People's Tribunal on Obstetric Violence and Obstetric Racism

During the last phase of this study, I spent the winter semester in New York City. One day, I went to the Birth Justice People's Tribunal to End Obstetric Violence and Obstetric Racism, organized by the Elephant Circle. In the middle of Manhattan, near Washington Square Park, on the top floor of one of the buildings of New York University, a big conference theater was transformed into a people's tribunal. We, the audience whose role it was to bear witness to the testimonies of the victims, were all asked to bring a picture of a loved one who experienced obstetric violence or obstetric racism. In the middle, there was an altar with flowers and all the pictures collected, including pictures of mothers who are no longer with us. The rest of the room was decorated with slogans such as "Trunks up for birth justice" and "Amplify community power."

As the skyscrapers all around us changed from tall gray immovable guards to a tidy arrangement of square stars patterning the black windows, the testimonies, hour after hour, continued. For six hours, all we did was listen. We listened to the parents and to the responses to their stories from a human rights panel consisting of activists, academics, lawyers, midwives, and doulas, who carefully interpreted and affirmed each and every testimony. They made sure that the parents felt listened to, and that their stories were dignified with detailed responses. They painstakingly repeated their experiences back to them: "this part, when you experienced this and this, this was obstetric racism. And this, when they did and did to you, this was obstetric violence."

During the day, the testimonies began to weigh more and more heavily on my mind, an experience I recognized from doing empirical research, as if with every minute that passed, their stories became more and more true. During the interviews and focus groups that I did for this study, I often had a fearful feeling of skepticism at the beginning: what if I had made it all up, what if I was exaggerating, was if it was not true at all? Then I went through a strange kind of relief when hearing the stories—no I did not make it up, it is indeed true—to then have this relief turn on me as sharply as it came—in fact, it is way worse than I thought, how have I been living in this world, working in this system all this time while not even knowing, truly knowing, how bad it is? I ended with a sense of defeat: how am I ever going to convey these stories in such a way that others will believe them?

Listening to testimonies at the people's tribunal and throughout my empirical research revealed something particularly tender and poignant—those who bear witness do not have to respond immediately. They can keep their feelings of disbelief or suspicion, their questions, affirmations or tendency towards saviorism to themselves. In these situations, the only thing that is asked of a witness is to listen to and be a holder of stories and all those testimonies. I want to propose to the reader that they do the same: to engage with the first part of this study as a people's tribunal. To bear witness, just as I did, to the stories of the participants, but then with the extra avowal of the interpretation that the human rights panel offered the participants during the tribunal: this is obstetric violence, and this here, this is epistemic injustice, that there what happened to you; yes indeed, we would say that that is obstetric racism as well. Opening this study with the image of a people's tribunal in mind—a grassroots form of justice, always organized by the people themselves—means reading the testimonies of the participants as a way to hold the obstetric institution accountable, like people's tribunals do, and to build a record of evidence. As a practice of accountability, it provides a grounding search for justice, from which to work toward a reproductive justice to-come.

1 Shroud Waving Self-determination: A Qualitative Analysis of the Moral and Epistemic Dimensions of Obstetric Violence in the Netherlands

Rodante van der Waal and Inge van Nistelrooij[1]

Abstract

The objective of the qualitative research presented in this chapter is to gain insight into the normalization of obstetric violence by focusing on the moral and epistemic injustices that both facilitate obstetric violence and make it look acceptable. We elaborate on two groups of results. First, we discuss the forms of obstetric violence most commonly mentioned by the participants, which were vaginal examinations, episiotomies, and pelvic floor support. Second, we demonstrate two major themes that concern practices related to moral and epistemic injustice: 1) "playing the dead baby card," with the subthemes of "shroud waving," "hidden agenda," and "normalizing obstetric violence"; and 2) "troubling consent," with subthemes of "not being asked for consent," "saying 'yes,'" "saying "no,'" and "giving up resistance."

Keywords

Epistemic injustice, informed consent, informed refusal, moral injustice, playing the dead baby card, care ethics.

1 A prior version of this chapter is published as Rodante van der Waal and Inge van Nistelrooij, "Shroud Waving Self-Determination: A Qualitative Analysis of the Moral and Epistemic Dimensions of Obstetric Violence in the Netherlands," *PLoS ONE* 19(4) (2024): e0297968: https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0297968.

Waal, van der, R., *Birth Justice. From Obstetric Violence to Abolitionist Care*. Amsterdam: Amsterdam University Press 2025
DOI: 10.5117/9789048562398_CH01

Introduction

Of course, there is a definition of what obstetric violence is, but I don't think we probably can just look at obstetric violence in itself, it has to be this intersection of looking at epistemic violence and … yeah. It's all interconnected, and you can only take one little thread, sort it one at a time and kind of critically shine a light and analyze these things.
—a mother

Obstetric violence (in Dutch: *obstetrisch geweld*) is not a common term in the Netherlands. The Royal Dutch Organization of Midwives (*KNOV*) and the Dutch Society for Obstetrics and Gynecology (*NVOG*) do not mention the term, nor synonyms of the term, in any official documents, statements, or guidelines. Before 2020, there were no scientific articles on obstetric violence or obstetric mistreatment and abuse in the Netherlands. Research on people's traumatic birth experiences did acknowledge that some forms of communication, rather than the unfolding of the events of birth itself, caused traumatic birth. Factors such as a lack of informed consent, lack of communication, and unilateral decision making were reported.[2] This was not connected explicitly to the already existing global critique on obstetric violence, mistreatment, and abuse, however. Recently, articles on the occurrence of obstetric violence, mistreatment, and abuse in the Dutch context have been published.[3] These articles show that 54% of parents experience mistreatment and abuse and that almost half of the people who had an episiotomy or medication during labor did not give consent for these

2 Martine Hollander et al., "Women's Motivations for Choosing a High Risk Birth Setting against Medical Advice in the Netherlands: A Qualitative Analysis," *BMC Pregnancy Childbirth* 17, no. 423 (2017); Yvonne Fontein-Kuipers et al., "Women's Traumatic Childbirth Experiences: Reflections and Implications for Practice," *Journal of Pregnancy and Child Care* (2018); Rodante van der Waal and Marit van der Pijl, "Obstetric Violence in the Netherlands," EU commission report, *forthcoming.*

3 Marit van der Pijl et al., "Client-Care Provider Interaction during Labour and Birth as Experienced by Women: Respect, Communication, Confidentiality, and Autonomy," *PLOS ONE* 16 (2021); Marit van der Pijl et al., "Disrespect and Abuse during Labour and Birth amongst 12,239 Women in the Netherlands: A National Survey," *Reproductive Health* 19, no. 160 (2022): 1-16; Marit S. G. van der Pijl et al., "Consent and Refusal of Procedures during Labour and Birth: A Survey among 11 418 Women in the Netherlands," *BMJ Quality & Safety* (2023); Rodante van der Waal et al., "Obstetric Violence within Students' Rite of Passage: The Relation of the Obstetric Subject and Its Racialised (M)other," *Agenda* (*Durban, South Africa*) 35, no. 3 (2021); Rodante van der Waal and Inge van Nistelrooij, "Reimagining Relationality for Reproductive Care: Understanding Obstetric Violence as 'Separation,'" *Nursing Ethics* 29, no. 5 (2021): 1186–1197; Rianne van Hassel, Rodante van der Waal, and Inge van Nistelrooij, "Mijn belichaamde kennis is van waarde. Een auto-etnografische, zorgethische analyse van epistemisch onrecht binnen de Nederlandse reproductieve zorg," *Tijdschrift voor genderstudies* (2022).

interventions.[4] Notably, first-time mothers and people with a migration background have a higher risk of being treated in a way that is upsetting.[5] The lack of public and professional awareness persists, however, while such mistreatment is a clear violation of human and patient rights.

This chapter aims to better understand the normalization of obstetric violence through a moral and epistemic analysis, as well as to contribute to delineating the problem of obstetric violence in the Netherlands. Because we specifically focus on moral and epistemic injustice related to obstetric violence, it is important to have some context on the awareness of obstetric violence in the Netherlands, which we first discuss below, followed by a brief note on the clinical organization of Dutch maternity care. Then, the existing research on obstetric violence in the Netherlands is elaborated upon, specifically highlighting work on epistemic injustice. Afterwards, we discuss the methodology of the study before we demonstrate the results, to close with a theorization of moral and epistemic injustice related to obstetric violence. We identify both the withholding of knowledge, the dismissal of mothers' knowledge, as well as conflicting moral understandings between mothers and medical staff on what is "justice" in reproduction. We understand these different moral understanding of justice to function as a mechanism that has the continuous dismissal of mothers as moral and epistemic agents during pregnancy and birth as a consequence—preventing both obstetrics and society in general, to take their violations of bodily autonomy and integrity seriously.[6]

Dutch Context of Obstetric Violence

In general, public awareness of the topic obstetric violence is low. There is less attention for the subject in the Netherlands than in neighboring countries such as Belgium, where a report on obstetric violence has just been accepted in the Senate, or France, where there has been a legal investigation ordered by the government.[7] In Germany, several books have appeared on

4 Van der Pijl et al., "Disrespect and Abuse"; Van der Pijl et al., "Consent and Refusal of Procedures."

5 Van der Pijl et al., "Disrespect and abuse during labour and birth."

6 Margaret Urban Walker, *Moral Understandings. A Feminist Study in Ethics* (2nd ed.; Oxford: Oxford University Press, 2007); Inge van Nistelrooij, "Humanizing Birth from a Care Ethics Perspective," (Keynote lecture, Critical Midwifery Studies Summer School, 2022).

7 Belgische Senaat, Informatieverslag over lichamelijke zelfbeschikking en het tegengaan van obstetrisch geweld. January 15, 2024, https://www.senate.be/www/webdriver?MItabObj=pdf&MIcolObj=pdf&MInamObj=pdfid&MItypeObj=application/pdf&MIvalObj=117441406; Lara Bullens, "'Too Little' Done to Combat Obstetric and Gynaecological Violence against Women," *France 24*, November 25, 2011, https://www.france24.com/en/france/20211125

the subject. Spain was found responsible for obstetric violence by the UN, and a law on obstetric violence almost passed.[8] In the Netherlands, however, there is not much public outrage on the subject, although pregnant people are more and more aware of the need for respectful care and the risk of over-medicalization. The awareness that is there was not raised through healthcare institutions or by the media, but mostly through social media accounts of momfluencers, and through workshops by activists, mothers, midwives, and doulas. Most effective was the #Breakthesilence (*#GenoegGezwegen*) campaign, in which people shared their experiences with obstetric violence, by the activist group The Birth Movement (Geboortebeweging).[9] Since a couple of years, this action has been succeeded by the action *#TakeResponsibility* (*#HandInEigenBoezem*), in which healthcare workers confess their culpability or complicity in obstetric violence.[10]

After the first *#Breakthesilence* campaign in 2016, The Birth Movement created a report with all the stories that were shared, asking for more attention to the bodily integrity of pregnant women and their right to informed consent. The report was offered to the Ministry of Health, Welfare, and Sport in February 2017. The ministry reacted in a letter in which the experiences are acknowledged, and it said that the patient should be involved in decision making.[11] However, the letter states that advisory professionals do not believe it to be a large-scale problem. They ministry wrote that by law, the rights of patients are already protected, that the organization of maternity care in the Netherlands is changing, and that different parties are working on this. The ministry stated that there were enough efforts to improve the position of pregnant people and nothing more needed to be done.[12] Even when recent numbers came out in 2022 and 2023 indicating that obstetric violence is in fact very much a large-scale problem—54% of parents experienced disrespect and abuse, almost half of the people did not

-too-little-done-to-combat-obstetric-and-gynaecological-violence-against-women; Mélanie Déchalotte, *Le livre noir de la gynecologie,* (Paris: Edi8, 2017).

8 United Nations, "Spain Responsible for Obstetric Violence—UN Women's Rights Committee Finds," *OHCHR*, July 14, 2022, https://www.ohchr.org/en/press-releases/2022/07/spain-responsible-obstetric-violence-un-womens-rights-committee-finds; Marta Borraz and Ana Requena Aguilar, "Una red de activistas, abogadas y matronas para romper el silencio de la violencia obstétrica," *El Diaro* June 19, 2021, https://www.eldiario.es/sociedad/red-activistas-abogadas-matronas-romper-silencio-violencia-obstetrica_1_8051020.html; Christina Mundlos, *Gewalt unter der Geburt: Der älltagliche Skandal*, (Berlin: Tectum Wissenschaftsverlag, 2015); Tina Jung, *Die Politik der Geburt. Kritische Perspektiven auf den Wandel von Gebären und Geburtshilfe* (Bielefeld: Transcript, 2024).

9 See: www.geboortebeweging.nl.

10 Van der Waal and Van der Pijl, "Obstetric Violence in the Netherlands."

11 Ibid.

12 Ibid.

consent to the episiotomy and medication that they got, and the refusal of interventions by patients was overruled in 20–60% of cases[13]—this ministerial statement was neither updated, nor has there been public outrage which would compel the ministry to do so. Instead, female columnists of major newspapers described the participants of the studies on obstetric violence as "whining" and "impolite" about their child being saved.[14]

The term "obstetric violence" did appear in several media outlets in the last couple of years, for instance in the newspaper *Algemeen Dagblad* ("General Daily") and on the Dutch public radio channel 1 (NPO1).[15] Brainwash, a renowned cultural platform, has an article on obstetric violence on its website and a short informative documentary on the term.[16] VICE published an article on the violation of women's rights in Dutch delivery wards mentioning the term.[17] The midwifery platform *et vroede geluid* ("The Wise Voice") has a long read on obstetric violence and has published an English and Dutch informative video on the term.[18] The pregnancy magazine *Baby op komst* ("Baby on the Way"), made by midwives for pregnant people, has an article on obstetric violence on its website.[19] And the magazine for professional birth workers *vakblad Vroeg* ("Early") has an article on obstetric violence as well.[20] *De Correspondent* ("The Correspondent") recently published an extensive article on obstetric violence.[21]

13 Van der Pijl et al., "Disrespect and Abuse"; Van der Pijl et al., "Consent and Refusal of Procedures."

14 Van der Waal and Van der Pijl, "Obstetric Violence in the Netherlands"; Linda Akkermans, "U wilt geen inleiding mevrouw? Pech, doen we lekker toch!" *Algemeen Dagblad*, May 23, 2023; Silvia Witteman (@silviawitteman), "Hebben ze je kind gered en dan zeiken dat het 'in overleg' had gemoeten," *Twitter*, May 23, 2023.

15 Margot van Dijk, "Geen knip, geen meting, geen inwendig onderzoek: nee zeggen tijdens je bevalling mág," *Algemeen Dagblad*, November 29, 2021; Rodante van der Waal, *Zomerradio Brainwash*, Human, NPO1, July 2022, https://open.spotify.com/episode/2lmwGTpRq68WHPgKE622Ny

16 Rodante van der Waal, "Niet de bevalling veroorzaakt trauma, maar het verlies van controle en autonomie," *Brainwash, Human*, August 4, 2022, audio, 1:00:00, https://www.brainwash.nl/programmas/brainwash-zomerradio/seizoen-2022/rodante-van-der-waal.html; Rodante van der Waal and Rianne van Hassel, "Obstetric Violence," *Brainwash* Bits, filmed November, 2022, video, 9:18, https://youtu.be/Rnvg6T2j3sY.

17 Adriana Ivanova, "Hoe vrouwenrechten grof geschonden worden in de Nederlandse verloskamers," *Vice* December 11, 2017.

18 Rianne van Hassel, "Obstetrisch geweld," *Het vroede geluid*, November 3, 2021, https://hetvroedegeluid.nl/?p=721.

19 "Obstetrisch geweld," *Baby op komst*, accessed on August 9, 2023, https://babyopkomst.nl/news/obstetrisch-geweld/.

20 "Omgaan met geweld tijdens de bevalling," *Vakblad Vroeg*, accessed on August 9, 2023, https://www.vakbladvroeg.nl/omgaan-met-geweld-tijdens-de-bevalling/.

21 Françoise Molenaar, "Wie is de baas bij jouw bevalling?" *De Correspondent* August 10, 2023, https://decorrespondent.nl/14707/wie-is-de-baas-tijdens-jouw-bevalling/93e10dc9-05f4-06cb-3fbc-f2f4f4dee2f2.

This fragmented media attention, dispersed over a couple of years, did not, however, cause public scrutiny of maternity care or a response from the broader feminist movement. Neither did it provoke any statements, working groups, or investigations in professional organizations for midwives or obstetricians.[22]

As has been studied globally, the consequences of obstetric violence can be severe, and there is reason to believe that this is also the case in the Netherlands. In the *#Breakthesilence* campaign, short- and/or long-term consequences were mentioned, such as emotional trauma, difficulty sleeping, and being (too) scared to give birth again (tokophobia).[23] Another study shows that 9% of people who give birth in the Netherlands have a very negative or traumatic birth experience.[24] This percentage is the same as the percentage found ten years earlier, indicating that not much has changed.[25] PTSD was found in 1.2% of the respondents.[26] There is evidence linking obstetric violence to the occurrence to PTSD and postpartum depression following labor and birth.[27] It is important to point out, however, that there can be negative consequences of a violent birth experience, such as a lack of trust, not being able to have a good birth experience anymore, feeling betrayed, and many other long-term ramifications, that are not captured by the above numbers because they did not lead to severe psychological trauma. We know that at least 36% of birthing people found something about the way they were treated during childbirth "upsetting,"[28] hence important enough—keeping in mind the amount of normalized obstetric violence—to regret the experience.

A Note on Clinical Context

Dutch maternity care is organized differently than in other countries. The system is divided in "primary" midwife-led care and "secondary" and "tertiary" obstetrician-led care. In case of a low-risk pregnancy, pregnant people receive midwife-led care in the community by a primary care midwife.

22 Van der Waal and Van der Pijl, "Obstetric Violence in the Netherlands."

23 Ibid.

24 Van der Pijl et al., "Disrespect and Abuse."

25 Claire A. I. Stramrood et al., "Posttraumatic Stress following Childbirth in Home-Like and Hospital Settings," *Journal of Psychosomatic Obstetrics & Gynecology* 32, no. 2 (2011): 88–97.

26 Ibid.

27 Van der Waal and Van der Pijl, "Obstetric Violence in the Netherlands"; Sergio Martinez-Vázquez et al., "Factors Associated with Postpartum Post-Traumatic Stress Disorder (PTSD) Following Obstetric Violence: A Cross-Sectional Study," *Journal of Personalized Medicine* 11, no. 5 (2021): 338.

28 Van der Pijl et al., "Disrespect and Abuse."

People can choose to give birth either at home, in a birth center, or in a hospital with the primary care midwife as the responsible care provider. Primary care midwives are therefore a strong independent professional group in the Netherlands. In case of risk factors or complications during pregnancy or labor, people are referred to obstetrician-led care, where they are tended to by nurses, hospital-based midwives, general doctors, gynecologists, and gynecologists in training. This makes the Netherlands a unique setting to study obstetric violence through a range of maternity care practices. When it comes to experiences of obstetric violence, midwives and obstetricians were mentioned by parents in roughly equal numbers in the *#Breakthesilence* campaign, indicating that people experience disrespect and abuse throughout the Dutch maternity care system.[29] However, several studies on experienced "client-care provider interaction" during labor and birth in the Netherlands showed that people who give birth with a community midwife at home experience more respect, communication, autonomy, and confidentiality in the interaction compared to women who give birth at the hospital with a (resident) obstetrician or hospital-based midwife.[30]

Despite the system of autonomous midwifery care, care is still often defined by a top-down hierarchical system in which doctors ultimately decide when someone should be referred to the hospital. The decisions of doctors can, in line with obstetrics globally, be described as risk-aversive.[31] If a midwife does not refer someone to the hospital when the hospital thinks they should, midwives are called out. This can cause differences of opinion on who is the deciding professional in terms of risk selection; officially this is the midwife, and these differences lead to discussions between doctors and midwives or unclarity in various protocols. This can be confusing for pregnant people—one moment they are in midwifery care and the next moment they have been taken over by obstetric care—and they have limited control over these referral policies, especially when they do not have much

29 Marit van der Pijl et al., "Left Powerless: A Qualitative Social Media Content Analysis of the Dutch #breakthesilence Campaign on Negative and Traumatic Experiences of Labour and Birth," *PLOS ONE* 15, no. 5 (2021): 1–21.

30 Van der Waal and Van der Pijl, "Obstetric Violence in the Netherlands"; Van der Pijl et al., "Client-Care Provider Interaction during Labour and Birth"; M.E. van den Akker-van Marle et al., *Evaluatie van zorg in geboortecentra in Nederland* (TNO, 2016).

31 Van der Waal and Van der Pijl, "Obstetric Violence in the Netherlands"; Eline van Manen et al., "Experiences of Dutch Maternity Care Professionals during the First Wave of COVID-19 in a Community Based Maternity Care System," *PLOS ONE* 16, no. 6 (2021); Jo Murphy Lawless, *Reading Birth and Death. A History of Obstetric Thinking* (Bloomington: Indiana University Press, 2021).

social privilege.[32] Consequently, pregnant people wishing to take more risks than is recommended in the official protocols are quickly seen as a problem. In an attempt to battle this, prominent birth activists such as the independent midwife Rebekka Visser and the gynecologist Gunilla Kleiverda have drawn up a professional guideline for care outside the guidelines, which has given pregnant people and care workers willing to go outside of the guidelines an important tool to advocate for their rights.[33]

Scientific Studies on Obstetric Violence in the Netherlands

Two quantitative studies on obstetric violence were conducted in the Netherlands based on one survey in which approximately 13,000 people participated.[34] 54.4% of respondents reported at least one form of disrespect and abuse. "Lack of choices" (39.8%) was reported most, followed by "lack of communication" (29.9%), "lack of support" (21.3%) and "harsh or rough treatment/physical violence" (21.1%).[35] 42% of the people who got an episiotomy did not give consent, 47% of people who got medication did not give consent, and around 36% did not give consent for electronic fetal monitoring or a fetal scalp electrode. Of the people who refused an intervention, many were overruled, respectively 40% in the case of vaginal examination, 60% in the case of medication, and 40% in the case of an episiotomy.[36]

In 2020, a qualitative content analysis was performed to investigate the stories shared in the *#Breakthesilence* campaign, based on Bohren's typology.[37] Situations of ineffective communication, loss of autonomy,

32 Van der Waal and Van der Pijl, "Obstetric Violence in the Netherlands"; Bahareh Goodarzi et al., "Towards a Better Understanding of Risk Selection in Maternal and Newborn Care: A Systematic Scoping Review," *PLOS ONE* 15, no. 6 (2020); Bahareh Goodarzi et al., "Risk and the Politics of Boundary Work: Preserving Autonomous Midwifery in the Netherlands," *Health, Risk & Society* 20, no. 7–8 (2018): 379–407; BaharehGoodarzi et al., "Models of Risk Selection in Maternal and Newborn Care: Exploring the Organization of Tasks and Responsibilities of Primary Care Midwives and Obstetricians in Risk Selection across The Netherlands," *International Journal of Environmental Research and Public Health* 9, no. 3 (2022): 1046.

33 Van der Waal and Van der Pijl, "Obstetric Violence in the Netherlands"; KNOV and NVOG, *Leidraad: Verloskundige zorg buiten de richtlijnen* (Utrecht: 2015), https://www.knov.nl/zoeken/document?documentRegistrationId=11862017

34 Van der Pijl et al., "Disrespect and Abuse"; Van der Pijl et al., "Consent and Refusal of Procedures."

35 Van der Pijl et al., "Disrespect and Abuse."

36 Van der Pijl et al., "Consent and Refusal of Procedures."

37 Van der Pijl et al., "Left Powerless"; Meghan A. Bohren et al., "The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review," *PLoS Med* 12, no. 6 (2015): 1–32.

and lack of informed consent and confidentiality were most commonly mentioned. Five main themes were established: "lack of informed consent," "not being taken seriously and not being listened to," "lack of compassion"; "the use of force," and "short- and long-term consequences." These situations were often described in combination with a lack or losing control, fear, being objectified, and being humiliated. "Left powerless" was identified as the overarching theme; people felt that power was taken away from them, or they experienced difficulties maintaining control due to situations that occurred. In around one fifth of stories, a form of use of force was described, mostly during the active stage of labor and in relation to interventions being carried out.[38]

In 2020–2021, a cross-cultural thematic analysis was done on the effect of obstetric violence and obstetric racism in the training of midwives and doctors.[39] Students' curricular encounters in two colonially related geopolitical spaces, South Africa and the Netherlands, were amplified to highlight global systemic tendencies that push students to cross ethical, social, and political boundaries towards the mother they are trained to care for. Obstetric violence was understood as a fundamental part of students' rite of passage in becoming professionals. The following violent instances within the rite of passage that lead to the reproduction of obstetric violence were identified: "having to adapt the goals, norms, and values of the obstetric institution that instrumentalize the mother," "establishing subjectivity through assertiveness, and competition," "learning at the cost of mothers," "colluding in explicit obstetric violence, obstetric racism, and sexual violence," "traumatic experiences," "complicity," "balancing guilt with numbness," and "taking responsibility at the cost of mothers." The article shows how the presence of obstetric violence in students' training is an essential part of its normalization, and hence of the perpetuation of obstetric violence within the obstetric system.

Epistemic injustice is broadly defined as an unequal relationship in the domain of knowledge, meaning either that some have less access to knowledge than others, that some people are regarded as epistemic agents and others not, or that authoritative knowledge is used to manipulate someone. The analysis of the *#Breakthesilence* campaign showed that in almost half the stories, people report being ignored and/or not taken seriously. For instance, when care workers talked not *to* but *about* mothers

38 Van der Waal and Van der Pijl, "Obstetric Violence in the Netherlands"; Van der Pijl et al., "Left Powerless."

39 Van der Waal et al., "Obstetric Violence within Students' Rite of Passage."

while they are present in the room.[40] In 2023, an auto-ethnographic study was published in which the epistemic component of obstetric violence was investigated.[41] This was the first study on obstetric violence in the Netherlands that specifically centered epistemic injustice as an important part of obstetric violence. Through a narrative analysis of four auto-ethnographic experiences with birth and miscarriages in the Netherlands, four forms of epistemic injustice in Dutch reproductive care were analyzed through the theoretical literature on the subject: "hermeneutic injustice," "testimonial injustice," "gaslighting," and "willful hermeneutic ignorance." Hermeneutic injustice is when a pregnant person does not have the right knowledge or discourse to understand and explain the obstetric violence being done to them. Testimonial injustice is when a pregnant person is not believed or not taken seriously with regards to the violence done to them. Gaslighting is when the knowledge of the pregnant person is doubted in such a way that it is insinuated that the pregnant person is crazy or a bad mother.[42] And, in the words of Gail Polhaus, "willful hermeneutical ignorance occurs when dominantly situated knowers refuse to acknowledge epistemic tools developed from the experienced world of those situated marginally. Such refusals allow dominantly situated knowers to misunderstand, misinterpret, and/or ignore whole parts of the world."[43]

Methods

Participants and Sampling

The study design is Responsive Evaluation (RE), adapted to care ethics.[44] Additionally, this study was specifically designed according to the insights of standpoint theory, which regards experiences of marginalized people as a

40 Van der Waal and Van der Pijl, "Obstetric Violence in the Netherlands"; Van der Pijl et al., "Left Powerless."

41 Van Hassel et al., "Mijn belichaamde kennis is van waarde."

42 Sara Cohen Shabot, "Amigas, Sisters: We're Being Gaslighted," in *Childbirth, Vulnerability and Law*, ed. Camilla Pickles and Jonathan Herring (London: Routledge, 2020): 14–29.

43 Gail Pohlhaus, "Relational Knowing and Epistemic Injustice: Toward a Theory of Willful Hermeneutical Ignorance," *Hypatia* 27, no. 4 (2012).

44 Tineke Abma and Guy Widdershoven, "Sharing Stories: Narrative and Dialogue in Responsive Nursing Evaluation," *Evaluation & the Health Professions* 28, no. 1 (2005): 90–109; Merel Visse, Tineke Abma, and Guy Widdershoven, "Practising Political Care Ethics: Can Responsive Evaluation Foster Democratic Care?" *Ethics & Social Welfare* 9, no. 2 (2015): 164–182.

source of knowledge.[45] The epistemic value of the knowledge of marginalized groups can remain unrecognized, which is why it is important in the study design to pay attention to how this is best brought to the fore. The study design was also adapted according to the insights of care ethics, which holds that theory and empirical data are always constituted dialectically and cannot be objectively separated.[46]

Thirty-one participants were recruited by the first author. The participants were ten mothers, eleven midwives, five doulas, and five midwives in training. Most of the birth workers are also mothers. People were contacted through personal networks, as well as through the activist organization The Birth Movement (Geboortebeweging). Participants were also recruited via snowball recruitment. Sample criteria were extensive knowledge (either scholarly, experiential, embodied, etc.) of obstetric violence, mistreatment in maternity care, violation of rights during pregnancy and birth, and/or active engagement with activism or alternative forms of care. This means that all participants were critical (ranging from quite critical to very critical) of Dutch maternity care, and that they had experience with, and ideas on, how care for birth can be better and more emotionally safe. To be able to include a breadth of perspectives, analyses, and practices, attention was paid to establishing a diverse group of participants in terms of both identity—such as people with and without a migration background—and practices—such as community midwives and caseload midwives. Some participants engaged in direct activism, for instance as part of The Birth Movement, others in reading and study, some privately and others as scientists and educators, while others made art related to the subject, and again others offered alternative forms of pregnancy and birth care, such as care outside professional guidelines.

It is important to note that this study, as a qualitative one, does not aim to represent the general experiences of the Dutch population with regard to Dutch maternity care. For this purpose, we refer to the work of Marit van der Pijl discussed above, who did a mixed methods analysis of a large group of participants based on a questionnaire, and a study of the *#Breakthesilence* campaign. In this study, we conducted in-depth interviews and held focus groups with critical and engaged people from the field, to be able to get a better understanding of the already existing practical knowledge on the main

45 Sandra Harding, *The Feminist Standpoint Theory Reader: Intellectual and Political Controversies* (New York: Routledge, 2004).

46 Carlo Leget, Inge van Nistelrooij, and Merel Visse, "Beyond Demarcation: Care Ethics as an Interdisciplinary Field of Inquiry," *Nursing Ethics* (2017).

patterns enabling obstetric violence and the potential solutions. Participants were hence selected on their ability to think critically about obstetric violence. So, most participants already thought that obstetric violence exists and is a serious problem prior to participating in the study. As such, we do not pretend that our participants present the average Dutch population; there are of course many midwives and mothers in the Netherlands who have never heard of obstetric violence, or who do not think that it exists or is a serious problem. We have deliberately selected our participants on their ability to analyze the root causes of obstetric violence, in order to tap into their critical capacity.

Data Collection

Following the method of Responsive Evaluation, data were collected in three rounds: individual interviews, homogenous focus groups, and heterogenous focus groups.[47] Interviews were conducted by the first author in 2020. Recruitment started on June 15, 2020 and ended on December 1, 2020. Because of the Covid-19 pandemic, almost all of them were online. Some participants did not want to participate online; these interviews were held in person. All interviews lasted on average a bit over two hours and were in-depth. They were semi-structured, based on familiarization by the interviewer with the interviewee's thought as expressed in previous conversations, publications, Facebook discussions, etc. There was a minor interview guide with themes and questions based on the familiarization of the interviewer with the thoughts and views of the participants; the guide was only applied when the need arose to lift the conversation to an analytical level, no additional external themes were added to the topic list. Open, non-directive formulations that were consistent with the interviewee's own vocabulary were used. Notes were made during the interviews. The interviews were recorded, anonymized, and transcribed ad verbatim. Two recordings were lost due to a technical failure, but the notes were still used. After the first round of individual interviews, they were preliminarily analyzed by the first author, and a general thematic analysis of the group as a whole was sent to the participants for a member check.[48] The participants were given the opportunity to give feedback in writing or during the following focus groups.

Homogenous focus groups were conducted at the end 2020 and beginning of 2021. For organizational reasons (primarily the difficulty of finding a

47 Abma and Widdershoven, "Sharing Stories."

48 Virginia Braun and Victoria Clarke, "Using Thematic Analysis in Psychology," *Qualitative Research in Psychology* 3, no. 2 (2005): 77–101.

suitable timeslot for the entire group), multiple homogenous groups were formed, six in total (two groups of four midwives each; one group of five doulas; one group of four midwives in training; one group of three, and one of four mothers.) The focus group interviews were semi-structured, with a topic list based on the analysis of the individual interviews. They lasted on average almost three hours. They were all done online, recorded, anonymized, and transcribed ad verbatim. The homogenous focus groups were then again preliminarily analyzed, and this thematic analysis was sent again to the participants for a member check.

Heterogenous focus groups were conducted in 2021. Three heterogenous focus groups were done, since it was difficult to get more people together on the same date (two focus groups with five participants, and one with six). The groups were all mixed. The focus group discussions were semi-structured with a topic list based on the analysis of the homogenous focus groups. They were done online, recorded, anonymized, and transcribed ad verbatim.

Data Analysis

The analysis was conducted by the main author through Atlas.ti under supervision of the second author. The Thematic Analysis (TA) method was used.[49] TA has 5 phases before drawing up the results: 1) familiarizing yourself with the data; 2) generating initial codes; 3) searching for themes; 4) reviewing themes; 5) defining and naming themes. The first and second phase were done after every step as part of the RE study design. After all the data were collected, we again familiarized ourselves with the dataset as a whole by reading through the transcripts again and comparing the different data that came out of the different phases of the RE design. We then searched for themes, and found many, due to the amount of data we collected. For this study, we therefore decided on the moral and epistemic dimensions of obstetric violence, and not, for instance, on the broader cultural causes and mechanisms of obstetric violence (for instance more historical and cultural theories on why there is obstetric violence), or on activist resistance against obstetric violence, or on obstetric racism. These are all discussed in separate studies, which can be found in chapters 2, 3, and 7 of this book. After making this decision, we reviewed all the themes and again went back to the data, to see if this differentiation made sense. Afterwards, we came to the last step of defining and naming themes for this specific study.

49 Ibid.

Positionality

We were aware of our positionality during the study. Rodante (she/they) is a cisgender white middle-class woman who is a practicing midwife in Amsterdam and a PhD candidate in care ethics. Inge is a cisgender white middle-class married mother of three who works as an associate and endowed professor in two universities respectively. Partly because of our positionality, we decided not to include the topic of obstetric racism in this chapter but to dedicate a separate study to this issue, with scholars and midwives of color to help us analyze the data and author the paper together. We recognize that our positionality, as a midwife and a mother, influences the way we understand the data and the participants. Therefore, we do not claim to be objective. Rather, we believe that our proximity as researchers to the standpoint of the participants makes it possible for us to deeply understand and represent the data within the limitations of our identity and position. Our positionality as researchers is hence in line with standpoint theory, on which our study design is based.

Ethical Considerations

This research was evaluated and approved by the Ethische Toetsing Commissie ("Ethical Judgement Committee") (ETC) of the University for Humanistic Studies in January 2021. The Medische Ethische Toetsing Commissie ("Medical Ethical Judgement Committee") (METC) of the University of Utrecht decided in 2019 that the Dutch Medical Research Involving Human Subjects Act (WMO) did not apply, as participants were not patients but mentally competent citizens, and participants were not subjected to treatment or required to follow a certain behavioral strategy as referred to in the WMO (art.1b).

All participants were given an information sheet prior to the study and there was room for questions at the beginning of the individual interviews. Privacy details were discussed and their right to withdraw at any moment was made explicit. They all gave written informed consent to their participation in the study and most for the anonymized publication of the interviews and focus groups in the DANS archives.

Results

Below, we present two sets of results. First, we list the most common forms of physical obstetric violence in the Netherlands that have come out of this

study, respectively "vaginal examination," "episiotomy," and "pelvic floor support." These are not the only forms, but they are the ones most mentioned by the participants—they came most often to the minds of the participants when discussing obstetric violence. We share these results so that the reader can get an idea of what the participants mostly understand physical forms of obstetric violence to mean, and since these forms of obstetric violence come back frequently in the second set of results. The second set of results concerns the main themes of the analysis of obstetric violence as related to moral and epistemic injustice. The main themes can be read, and judged, as practices that facilitate, reproduce, and justify the forms of physical obstetric violence in the first set of results. The two main themes established when it comes to epistemic injustice are: 1) "playing the dead baby card," with the subthemes of "as shroud waving," "as hidden agenda," "as the normalization of obstetric violence"; and 2) "troubling consent," with the subthemes of "not being asked for consent," "saying 'yes,'" "saying 'no,'" "giving up resistance."

Most Common Forms of Physical Violence

In this study, most cases of physical obstetric violence consist of interventions done without consent, without sufficient consent, or despite explicit refusal. Neither in this study, nor in the those by Van der Pijl, was physical violence outside of medical interventions mentioned, such as pinching or slapping, which were reported in other countries.[50] The examples below are the physical forms of obstetric violence that came up in conversation most often (at least in three individual interviews and one focus group), listed from most to least often, and that were recognized by the participants as interventions that happen on a regular basis. Other forms of obstetric violence were recounted as well, such as getting an IV or medication without consent, being stitched without proper anesthesia or having to wait very long for anesthesia, or inspection of the anus after labor without sufficient consent and information, but they were reported less often. Interestingly, all forms below have to do with unconsented, unwarranted, or unwanted vaginal penetration.

50 Dubravka Šimonović, "A Human Rights-Based Approach to Mistreatment and Violence against Women in Reproductive Health Services with a Focus on Childbirth and Obstetric Violence. Note by the Secretary-General," *Report of the Special Rapporteur on Violence against Women* (New York: United Nations, 2019). https://digitallibrary.un.org/record/3823698; Rachelle Chadwick, *Bodies that Birth: Vitalizing Birth Politics* (London: Routledge, 2018).

The first physical form of obstetric violence, vaginal examinations, was mentioned in nine individual interviews and two focus groups. The second one, episiotomy, was mentioned in eight individual interviews and two focus groups. The third and last one, pelvic floor support, was mentioned in three individual interviews and one focus group. Note that the participants were not explicitly asked to list forms of obstetric violence that they had experienced or encountered, since the interviews were focused on the causes of, and solutions to, obstetric violence. These are hence all experiences that the participants mentioned as exemplary cases of obstetric violence on their own account. For each form of obstetric violence, one quote is provided.

Vaginal examination
It's always annoying when people touch you. And if someone touches you down there, you just feel like an object, you know? [...] *At one point, they told me: "We have to let the next shift know how far you are." And then I said: "Do you really have to?"* [...] *Until then I said every time: "I do not need to be examined, we will just see." And then they said again: "We need to know how far you are for the next shift."* [...] *I told her beforehand: "If I say stop, you have to stop." And then I said stop, but she just wanted to know how far I was. So, as I said stop, I felt her fingers go further and I felt her fingers spreading. Later I said to her: "I said no, but you continued." When she left, I had to cry.* (*Mother 10*)

Unconsented, unwarranted, or unwanted vaginal examinations are the most common form of physical obstetric violence listed in this study. As a procedure in a highly intimate region of the body which might have been part of experiences with sexual violence, it is experienced as very invasive. Mothers complain about multiple people doing vaginal examinations during their labor. The participants, both mothers and midwives, say mothers often do not know that they can refuse vaginal examinations, neither do they know that the regular performance of such examinations is a highly contested and often a non-evidence-based intervention.[51] While only 7% of participants in Van der Pijl's research list that they were not asked for consent for vaginal examinations, 60% of those who refused the examination said that their refusal was overruled.[52]

51 Soo Downe et al., "Routine Vaginal Examinations for Assessing Progress of Labour to Improve Outcomes for Women and Babies at Term," *Cochrane Database of Systematic Reviews* 7 (2013).
52 Van der Pijl et al., "Consent and Refusal."

Episiotomy
A few moments later, the doctor pulled out the scissors, and the woman cried out: "No, I don't want to be cut." And then the doctor went to her and said: "You and I both know that the only thing that is important, is that the baby gets out alive." And then she said: "But I don't want to be cut, I want to do it myself." And even the midwife that was there said afterwards: "There was really no need to cut, also not from the monitor, the baby was doing fine, there was no need to cut." [...] *And the doctor said to her: "Okay, I will give you two contractions. And if by then, the baby is not born, I will cut."* [...] *And then, after only one contraction, instead of keeping her promise, she made the cut.* (*Doula 4*)

Episiotomies, when done unconsented, are probably the most well-known form of obstetric violence. It is a cut through the vaginal wall and the muscles of the pelvic floor. As in the quote above, the "dead baby card," a form of shroud waving where the risk to the baby's life is exaggerated to make the mother comply with the proposed policy, is often played to convince the mother, as well as to justify the obstetric violence being done. This form of manipulation will be further elaborated in the second set of results below. In the Netherlands, the only indication for an episiotomy is when the life of the fetus is in danger. But there is an enormous difference in the number of episiotomies between hospitals and between birth workers in the Netherlands, ranging from 14% to 67% depending on whether the birth was midwife- or obstetrician-led and depending which hospital one is in, and an 8% to 48% difference depending on the individual care worker within the hospital.[53] This variation indicates that episiotomies are done much more frequently than only in cases of life-threatening emergencies, and that the chance of having or not having an episiotomy depends more on external circumstances than on the process of birth. Additionally, 42% of participants who had an episiotomy in Van der Pijl's research were not asked for consent, and 25% of those who refused the cut were overruled.[54]

Pelvic floor support
Pelvic floor support is something that I find very intense—that you just keep putting your fingers in someone's vagina every contraction, just like that, and

53 Renate Simmelink, Etelka Moll, and Corine Verhoeven, "The Influence of the Attending Midwife on the Occurrence of Episiotomy: A Retrospective Cohort Study," *Midwifery* 125 (2023); Anna Seijmonsbergen-Schermers et al., "Regional Variations in Childbirth Interventions and Their Correlations with Adverse Outcomes, Birthplace and Care Provider: A Nationwide Explorative Study," *PLOS ONE* 15, no. 3 (2020).
54 Van der Pijl et al., "Disrespect and Abuse."

hard too [...] *Especially if you also put someone on their back in a bed. I always have to think of an insect when I see it, you know? An insect that lies on her back, on her shield, incapable of moving.* (*Midwife 11*)

Pelvic floor support is a very unknown form of obstetric violence, which is almost never listed in any of the international literature. Nor was it part of the other Dutch studies on the subject. Pelvic floor support is a technique in which the birth worker during the second stage of labor inserts two fingers of each hand into the vagina to "pull," or, euphemistically, "massage," the pelvic floor away during each contraction, to create more space for the head; it is often performed without (sufficient) consent. It is an intervention done to speed up the pushing phase and sometimes to make clear to the laboring person in which direction to push. It is an invasive intervention, given the weight the birth worker throws behind stretching the pelvic floor. Sometimes, if done without enough lubrication or with the wrong gloves, or if it is simply done with too much force, it can cause ruptures of the vaginal wall.

These three forms of physical obstetric violence—unconsented vaginal examinations, episiotomies, and pelvic floor support—that are some of the most common in the Netherlands, will return amongst other instances of violence in the moral and epistemic dimensions of obstetric violence studied below.

Moral and Epistemic Injustice

Many different forms of moral and epistemic injustice are mentioned in the study. We choose to zoom in on two specific practices in which both moral and epistemic injustice come to the fore, namely 1) "playing the dead baby card," with the subthemes of 'shroud waving," "hidden agenda," and "normalizing obstetric violence," and 2) "troubling consent," with the subthemes of "not being asked for consent," "saying 'yes," "saying 'no,'" and "giving up resistance."

Playing the Dead Baby Card

Something that was mentioned often by the participants in discussing obstetric violence was the moral priority of the baby over the mother, made explicit in what is known as "playing the dead baby card," a form of shroud waving specific to obstetrics. This practice happens globally in maternity care, and consists of care workers either not properly explaining the precise

risk of the baby dying (for instance, when it is said that the risk that the baby dies "doubles," when it only goes from 0.1% to 0.2%), or simply exaggerating the chance of the possible death of the fetus to get the parent to comply with their proposed policy. But the dead baby card can also be played not as an explicit form of shroud waving, instead appearing as an implicit accusation or a hidden agenda, or it can be used after labor to normalize or justify the obstetric violence that took place during birth. In all three cases discussed below, an implicit moral understanding on the part of birth workers of what the right thing to do is in matters of reproduction becomes tangible which is sometimes in conflict with mothers' own normative configurations.

As shroud waving

She was the head of the department. She was a big, very beautiful older woman and you saw that she really feels her place of power. [*During our prenatal consult*]*, she started to cry. She teared up and then she said: "I am sorry, I know it is not professional, but I have just seen a lot of dead babies." Yeah … I am not shitting you. And I thought: she can't help me. This is obviously not a place where they have their shit together because the top of the gynecology department is crying in front of me. That's not what I had in mind, you know. But my partner, he bought it.* […] *And he said: "I don't want the baby to die. I don't want the baby to die." And I felt so manipulated. I felt so coerced.* (*Mother 1*)

In the quotation above, the dead baby card is played very directly and theatrically. It was used as the last resort by the doctor to get the mother to comply with hospital policy. This particular discussion was about the fact that the mother did not want to be induced when this was recommended by the guidelines. Note that induction rates in the Netherlands are highly dependent on the region, ranging from 14.3% in some areas to 41.1% in other areas.[55] Moreover, the mother was considered high-risk due to a high BMI, so they wanted her to birth in the hospital while she wanted to give birth at home. And while there was a medical reason to be induced because of a slight increase in risk, it remained, of course, the mother's decision. Due to the mother's desire to give birth at home despite a slight increase in risk, the midwife wanted her to speak with a gynecologist, which is something that is often recommended by independent primary care midwives when people have alternative care plans. And while the mother did not want to

55 Pien Offerhaus et al., "Regional Practice Variation in Induction of Labor in the Netherlands: Does It Matter? A Multilevel Analysis of the Association between Induction Rates and Perinatal and Maternal Outcomes," *PLoS ONE* 18, no. 6 (2023).

do this herself, she made an appointment with the gynecologist to satisfy the midwife. At the time of their meeting, the mother had already made her decision and already had to defend it multiple times to her own midwife. She experienced the encounter with the gynecologist as very manipulative. Five days later, she gave up her resistance, since she was tired, scared, and without support, and she went into the hospital. There, they started the medication for the induction without her consent: "At one point I went to sleep, and while I was sleeping they started contractions." (Mother 1)

Multiple forms of shroud waving were used to get the participants in this study to comply with proposed interventions. Doulas and midwives in training also reported shroud waving as a form of obstetric violence. Midwives, however, more often recognized the dilemma between trying to convince someone of the proposed policy and avoiding manipulation and pressure.

As a hidden agenda

The first thing [*the psychiatrist of the hospital*] *said* [*during the prenatal consult*] *was: "So, you had a psychosis three times?" He looked at us very intensely: "That is extremely bad, of course you do not want that to happen again?"* [...] *The thought behind it was that in a bout of madness I could kill my child, and that had to be prevented. I think this is the thing that is not spoken about but that* [*birth workers*] *find the scariest. That they would have to deal with a mother who would kill her own child and that they could have prevented it.* [...] *So, they will ensure that a path is followed in which this is prevented by any means necessary.* [...] *They put you under supervision in an institution, including the flattening of my mind* [*by medication during pregnancy, birth and postpartum*] *and everything.* (*Mother 2*)

This mother had experienced psychosis in the past, which made her high-risk for another psychosis. She had been off medication for a long time, however, and she and her husband had a lot of experience with managing her mental health. She had a deep desire to experience childbirth consciously, without medication that, based on her own experiences with it, "flattens" her mind. She had her own familiar psychiatrist who also thought it would be possible to give birth without medication. The consultation with the psychiatrist from the hospital was planned, the parents thought, to discuss how she could go through pregnancy and childbirth without using medication. The hospital psychiatrist, however, refused to think along with them. Instead, the mother felt like the possible death of the baby—or more precise: the possible murder of the baby by the mother—was given as an implicit reason

for her to start medication. The fact that the dead baby card was not played openly, but that the psychiatrist beat about the bush,like it was a kind of taboo, made the situation even more stigmatizing for the mother, as if she was already rendered "mad" at the time of the conversation, making it safer not to address the baby's death explicitly to keep the conversation calm. Not only did the mother experience the implicit reference to the baby's life as a way to gently coerce her into taking medication she did not want, but she also felt dismissed as an epistemic agent during the conversation itself, as if the hypothetical death of the baby during her hypothetical psychosis already compromised her epistemic capabilities at the moment of the consultation. Just as in the case above, this consultation happened while the parents had no need for more information on the benefits of the hospital policy, and they had already been through multiple consultations having to defend themselves. At the time of writing, they have two children who were born without the mother having taken any medication and without her having had a psychosis. They have carefully managed the pregnancy, childbirth, and postpartum period together with community midwives, social workers, and her own psychiatrist.

As the normalization of obstetric violence
There's a whole normalization throughout society about it being okay and normal for you to be treated this way. In my case, there were three people [*birth workers*] *present at the birth of my kid. All three apparently thought it was super normal what happened while I was being traumatized.* [...] *And then* [*at the consultation*] *afterwards, he* [*the gynecologist*] *was being very nice while turning my story around completely, really gaslighting.* [...] *He said: "Of course you experienced that as horrible, but yes, it was necessary, because otherwise we don't know what would have happened..."* (*Mother 9*)

After experiencing obstetric violence during a severely traumatizing birth, this mother went to the hospital a couple of weeks later to talk about her birth experience. She had many questions about everything that had happened. But rather than taking responsibility for the traumatizing care that was given, the doctor continuously suggested that it was absolutely necessary for the procedures to have gone this way, otherwise the baby might have died. In the quote above, he again implicitly plays the dead baby card, in order to both normalize and justify the obstetric violence during her birth. The doctor did not give evidence-based reasons why they handled the birth this way, and hence did not answer the mother's questions, but simply insinuated that otherwise her baby would be dead. The mother calls this

normalization of obstetric violence through the playing of the dead baby card "gaslighting": her experience is first acknowledged, but then she felt that the doctor implied that it was wrong for her to question what happened, as if she was risking the life of her child in retrospect, making her out to be a bad or mad mother.[56]

Troubling Consent

While research in the Netherlands shows that almost half of the mothers who received medication or an episiotomy did not give consent,[57] this study additionally reveals that even when mothers do give consent, it is often the case that this consent is illegitimately obtained through a form of moral or epistemic injustice. All groups of participants recognized this trouble with consent, especially the midwives. The troubling of consent is described through the subthemes of "not being asked for consent," "saying 'yes,'" "saying 'no,'" and "giving up resistance."

Not being asked for consent
Well, I believe the gynecologist said very simply: "What you have in your birth plan, you cannot do here. If your delivery is medical, we want to check the heart, so you need to have an ECG." I said: "Yes, but what if I just do not want to?" "No, you just have to." I said: "But I really don't want to." She said: "Well, if it comes to that, you will just have to." I looked at my husband like: "Who is going to do something about this? Something is about to happen that I don't want." I said: "But I do not give permission for this." She said: "Well if you come here, you have no choice. And the chances are very high that you end up here, because with a first child 70% of women end up in the hospital, so I would prepare myself for it, if I were you." [...] *I still don't understand how someone can just say: "We're going to do something with your body that you do not give consent for."* (*Doula 3*)

To this mother, the doctor blatantly said that it did not matter whether consent would be given or not. It was going to happen the way they wanted anyways. The mother was shocked, and she objects that something is going to happen against her will, but this has no effect as it does not seem to matter. Not only her consent, also her objections were silenced. Many

56 Sarah Lachance Adams, *Mad Mothers, Bad Mothers, and What a "Good" Mother Would Do*, (New York: Columbia University Press, 2014)
57 Van der Pijl et al., "Consent and Refusal."

participants in this study report instances where pregnant people were not asked for consent. This is congruent with the approximate 36% who received electronic fetal monitoring or fetal scalp electrodes, and the 42% of parents who were given an episiotomy, and the 47% who were administered medication without being asked for consent.[58] While not asking for consent can sometimes be understood as a form of presumed or opt-out consent (which are considered to be insufficient forms of consent), there were many stories like the one above where it becomes painfully clear that there seems to be no need for consent from the mother at all. Even when not asking for consent is understood as a form of opt-out or presumed consent, this can still imply a serious negation of the mother, as this midwife indicates:

It's the same in the whole debate around rape and what rape is. Often, we say to each other: "She didn't say 'no.'" (*Midwife 7*)

In making the comparison with rape, the midwife above explains that the violation in not asking for consent is severe, and that it is a bad excuse that "she did not say 'no.'" She flags that there should be a moral awareness that many of the interventions done during birth are simply not interventions where opt-out or presumed consent suffices.

It depends on who care workers have in front of them whether consent or not is asked. Students signal that especially people who find it harder to advocate for themselves are exploited. An epistemic inequality is established by keeping parents in the dark, or it exists due to social and economic inequalities, language barriers, or differences in culture, which make it seem less necessary to ask for consent. Participants explained how stigmatized identity characteristics are used to justify making even less of an effort to establish a relationship of mutual trust and knowledge exchange:

I told them: "I have a history of sexual violence, so I feel very vulnerable and very afraid of what's going to happen." And looking back, I really feel like disclosing this did not help me at all, instead it turned against me. The fact that I had said that made that they took me even less seriously, and apparently made it even more difficult for them to talk to me, to relate to me or to have any idea what to do. It was awful, it was awful. (*Mother 6*)

58 Van der Pijl et al., "Consent and Refusal."

This quote is one of the many examples where participants were taken even less seriously on the basis of their identity, which can result in less explicit asking for consent and more so-called presumed or opt-out "consent," influenced by the level in which the mother is taken seriously as an epistemic actor.

Saying "yes"
It's so incredibly easy to say to someone: "I want to do a vaginal examination." And then they almost always say yes. (*Midwife 10*)

Even if consent is asked, it can be more of a formality than a real question, especially since birth workers are used to people responding affirmatively. Many mothers in this study recount that they gave consent because they did not know that it was an option to say "no" (of course their consent cannot really count as consent in this case). The epistemic authority on the medical side of pregnancy and birth can thus create a form of opt-out consent or presumed consent, even when consent is formally asked and mothers have explicitly said "yes."

Mothers explain that sometimes they say yes because they feel that they cannot really say "no":

You have to give permission for everything yourself. But "yes" is the only correct answer. (*Mother 5*)

This quote is congruent with the recent numbers that show that refusal is overruled at a rate of 50% or more, in the case of vaginal examination, augmentation of labor, and electronic fetal monitoring.[59] Only the cesarean section, with a 12% overruled refusal rate, scores below 20% of all the interventions during labor for which refusal was overruled. Considering that a cesarean section against one's will when one explicitly says no is an extremely invasive form of obstetric violence, this is still a shocking number. So, the feeling that mothers have is that "yes" is the only correct answer, which is indeed mostly true based on these numbers.

Just like presumed or opt-out consent, consent obtained through an explicit "yes" without sufficient counseling should not be confused either with true, informed, opt-in consent, as it often still based on a negation of the mother as an epistemic agent—a form of epistemic injustice that midwives are very aware of. There is also a certain ignorance at play here,

59 Van der Pijl et al., "Consent and Refusal of Procedures."

where care workers are either not aware of the need for consent in these kinds of intimate situations, or where it seems to be okay to not take the need for true informed consent too seriously.[60]

Saying "no"
I very loudly yelled: "NO!" [*during a prenatal consultation at the end of pregnancy*]. *I got off the bed. I tried to run to the exit. They pushed me back onto the bed and took off my clothes.* [...] *I felt my baby kick. I thought everything was going well. I can still see myself crawling off that bed, but I just got pushed back. And that was it. End of story. And then I sort of went into shock* [...]. *No one has ever cut me open to do what they thought was right without letting me say anything about it. And no, it cannot get any worse than this. They cut me open, opened me up. And what I loved most, they took out of me. And the bizarre thing is, I know that all those doctors would say that it was a very successful operation. While all I think is: "What have you done?" My human rights were violated, but I am the only one who thinks so.* (*Mother 4*)

In the quote above, the mother recounts her unconsented emergency cesarean section to which she explicitly objected. As mentioned above, in the Netherlands 12% of the refusals of cesarean sections during labor are overruled.[61] The doctors believed the cesarean section to be necessary based on the electronic fetal monitoring. The mother knew that there was nothing wrong with her baby, since she felt the baby kick, and she tried to tell that to the doctors. The doctors thought that they were doing the right thing and that they were saving the baby's life in an emergency. Eventually, the baby was born healthy and not in a critical condition, so, in this case, the mother was right. The negation of her objection led to direct physical violence. Consequently, she had a highly traumatic experience. What comes to the fore here is how moral and epistemic injustice work together: it was the negation of the mother's knowledge that made the cesarean section seem highly necessary, and it was the moral belief that saving the life of the baby even when the mother objects to the operation is the right thing to do that made the doctors do the surgery without consent. Due to the combination of these two factors, the doctors were able to think that it had been a successful operation even though the mother turned out to be right about the condition of the baby and was traumatized. Although the

60 Charles Mills, *Black Rights/White Wrongs: The Critique of Racial Liberalism* (Oxford: Oxford University Press, 2017).
61 Van der Pijl et al., "Consent and Refusal of Procedures."

complete negation of an explicit objection is rarer than not being asked for consent, most participants did recount a story in which an explicit objection was overruled.

What is important to note, is that saying "no" can also occur after consent is given or presumed. Consent can thus be taken back, either with an explicit no, or through another utterance which indicates "no," but this second "no" is often overruled. The student below explains that she regularly comes across situations in which consent was asked for pelvic floor support in a euphemistic way, namely as "helping" the woman a bit to push. And that then when the mother clearly indicated that she was in pain, the consent was not renegotiated, although the student experienced these utterance as clear ways of saying "no":

When a woman says "ouch" or something like that, then they [*the midwives*] *act very empathetically, they say: "Yes, I know it hurts, but I have to help you." But they do not stop or ask if they can continue.* (*Midwife in training 3*)

Many of the midwives also described the experience that consent is given, but afterwards they notice from the body language of the client that they are not consenting anymore:

If you ask someone "Can I cut?" and she says "yes," but she pushes her legs together, I do not call that consent. [...] *You can say: "Yes, I want to have sex with you now" and say five minutes later: "I don't want to anymore." Does it no longer count because you already said yes? The same applies here, I think it's the same kind of discussion.* (*Midwife 7*)

While some midwives in this study used to continue in situations like this, because the mother did consent before and they were trained to go further, most said that they are currently trying to listen carefully to body language and everything that is being communicated. Especially listening to body language and utterances such as "ouch" are important, because many mothers do not dare to explicitly take back consent. Midwives attempt to be aware of signs of taking back consent or "false" consent. One midwife describes this as: "If you do not want to cross someone's boundaries, you have to be aware in each fiber of your body what her borders are." (Midwife 11)

Giving up resistance

My resistance just ran out at some point, I think. So that's why I agreed to it. [...] *But I was angry, I was sad. Actually, it was not okay.* [...] *It did not feel*

right to me. I actually could not support the decision to go with this plan. [...] *So, going down that road, it was not with conviction on my part. I mean, it was how it was, my resistance ran out. And then the gynecologist had such a complicated story on why electronic fetal monitoring was so important.* [...] *I did not really understand it either. And then I thought: "Well, then it must be my fault that I do not understand it."* (*Midwife 6*)

Here, a midwife tells the story of her own birth. In the last weeks of pregnancy, she had lost an argument with the gynecologist about her care. This midwife ran out of resistance within an exchange of knowledge and arguments, feeling at some point like she "lost," and she gave in. Her resistance hence ran out due to a form of epistemic injustice: she recounts not being able to follow it anymore, while, unlike most mothers, she had extensive knowledge on the subject as she was a senior midwife. So even when someone has a lot of experience with childbirth, has been trained for four years, and has been practicing as a midwife for years, an epistemic hierarchy can be inserted into a relationship between more or less equal epistemic agents, in order to push the mother to consent to the policy proposed.

Another midwife recognizes this push to give up resistance as a kind of powerplay. She describes it as follows:

Consent is really just a negotiation of someone's boundary. [...] *A woman suffers from the fact that she lacks certain knowledge and experience needed to assess the situation, and she does not know whether I am sincere. When I want to do something, I can exaggerate that.* [...] *I think that as a healthcare provider you ultimately have the power and can therefore use that as violence, and as a woman you have very little to defend yourself against it. It is dangerous, because I can say anything, I can say anything I want, she has to trust that what I say is correct.* (*Midwife 7*)

As we also saw above, many midwives voiced concerns about the sincerity with which they obtain consent. They explained that the trouble with consent is based on a power difference due to a difference in knowledge, or it is justified by a difference in knowledge. In the quote above, it becomes painfully clear how this difference in knowledge can be used to obtain consent on false grounds, and how that directly leads to physical interventions, hence troubling the right to true bodily self-determination.

In the quote below, the troubling of consent and the playing of the dead baby card come together, and ultimately make this mother give up her resistance as well:

I have seen that birth workers just keep insisting. That someone says: "No, I don't want a needle just in case." And they say: "Yes, but if it does end up being a cesarean section, then it can really be very … it will take us way too much time. That can really make a difference between life and death." And the mother says "Yeah, but I really just do not want it." And they say: "But you know that not doing it puts your baby at risk." And that woman was really like: "I do not want to. I do not like needles, I know it takes me out of my concentration." It was a 5-minute discussion. It went on and on. And then she said: "Just do it then." Afterwards, all her courage was gone. She said: "I cannot handle it, I cannot take the contractions anymore." She panicked. The needle hurt her and there was nothing they were going to do about it. She said: "I want the needle out." But they did not do it. It was really … and she was like: "Give me an epidural then." (*Doula 3*)

Here, the threat to the baby's life is entirely unfounded (and not only exaggerated as in certain situations above), since the "needle" is not really needed as a life-saving measure, it is just a precaution, so we also again see the playing of the dead baby card to get the mother to comply with the proposed policy. In the quote above, it becomes visible how the constant negotiation of the mother's consent, and thereby the implicit questioning of her moral and epistemic capacity to give consent, pushes her to give up.

Epistemic Firewalls and Conflicting Moral Understandings

How is it possible that mothers are treated in the way they are, presuming that care workers are generally well-meaning individuals who dedicate their lives to the care of others, and why is there not more public outrage about obstetric violence? From the results spring, we believe, two main answers. The first can be understood as conflicting moral understandings of reproductive justice between the medical establishment and pregnant people, which is a struggle that goes back to the beginning of the obstetric and gynecological institution. The second is that there is epistemic injustice at play in which mothers are disregarded as epistemic agents, which makes it seem necessary for doctors to take charge. Epistemic injustice has been understood as an integral part of obstetric violence before,[62] but the

62 Sara Cohen Shabot, "Why 'Normal' Feels So Bad: Violence and Vaginal Examinations during Labour – A (Feminist) Phenomenology," *Feminist Theory* 22, no. 3, (2020): 443–463; Rachelle Chadwick, "Breaking the Frame: Obstetric Violence and Epistemic Rupture," *Agenda* (*Durban, South Africa*) 35, no. 3 (2021): 104–115; Rachelle Chadwick, "Practices of Silencing: Birth, Marginality

combination of epistemic injustice and conflicting moral understandings is particularly dangerous since it makes it possible to disregard people as epistemic agents *and* be either morally ignorant about this or make it morally justifiable to do so. To our knowledge, epistemic injustice in combination with an analysis of what could be termed moral injustice has not been used before to understand the widespread and normalized occurrence of obstetric violence.

The combination of an analysis of epistemic injustice and conflicting moral understandings form the heart of the feminist field of care ethics, in which these two dimensions of injustice have been articulated most explicitly by Margaret Urban Walker. According to Walker, three processes contribute to the moral and epistemic injustice of making some violence seem normal, seem "matter of course": *naturalizing*, *privatizing*, and *normalizing*.[63] The naturalizing, privatizing, and normalizing of violence through moral and epistemic injustice constitutes an "epistemic firewall" by "sealing off recognizable injuries and credible complaints."[64] Hilde Lindemann Nelson described Walker's concept of the firewall as:

> A barrier that is erected between the privileged and the disenfranchised by various practices that naturalize, normalize, hire, or legitimate coercive behaviors and relations. The firewall makes a state of affairs seem so obvious, so in keeping with the right and good order of things, that the counter story gets dismissed as offensive, tiresome, threatening, or ridiculous. Often, it received no sort of hearing at all. The task, then, is to figure out how to push a counter story through the firewall.[65]

All three processes of naturalizing, privatizing, and normalizing that are constitutive of an ethico-epistemic firewall when it comes to the practice, justification, and invisibility of obstetric violence can be recognized in the main themes, "playing the dead baby card" and "troubling consent," that arose from our study.

First, *naturalizing* identities is the process of making identities look "naturally" morally and epistemically disadvantaged, which is something

and Epistemic Violence," in *Childbirth, Vulnerability and the Law*, ed. Camilla Pickles and Jonathan Herring (Routledge, New York, 2020), 30–48; Stella Villarmea, "Reasoning from the Uterus: Casanova, Women's Agency, and Philosophy of Birth," *Hypatia: A Journal of Feminist Philosophy* 36, no. 1 (2021).

63 Urban Walker, *Moral Understandings*, 180–182.

64 Hilde Lindemann Nelson, "Stories of My Old Age," in: *Mother Time: Women, Aging, and Ethics*, ed. Margaret Urban Walker (Oxford: Rowman and Littlefield Publishers, 1999).

65 Urban Walker, *Moral Understandings,* 182.

that we saw in the subtheme of "not being asked consent." Here, it seems natural that the doctors know better than the pregnant people what is the right thing to do; no consent is needed and this is not considered a moral problem. The epistemic inequality that comes with being pregnant can seem like a natural given within obstetrics. Stella Villarmea has historically traced the reality that being pregnant directly puts a person far behind in terms of epistemic injustice, due to the prejudice of "the more present the uterus, the less rational the pregnant subject."[66] In terms of moral authority, Trudy Dehue has revealed in her history of pregnancy and abortion in the Netherlands that moral authority on reproduction, which had previously been in the hands of the church, was given in the 1980s to gynecologists and obstetricians rather than to women themselves.[67] As such, doctors took up the moral position of priests, managing access to abortion, leaving pregnant people in a dependent position not in charge of their own bodies. Our study indicates that the hegemonic moral configuration of what is justice in matters of reproduction is still in the hands of the obstetric institution, as if pregnant people are *naturally* not only epistemically but also morally less capable of determining what the right thing to do is.

Second, *privatizing* happens when certain treatments or practices are organized in such a way that their scrutiny is prevented:

> Effected by customs, moral understandings, or laws that declare certain interactions outside legitimate or acceptable scrutiny, reaction, or public comment by others, even if those interactions take place in plain sight.[68]

The playing of the dead baby card, captured in subtheme one, contributes significantly to the prevention of scrutiny when it comes to obstetric violence, as it effectively reproduces the moral understanding that the life of the baby is a priority over the life and experiences of the mother. As a consequence, violence that happens to the mother is hidden in plain sight, since anything is justified with the supposed rescuing of the baby's life. Dehue has revealed the extensive history of saving the life of the child at the cost of the mother in the Netherlands.[69] Up to the beginning of the

66 Stella Villarmea, "When a Uterus Enters the Room, Reason Goes Out the Window," in *Women's Birthing Bodies and the Law: Unauthorised Medical Examinations, Power and Vulnerability*, ed. Camilla Pickles and Jonathan Herring (Oxford: Hart, 2020): 63–78.

67 Trudy Dehue, *Ei, foetus, baby: Een nieuwe geschiedenis van de zwangerschap* (Amsterdam: Atlas Contact, 2023).

68 Urban Walker, *Moral Understandings*, 182.

69 Dehue, *Ei, foetus, baby.*

twentieth century, there were Catholic guidelines for doctors to make a cesarean section (which was not yet safe at the time) if the fetus was dying during birth in order to baptize it before its death, although this often meant the final blow to the life of the mother. Similarly, until the revision of the abortion law in the late twentieth century, abortions were not allowed in the Netherlands even for medical reasons that threatened the life of the mother, as they are still not in other European countries.[70]

Playing the dead baby card can hence be understood as a continuation of a patriarchal moral configuration of "justice" in matters of reproduction, which has for centuries been to prioritize the child over the mother. Although this moral claim can no longer unproblematically be made explicitly, it is, as we saw in the results, still made implicitly. In reaction to the shocking numbers on obstetric violence in the Netherlands in Van der Pijl's research, the gynecologist who co-authored the research that revealed these numbers explained that care workers often intuitively prioritize the interests of the baby above those of the mother, without problematizing this prioritization.[71] We saw the same thing happening in our study in the case of the mother who merely questioned the way things had gone during her birth: it was immediately suggested by the doctor that if it had gone any other way, the baby might have died. That means that even if a mother questions or explores other ways in which the delivery might have gone, or thinks the birth through step by step, she is made to feel as if she is putting the baby's life at stake retrospectively. The mother's epistemic participation in trying to understand what happened is made impossible or illegitimate based on an implicit moral claim to the baby's life and a configuration of justice in matters of reproduction that implies her self-sacrifice. The dead baby card is hence not only a "threat" to the baby's life used to manipulate the mother via her love for her child, but also a moral justification for the dismissal of the mother as an epistemic and moral agent *and* a justification for the dismissal of the moral duty of the doctor to protect the bodily integrity and self-determination of the mother.

The persistence of this specific configuration of justice in the case of reproduction, is also signaled by De Vries, who argues that it is the bioethicist concept of the maternal-fetal conflict in which the principle of autonomy of the mother is weighed against the obligation of beneficence to the baby.

70 Ibid.

71 Elselijn Kingma, "Harming One to Benefit Another: The Paradox of Autonomy and Consent in Maternity Care," *Bioethics* 35, (2021): 456–464; Van der Pijl et al., "Consent and Refusal of Procedures."

This continuously reproduces a moral configuration of justice that prioritizes the fetus and makes the mother invisible.[72] The moral prioritization of the child produces a moral ignorance towards the mother. If this were not the case, the prioritization of the child would not look like justice or like a "matter of course," but would be clearly visible as injustice against the mother. The moral claim to the life of the child and the (often exaggerated) threat to it hence effectively prevent medical and public scrutiny when it comes to the autonomy and self-determination of the mother: the moral need for self-determination of the mother evaporates in plain sight through the shroud waving with regard to the baby. The playing of the dead baby card—either as explicit shroud waving, or implicitly, as the normalization and justification of obstetric violence—is hence based on both the moral understanding that it is justified to prioritize the baby's life over the mother's, *and* the epistemic inequality that establishes the authority of the obstetric institution as medical specialists when it comes to saving babies. As a result, the practices that are being called out as obstetric violence, can be kept "private" behind a moral and epistemic firewall, both during medical consultations and in public, for no one else dares to judge or scrutinize, since the obstetric institution has both the moral and epistemic authority.

Finally, the third process that constitutes the firewall is the process of *normalizing* certain patterns of practices. This happens when "practices that otherwise would look bad are rendered normal [...] for certain contexts or certain people in them."[73] When these "otherwise bad" patterns of practice are normalized for "certain contexts or certain people in them," three things happen: first, the presumptions underlying these patterns of behavior are left unquestioned (e.g., when it is presumed that a person is irrational, the focus shifts from the coercion that they experience to actions that are permitted); second, normalizing then consists in the regulation of the patterns of practice, instead of prohibiting them (under conditions x and y, it is normal to overrule a person's right to consent); and third, the ones who demand to be heard or have self-control, are discredited. All three return in the results in the theme "troubling consent."[74]

First, it is an inheritance of moral and epistemic conceptions of the past that people in labor are not asked for consent, and hence considered to be normal. Not asking for consent indeed goes unquestioned—again, in the

72 Raymond de Vries, "Obstetric Ethics and the Invisible Mother," *Narrative Inquiry in Bioethics* 7, no. 3 (2017): 215–220.

73 Urban Walker, *Moral Understandings*, 182.

74 Ibid.

Netherlands, 42% did not give consent for their episiotomies, 47% did not consent to medication during labor, and 37% did not consent to their ECG monitoring, while 40% of refusals in case of vaginal examinations were overruled.[75] Rather than focusing on this grand-scale violation of bodily integrity, the focus in the media, including of doctors in the media, was to justify instead of question these patterns, while in any other context, justifying penetrative intimate practices without consent would seem absurd. Second, while juridically, pregnant people have the right to bodily self-determination, the violation of it is indeed regulated, instead of prohibited, through moral configurations of when it is fair to overrule someone's refusal, for instance when the life of the fetus is believed to be at risk. The playing of the dead baby card, for instance, functions to regulate and justify the negation or "troubling" of consent. Obstetric violence is hence normalized as a practice through a regulatory moral and epistemic troubling of consent: consent is constantly renegotiated. And third, the people who raise the issue are indeed discredited. This is what happens often to individual parents, but opinion columnists of various major newspapers in the Netherlands similarly condemned the women who participated in research on this subject.[76] This last aspect of normalizing bad practices makes "those who rebel against what 'everybody' accepts appear as irrational freaks, malcontents, complainers, unstable deviants, or dangerous elements out of control."[77] And in the case of obstetric violence it makes them into bad or mad mothers who would put their own interests above the life of their child. The effect of the normalization of a bad practice is that people with claims against this practice, "prove" that they are "abnormal," and even prove "their unreliability as judges and informants, and the incredibility of their testimonies."[78]

Naturalizing moral and epistemic injustice between pregnant people and those who take care of them, privatizing obstetric violence and preventing public scrutiny through the playing of the dead baby card, and normalizing obstetric violence through the troubling of consent, constitute moral ignorance towards mothers in the form of a firewall that repels and ridicules maternal quests for knowledge, mothers' questioning of practices, their testimonies of traumatic experiences, their alternative treatment plans, their usage of the term "obstetric violence" and their attempts at moral and

75 Van der Pijl et al., "Consent and Refusal of Procedures."

76 Witteman, "Hebben ze je kind gered"; Akkermans, "U wilt geen inleiding mevrouw?"

77 Urban Walker, *Moral Understandings*, 182.

78 Urban Walker, *Moral Understandings*, 182–183.

epistemic authority and bodily self-determination. The firewall creates a pipeline from moral and epistemic injustice to physical forms of obstetric violence. Acknowledging this is important for the demystification of obstetric violence: it is not difficult to see how even well-meaning midwives, doctors, and nurses would appropriate someone's most intimate body parts in the unconsented carrying out of their decision, based on what they think is best.

That professionals in the obstetric institution do not see the harm they do to mothers is a problem of the normative standpoint from which they think and act in the world. Just as standpoint theory developed an analysis of different epistemic standpoints in which some are more advantaged than others, Daniel Loick discusses how care ethics has developed a similar theory when it comes to moral standpoints.[79] A different social position in the world shapes one's values, and in this case, one's moral understanding of, and normative relation to, what is justice. In our case, there are conflicting normative standpoints on what justice is in matters of reproduction. That there can be different moral configurations of justice within different social positions, has been a critical feminist insight from the field of care ethics ever since the groundbreaking work of Carol Gilligan.[80] Gilligan theorized that gender influences the way justice is conceptualized: while children socialized as boys tend to conceptualize justice through abstract principles, girls have a care-based understanding of justice, and determine through an evaluation of context, practice, material dependencies, and affected relationalities what the "good" is in a specific situation.

If we translate this to reproductive justice, it can be, for instance, that while the doctor is unable to morally understand why a mother would take any unnecessary risks with regard to the fetus because of a general moral conception of justice that babies should be born with the least risk possible, the mother can have a plural and relational understanding of justice in which she is able to want the best for her child *and* the best for herself, since she understands herself and her child as an inseparable sociality of care. These two moral configurations of justice are currently not of equal standing, however, due to the dismissal of mothers as moral epistemic agents. And it is precisely because of the dismissal of mothers as moral epistemic agents due to the firewall, that mothers' normative standpoint should be valued higher when it comes to reproductive justice, since the obstetric institution is

79 Daniel Loick, "Fugitive Freedom and Radical Care: Towards a Standpoint Theory of Normativity," *Philosophy and Social Criticism* (2023).

80 Carol Gilligan, *In a Different Voice: Psychological Theory and Women's Development* (Cambridge: Harvard University Press, 182).

stuck in a moral ignorance when it comes to pregnant people that causes an inability to see and understand the harm that obstetric violence causes them. Since mothers have a more complete moral understanding of the situation and all actors involved, people with the capacity for pregnancy are hence in a better position to make normative claims when it comes to reproductive justice, just as marginalized people have an epistemic advantage according to standpoint theory. Since the mother is most affected by the situation and has the most epistemic insight in her own life and circumstances, her moral understanding of what is justice in her specific situation is more developed than the midwife's, the doctor's, the state's, or society's configuration of reproductive justice. And this insight has potentially universal reach: it is precisely because the mother is confronted with moral and epistemic injustice and violence, and hence, with the experience of "struggle,"[81] that she understands, better than the midwife or doctor, that reproductive justice in all situations depends on the beliefs and insights of the mother and should therefore always be primarily morally deliberated by her.

While we cannot change the whole culture within obstetrics at once, and while the elimination of obstetric violence would mean a fundamental reorganization of maternity care and of our moral and epistemic configurations of justice in reproduction, it is possible to resist the moral and epistemic injustice mothers face, and the normalization of obstetric violence on a relational level. This would entail radically taking mothers seriously, also if that makes a health care provider uncomfortable, and upholding their right to autonomy and self-determination, not manipulating or gaslighting mothers into accepting proposed policy, but making sure they are informed in such a way that epistemic inequality between a birth worker and a mother is reduced to a minimum, and following pregnant people in their wishes and their concerns by thinking along with them. This is something that every individual healthcare provider can do on a daily basis. Truly centering pregnant people will transgress the borders of the current system and protocols, and eventually change them. Rather than normalizing the shroud waving of autonomy and self-determination, the lack of consent and overruling of refusal, the aim must be to normalize the autonomy of pregnant people to a point that any lack of self-determination and consent is immediately recognized as an injustice. On an organizational level this would mean that continuity of care, culturally sensitive and personalized care, as well as time, should be priorities in order to facilitate birth workers in their desire to take the people they care for seriously in a radical way.

81 Loick, "Fugitive Freedom and Radical Care."

2 Obstetric Racism as Necropolitical Disinvestment of Care: How Uneven Reproduction in the Netherlands Is Effectuated through Linguistic Racism, Exoticization, and Stereotypes

Rodante van der Waal; Alana Helberg-Proctor*, and Bahareh Goodarzi*

Abstract

In this chapter, we theorize how Dána-Ain Davis's "uneven reproduction" and "obstetric racism" are effectuated in the Netherlands through linguistic racism, othering, and racial stereotypes. We conceptualize uneven reproduction as consisting of a bio- and necropolitics that optimizes certain life through investments and negates "other" life through disinvestments in reproductive care. Based on interviews with mothers, doulas, midwives, and midwives in training, we study how uneven reproduction plays out in daily practices of obstetric racism within the obstetric institution. In daily practice, we differentiate between a logic of investment and disinvestment which takes place through linguistic racism, othering, and exoticization, and the racial stereotype of Black women being "natural" birthers, while other marginalized racialized women are seen as "bad" birthers.

Keywords

Obstetric violence, reproductive violence, Achille Mbembe, midwifery, birth, othering.

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Introduction

In the Netherlands the risk of maternal and perinatal morbidity and mortality are unevenly divided. Maternal mortality ratios are at least 50% higher for pregnant people from marginalized racialized communities.[1] Ruth Wilson Gilmore defines racism as "the institutional and state-sanctioned practices that make particular groups of people vulnerable to harm and premature death."[2] Drawing on Gilmore's definition of racism, Dána-Ain Davis was the first to theorize obstetric racism in the context of the United States as that which happens at the intersection of medical racism and obstetric violence.[3] According to Davis, obstetric racism should be recognized as a separate form of obstetric oppression in addition to obstetric violence. Davis makes clear that, in order not to miss important dimensions of experiences of people racialized as Black, it is only possible to fully understand Black women's experiences with violence in obstetrics through the lens of racism.[4]

While the concept of obstetric racism emerged in the US, with its specific history of chattel slavery, Davis notes that obstetric racism is a useful concept in any context where reproduction is racially stratified, or—as Davis has recently said, adding to the conceptualization of obstetric racism and reproduction—where reproduction is "uneven," which is nearly everywhere.[5] With the concept of uneven reproduction, Davis theorizes the difference in investments and disinvestments when it comes to different groups of people, resulting in different mortality and morbidity rates. Where the concept of stratified reproduction lays bare these differences, the concept of uneven reproduction aims to understand how these differences are effectuated through broader bio- and necropolitical investments and disinvestments, such as uneven policy measures globally.[6] Examples are for instance the repudiated NICE guideline which recommended induction of labor at 39 weeks for everyone racialized as non-white, or the inclusion of racial categories in tools that predict the success of a vaginal trial of

1 Caroline Diguisto et al., "Maternal Mortality in Eight European Countries with Enhanced Surveillance Systems: Descriptive Population Based Study," *BMJ* 379 (2022).

2 Ruth Wilson Gilmore, *Golden Gulag. Prisons, Surplus, Crisis, and Opposition in Globalizing California.* (Berkeley: University of California Press, 2007).

3 Dána-Ain Davis, "Obstetric Racism: The Racial Politics of Pregnancy, Labor, and Birthing," *Medical Anthropology* 38, no. 7 (2019): 560–573.

4 Ibid., 561.

5 Ibid., 570; Dána-Ain Davis, "Uneven Reproduction: Gender, Race, Class, and Birth Outcomes," *Feminist Anthropology* 4, no 2 (2023): 152–70.

6 Ibid.

labor after a previous cesarean section.[7] Obstetric racism, then, as a third concept, can be understood as effectuating the inequality in commitment to the successful reproduction of different groups in daily practice, such as racist remarks or the underestimation of pain. Obstetric racism comes to the fore in different ways for different groups, depending on their specific racialization and colonial oppression.[8]

More studies on uneven reproduction and obstetric racism are emerging outside the US. Williamson for instance, points out that obstetric violence against people racialized as Black is described by Brazilian scholars as a form of misogynoir, that is the intersection of misogyny and anti-Blackness.[9] In the United Kingdom, there is the Five X More campaign which draws attention to the study that revealed that mothers racialized as Black die five times more often than mothers racialized as white in the period surrounding childbirth.[10] And in Portugal, obstetric racism comes to the fore in the prejudice that Brazilian migrants have a "bad uterus" due to miscegenation, making "Brazilian women's bodies unsuitable for birth," causing the high rate of cesarean sections.[11] In Europe, including the Netherlands,

7 National Institute for Health and Care Excellence (NICE), "Inducing Labour," last modified November 4, 2021, https://www.nice.org.uk/guidance/ng207/resources/inducing-labour-pdf-66143719773637; Nicholas Rubashkin, "Epistemic Silences and Experiential Knowledge in Decisions After a First Cesarean: The Case of a Vaginal Birth after Cesarean Calculator," *Medical Anthropology Quarterly* 37 (2023): 341–353.

8 Camille Kroll et al., "Cultivating the Ideal Obstetrical Patient: How Physicians-in-Training Describe Pain Associated with Childbirth," *Soc Sci Me* 312 (2022); Shruti Mukkamala and Karen L. Suyemoto, "Racialized Sexism/Sexualized Racism: A Multimethod Study of Intersectional Experiences of Discrimination for Asian American Women," *Asian American Journal of Psychology* 9, no. 1 (2018): 32–46.

9 K. Eliza Williamson, "The Iatrogenesis of Obstetric Racism in Brazil: Beyond the Body, beyond the Clinic," *Anthropology & Medicine* (2021). See also: Jussara Francisca de Assis, "Intersectionality, Institutional Racism, and Human Rights: Obstetric Violence Comprehension," *Serviço Social & Sociedade* 133 (2018): 547–565; Kelly Diogo de Lima, Camila Pimentel, and Tereza Maciel Lyra, "Racial Disparities: An Analysis of Obstetrical Violence in Black Women," *Ciência & Saúde Coletiva* 26, no. 3 (2021).

10 Marian Knight et al., *Saving Lives, Improving Mothers' Care: Lessons Learned to Inform Maternity Care from the UK and Ireland. Confidential Enquiries into Maternal Deaths and Morbidity 2014–16, MBRRACE-UK Report* (Oxford: National Perinatal Epidemiology Unit, University of Oxford, 2018), https://www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202018%20-%20Web%20Version.pdf.For more information on the campaign, see: https://fivexmore.org.

11 Catarina Barata, "'Mix of Races, Bad Uterus:' Obstetric Violence in the Experiences of Afro-Brazilian Migrants in Portugal," *Societies* 12, no. 3 (2022); Catarina Barata, "Body Broken in Half: Tackling an Afro-Brazilian Migrant's Experience of Obstetric Violence and Obstetric Racism in Portugal through Art Making," (*Con*)*textos* 10, no.1 (2022): 65–84.

there is evidence that being racialized as non-white or having a migration background increases the risk of obstetric mistreatment.[12]

Dutch people racialized as non-white have worse maternal and neonatal mortality and morbidity outcomes than people racialized as white without a migration background. In recent research conducted in the Netherlands it emerged that mothers from, or with ancestors from, the Dutch Antilles and Suriname have a three times higher mortality rate than mothers categorized as white in the study.[13] In another study, mothers categorized as African, South Asian, and Turkish and Moroccan had a higher risk of stillbirth and early neonatal death in the Netherlands compared to women categorized as Dutch.[14] Mothers categorized as having an African ethnicity have the highest risk of preterm birth in the Netherlands compared to other groups.[15] And lastly, asylum seeking pregnant people have a five times higher perinatal mortality rate, including a twelve times higher intrauterine fetal death rate.[16] With regard to the quality of care, there are indications that there are various racial and cultural stereotypes that influence how long it takes for birth workers to respond to signs of pain, such as the stereotype that people from India exaggerate in their presentation of pain, while Black people are thought to have a high tolerance for pain.[17] Midwives in training furthermore report signs of medical apartheid, such as being allowed to practice more on people of color, lack of translation services and hence consent, and discriminatory treatment.[18]

12 Marit van der Pijl et al., "Disrespect and Abuse during Labour and Birth amongst 12,239 Women in the Netherlands: A National Survey," *Reproductive Health* 19, no. 160 (2022): 1-16; Marit S.G. van der Pijl et al., "Consent and Refusal of Procedures during Labour and Birth: A Survey among 11 418 Women in the Netherlands," *BMJ Quality & Safety* 0 (2023): 1–12; Stephan Oelhafen et al., "Correction to: Informal Coercion during Childbirth: Risk Factors and Prevalence Estimates from a Nationwide Survey of Women in Switzerland," *BMC Pregnancy and Childbirth* 21, no. 437 (2021).

13 Athanasios F. Kallianidis, "Confidential Enquiry into Maternal Deaths in the Netherlands, 2006–2018," *Acta Obstet Gynecol Scand* 101: 441–449 (2022).

14 Anita C.J. Ravelli et al., "Ethnic Differences in Stillbirth and Early Neonatal Mortality in The Netherlands," *J Epidemiol Community Health* 65, no.8 (2010): 696–701.

15 Anita C.J. Ravelli et al., "Decreasing Trend in Preterm Birth and Perinatal Mortality, Do Disparities also Decline?" *BMC Public Health* 20, no. 783 (2020).

16 A.E.H. Verschuuren et al., "Pregnancy Outcomes in Asylum Seekers in the North of the Netherlands: A Retrospective Documentary Analysis," *BMC Pregnancy and Childbirth* 20, no. 1 (2020): 320.

17 Syllona Kanu. *"You Care Better for People Who Look like You": A Mixed-Methods Study of Ethnic Bias in Pain Assessment in Maternal and Newborn Care in the Netherlands* (Master's thesis, Global Health, 2023).

18 Rodante van der Waal et al., "Obstetric Violence within Students' Rite of Passage: The Relation of the Obstetric Subject and Its Racialised (M)other," *Agenda* (*Durban, South Africa*) 35, no. 3 (2021): 36–53.

Studies into racialization as a determinant of maternal mortality in the Netherlands consistently show an association between racial and ethnic classification and maternal and perinatal morbidity and mortality—indicating severe diagnostic lapses and other forms of obstetric racism.[19] Substandard care factors in the cases of maternal mortality were identified amongst mothers classified as non-Western, such as communication difficulties, delay in consultation of a doctor, and delay in referral to a hospital.[20] Bahareh Goodarzi has for the first time intersectionally analyzed perinatal mortality amongst a healthy cohort of pregnant people and found that those characterized as non-Dutch have 1.24 times higher odds of perinatal mortality compared those characterized as Dutch—this was 1.76 when socioeconomic status was taken into account.[21] A cross-cultural study on obstetric violence in students' training reveals the Dutch history of colonialism as a root cause of structural obstetric racism.[22]

In this chapter, we aim to further our understanding on obstetric racism in the Netherlands as an occurrence of uneven reproduction through an exploratory qualitative study. Following Davis,[23] we understand obstetric racism to be both a symptom of uneven reproduction and as a way to effectuate it in daily practice. We show how the daily practice of obstetric racism is tied to broader structures of uneven reproduction in three different ways, namely through linguistic racism, othering and exoticization, and through racial stereotypes. These three forms of racism can be understood as the link between uneven reproduction, which is an analysis of reproduction on a more structural level, and obstetric racism, which contains an analysis of reproduction in daily obstetric practice. Based on our exploratory data, we believe it is through at least these three forms that uneven reproduction in the Netherlands is effectuated in daily practice, but these three are by no means exhaustive and further research is urgently needed.

Theoretical Backdrop

Davis defines obstetric racism as "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,

19 Ravelli, "Decreasing Trend"; Kallianidis et al., "Confidential Enquiry."

20 Kallianidis et al., "Confidential Enquiry."

21 Bahareh Goodarzi et al., "Maternal Characteristics as Indications for Routine Induction of Labour: A Nationwide Retrospective Cohort Study," *Birth* 49 no. 3 (2022): 569-581.

22 Van der Waal et al., "Obstetric Violence within Students' Rite of Passage."

23 Davis, "Uneven Reproduction."

prenatal care, labor, birth, and postpartum care."[24] When it comes to the specific forms of obstetric racism, Davis lays bare seven dimensions of obstetric racism: 1) "diagnostic lapses"; 2) "neglect, dismissiveness, or disrespect"; 3) "intentionally causing pain"; 4) "coercion"; 5) "ceremonies of degradation"; 6) "medical abuse"; and 7) "racial reconnaissance."[25] Racial reconnaissance is currently understood more to be a response to obstetric racism, rather than part of obstetric racism. Mauric similarly adds the specific practice of "bawling" in which Black people have to demand they are heard in order to counter medical neglect, which could be understood as a form of racial reconnaissance.[26] In short, obstetric racism "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."[27]

On the basis of Davis's seven dimensions, a validated measuring scale of obstetric racism was developed (the Patient-Reported Experience Measure of Obstetric Racism Scale, in short PREM-OB Scale), which measures obstetric racism in three domains. First, "humanity" (including the violation of safety and accountability, autonomy, communication and information exchange, and empathy). Second, "racism" in the form of anti-Black racism and misogynoir (including the weaponization of societal stereotypes and scripts). And third, "kinship" (including the denial or disruption of familial bonds that support Black birthing people).[28]

Hemphill et al.[29] have found two overarching themes in the obstetric experiences of young Black mothers, namely obstetric racism and, as an important form of struggle against it, obstetric resistance. Under obstetric racism fall "intersectional identities," i.e., how the intersection of age, race, and gender led to disrespectful and harmful care, "medical mistrust," rooted in the historical dehumanization of Black people in medical care, and

24 Dána-Ain Davis, Cheyenne Varner, and LaConté J. Dill, "A Birth Story: How Cross-Disciplinary Collaboration Illuminates the Burdens of Racism During Birth," *Anthropology News*, August 27, 2021, https://www.anthropology-news.org/articles/a-birth-story/.

25 Ibid.

26 Rochelle Maurice, "We Bawl so We Are Heard: The Stories We Must Tell about Obstetric Racism," *Sexual and Reproductive Health Matters* 31 (2023).

27 Ibid.

28 Emily White vanGompel et al., "Psychometric Validation of a Patient-Reported Experience Measure of Obstetric Racism© (The PREM-OB Scale™ suite)," *Birth* 49, no. 3 (2022): 514–525; Elle Lett et al., "Community Support Persons and Mitigating Obstetric Racism During Childbirth," *The Annals of Family Medicine* 21, no. 3 (2023): 227–233.

29 Nefertiti OjiNjideka Hemphill et al., "Obstetric Experiences of Young Black Mothers: An Intersectional Perspective," *Social Science & Medicine* 317 (2023).

"pregnancy trauma" caused by enduring discrimination, racism, and the lack of patient autonomy and informed consent. Obstetric resistance can be understood as complementary to what Davis terms "racial reconnaissance" and Maurice calls "bawling"; another way in which participants protect themselves against obstetric racism.[30] The difference is that obstetric resistance is more positively regarded, in the sense that it is constitutive of community, while racial reconnaissance and bawling describe "the Herculean effort made by people experiencing obstetric racism to avoid or mitigate racist encounters."[31] Methods of resistance include "advocacy and autonomy," consisting of the identification of advocates (for instance family members), and "relying on trusted providers."[32]

Studying the link between postpartum depression and obstetric racism, Claxton found four main themes in the way that Black women experience obstetric racism. First, "isolation," often caused by being the only person of color. Second, "prior knowledge" of the existence of racism in healthcare institutions, and the belief that, despite their best efforts to find trustworthy care workers, they will be subjected to mistreatment in the course of pregnancy and birth, and postpartum. Third, "fear of mistreatment and medical neglect." And fourth, "community construction."[33] The latter corresponds again to obstetric resistance, as it describes the community built by Black mothers to protect themselves against racism, for instance through seeking the assistance of doulas and independent midwives of similar racial and cultural backgrounds, and peer-to-peer support.[34]

Midwife Pia Qreb shared her own experiences with obstetric racism in the Netherlands on Twitter, recounting such things as intentionally causing pain in the form of refusal of pain medication and prioritizing white women over Black women with regard to administering pain medication.[35] Qreb also reports ceremonies of degradation such as many racist and paternalizing remarks like "we don't scream like that in the Netherlands."[36] To further our understanding of obstetric racism in the Netherlands, for this study

30 Davis, "Obstetric Racism."; Maurice, "We Bawl so We Are Heard."

31 Davis, Varner, and Dill, "A Birth Story."

32 Hemphill et al., "Obstetric Experiences."

33 Miguel A. Claxton, "An Investigation into the Relationship between Obstetric Racism and Postpartum Depression in Black Women" (Bachelor's thesis), *University Honors Theses*, Paper 1159, 2021.

34 Claxton, "An Investigation."

35 Britt Willemsen, "Verloskundige deelt verbijsterende verhalen van racisme in de geboortezorg," *The Best Social Media*, February 4, 2021, https://www.thebestsocial.media/nl/kraamzorg-racisme-twitter/.

36 Ibid.

interviews with midwives, doulas, midwives in training, and mothers were analyzed to investigate the seven dimensions of obstetric racism outlined by Davis.[37]

Method[38]

Participants and Sampling

This study results from empirical research on obstetric violence in the Netherlands, which is recounted in the first chapter, in which the participants themselves continuously reported racism and obstetric racism as important causes of obstetric violence, despite not being asked about it specifically. The study on obstetric violence included 31 participants: ten mothers, eleven midwives, five doulas and five midwives in training. In this chapter, we focus on those mentions of obstetric racism that were differentiated from experiences of obstetric violence and racially stratified obstetric violence by three midwives, four doulas, four midwives in training, and two mothers in total.

Linguistic Racism, Exoticization, and Othering Stereotypes

We differentiate three ways in which uneven reproduction is effectuated through obstetric racism in the Netherlands. Firstly, "medical abuse" and "coercion" are two dimensions of obstetric racism facilitated through the mechanism of *linguistic racism* in the Dutch context. Second, "ceremonies of degradation" are observed in *exoticization and othering*. And third, the dimensions of "diagnostic lapses," "neglect" and "dismissiveness or disrespect" were seen in relation to stereotypes.

Linguistic Racism: Medical Abuse and Coercion

"Medical abuse," as described in the context of obstetric racism by Davis, entails medical professionals engaging in experimentation or repetitive behavior that is motivated not by concern for the patient but serves to

37 Davis, Varner, and Dill, "A Birth Story."

38 This methodology is very similar to the methodology of the study as a whole, which has already been recounted in the first chapter.

validate the clinician's self-worth and uphold their domination over the patient. Most of the instances of medical abuse which emerged in this study were related to linguistic racism, where language formed a significant factor in facilitating medical abuse. Midwives and midwives in training describe how a language barrier between the patient and the healthcare provider leads to the occurrence of medical abuse when the language barrier is seen as a reason to no longer require consent. Strikingly, a language barrier between the patient and the healthcare provider is even viewed as an opportunity, namely an opportunity to allow midwives in training to practice as the patient is perceived as submissive and uninformed. One midwife in training recalls

If someone is Dutch, they always ask nicely "do you think it's okay that the midwife in training is going to feel first, for example, and that I feel afterwards," or the other way around. And with foreign people, they are more likely to state in English, "okay, the midwife in training is going to feel." And then afterwards they put on their gloves and then they say, "and now I will feel also." Those people don't … they might think that that it's normal, that there are always two people feeling, you know. (*Midwife in training 3*)

Trying to make sense of how such violence can occur among their colleagues and in their places of work, both midwives and midwives in training connect not knowing the Dutch language to associated racialized prejudices which lead to healthcare providers denying patients the right to consent. Another midwife in training explains:

I think racist prejudice is more likely to provoke obstetric violence. Or that a certain perception of a person based on racist thinking also provokes obstetric violence. So, for example thinking that someone who doesn't speak the language is stupid, those lazy foreigners who haven't learned Dutch yet. And because of that not practicing informed consent. That's obstetric violence. That's an example I really see very often. (*Midwife in training 5*)

Similarly, a midwife described an example of how a gynecologist shared with her that when there is a language barrier, they skip the option of using a vacuum for vaginal delivery and will elect to directly perform a cesarian section:

The doctor said: "If I have someone with a language barrier, and they really don't speak the Dutch language, I'm not even going to start a vacuum extraction. Then I'll skip the vacuum extraction and directly do a caesarean section." (*Midwife 5*)

Such actions and choices serve to uphold the clinicians' domination over the patient, and in doing so impede the patient's right and ability to consent—resulting in coercion. "Coercion," as described by Davis, is when medical professionals perform procedures without consent or intimidate patients to make decisions. In documenting the experiences of doulas, similar examples were found, in which medical professionals attempt to enlist doulas to facilitate coercion. Reflecting on this one doula describes her observations:

And especially if they don't speak the Dutch language, that the attitude of caregivers is really totally different. [...] *I'm never called to the hallway as a doula to discuss anything. But when I'm with a victim of trafficking as a volunteer doula, it happens regularly. They want to discuss what we are we going to do. Or I'm deployed to convince a woman to accept a proposed policy.* (*Doula 1*)

Othering and Exoticization: Ceremonies of Degradation

Davis describes "ceremonies of degradation" as the ritualistic ways in which patients are humiliated or shamed. This includes experiencing being sized up to determine the worthiness of the patient or their support person(s) who may be viewed as a threat. In the Dutch context, we observed that language also functioned as one of the ways through which a patient can be othered. As one mother in our study explained, questioning a pregnant or birthing patient's language proficiencies is a process of othering—a ceremonial communication implicitly saying: *you are different*. One mother recalls:

I have experienced two times, both with this pregnancy and with the previous one, that the midwife walked past me and said, "Can I just speak Dutch?" I did find it a bit racist, because I think, with a WHITE person you wouldn't have done that and you would have just addressed me directly. And besides, I think it's very unprofessional, because I had an intake, and if I didn't speak Dutch, it would be in my file. So, I find it both racist and I find it unprofessional. (*Mother 10*)

As with "ceremonies of degradation," asking whether a patient speaks Dutch at this stage of care serves no functional purpose. As noted by the mother herself, this was not her first visit and thus any language barriers would have been known and noted in her file. Rather, posing this question gives the patient the feeling of being sized up based on their racialization—with critical awareness that those who are racialized as white are most likely not treated in this matter.

Ceremonies of degradation were also identified as processes of *exoticization* based on racialized and ethnicity-based stereotypes. Here a ceremonial communication implicitly saying *you are different* involves referring to Black bodies as something exotic, a sight to be seen. One mother recalls such an incident with a midwife being excited to see her body:

The midwife who looked after me, all the time she was saying oh, you are Black, but you have a beautiful belly, I always get so excited about Black bodies you know, and she meant well, but those little comments, you're just: yeah. (*Doula 4*)

Similarly, a midwife describes a nurse's excitement to go look at a "[n-word]" newborn:

So, an Ethiopian woman from the AZC [*refugee center*] *had given. Had given birth to a daughter and everything went well so she was allowed to go home, but she was just waiting for the cab. And so, we didn't need the pediatric ward at all because everything was going well. But the nurse from the pediatric ward came to us when we went to lunch and she said: "I heard there's a* (*n-word*) *in your ward. Is it okay if I take a peek?" Oh no, she didn't say "Is it okay," she just said, "I'm going to take a peek."* (*Midwife 9*)

Using the n-word is a racial slur, an obvious case of humiliation. But ceremonies of degradation related to *exoticization* and *othering* also produce racialized imaginaries which contain narratives of essentialist biological and cultural differences that can lead to further dimensions of obstetric racism—namely, "diagnostic lapses," "neglect" and "dismissiveness or disrespect."

The "Natural Birther" Stereotype: Diagnostic Lapses, Neglect, and Dismissiveness or Disrespect

One doula explained how a doctor's continuous emphasis on her client's race led to the dismissal of what the patient was saying and thus to a lapse in the accurate assessment of the progression of the delivery:

I had a lady in Leiderdorp and she was from Suriname and the doctor kept saying: "Yeah, but Black women carry babies differently. And so, your baby hasn't dropped." Actually, she was like, "I'm actually feeling like I'm going to push." And the midwife said: "No, you can't possibly be ready to push." But in a very undermining tone also and when they checked, she was actually pushing. Ah look at that! How biased

can you be and have this idea that, you know? Or it happens that somebody has been told that it is normal that it takes quite a while to establish breastfeeding with Black people, but that they got it, that they have it under control, and can't possibly need a lactation consultant. You know, they can wait. (*Doula 4*)

This example shows the perception that the racialized other somehow needs less assistance and is naturally good at birthing and breastfeeding; their concerns are *dismissed* with little respect and regard for their self-communicated needs. The doula further explains:

There's this notion that you know, they deal with it better you know, Black women yeah, it's done, it's dusted, and they are okay—a breastfeeding mom being told you don't need a lactation consultant because people of your race are made for this, well maybe the generation before me only bottle fed, how do you know?

Paradoxically, we found that respondents discussed various contradictory narratives of essentialist biological and cultural differences. They mentioned the idea that Black women have a higher pain tolerance, while simultaneously they observed the narrative of African women supposedly exaggerating their pain and being highly dramatic. While our sample was small, several of the respondents commented on these narratives circulating in their work fields. A midwife summarized:

For example, Black women are thought to have a higher pain threshold or experience less pain. Muslim women are thought to want an epidural right away. Not wanting to try. Women from immigrant backgrounds are generally thought to have a good delivery or I don't know what. (*Midwife 9*)

Another doula said:

The midwives know that these refugees are traumatized women with their own pain experience, but they say very quickly: "Oh yes, African women are so theatrical." There are just a lot of really nasty comments like that. Or they say out loud that you cannot give African women an epidural. Well, many things like that. And very often no consent is asked. Then I think: why specifically do that with these women …

Why do you think that is?
Because they are just, even less than white women, seen as human beings. It is assumed by definition that they are a problematic case. I've also heard

primary care midwives who counsel these women and say: "Oh yes, we do counsel them, but you can actually just be sure that they end up in the OR." Then I think: "Yes, how come they end up in the OR?" (*Doula 1*)

The above quote illustrates two striking paradoxes. First, the biological stereotype that Black women have a higher pain tolerance alongside the cultural stereotype that African women specifically are theatrical in expressing pain. And second, we observe the simultaneous narratives of migrants and especially Black women being natural birthers alongside the contradictory notion that women migrant mothers and mothers racialized as Black are per definition also more likely to need a cesarian section.

Obstetric Racism as Necropolical Disinvestment of Care

In this study, we interviewed midwives, doulas, midwives in training, and mothers about obstetric violence. Our thematic analysis of the interviews, using Dána-Ain Davis's seven dimensions of obstetric racism, shows how medical abuse and coercion are two dimensions of obstetric racism that are facilitated in the Netherlands through the mechanism of *linguistic racism*. Another dimension of obstetric racism, ceremonies of degradation, is effectuated and justified through *exoticization and othering*. Finally, the dimension of obstetric racism that includes diagnostic lapses, neglect, and dismissiveness or disrespect is enabled though *the natural birther stereotype.* What our study adds to the seven dimensions of Davis's conceptualization of obstetric racism and the concept of uneven reproduction is the awareness that these dimensions can be facilitated and effectuated through broader racist patterns and prejudices in society, in the form of linguistic racism, othering, and exoticization, as well as stereotypes related to who can and cannot give birth "naturally."

The question is how to conceptualize the link between uneven reproduction and the daily reality of experiences of obstetric racism. Our analysis shows that structural racism is linked to obstetric racism through the usage of language, the process of othering, and the deployment of stereotypes. Understanding uneven reproduction as a form of biopolitics and necropolitics enables us to theorize the link between daily practices of obstetric racism that come to the fore in language, othering, and stereotypes as an essential part of the structural racism of uneven reproduction; these practices together are responsible for uneven birth outcomes between differently racialized groups.

Achille Mbembe's conceptualization of "necropolitics" makes it possible for us to conceptualize uneven reproduction as a "bio-necro collaboration"

that can "conceptually acknowledge biopower's direct activity in death, while remaining bound to the optimization of life."[39] From the results it becomes clear, for instance, that while care workers are formally committed to the optimization of life, they use language as an excuse (e.g., not speaking Dutch or not speaking Dutch well), to disavow their commitment to the optimization of life for some. While it seems on the outset that the goal of obstetric care is the improvement of birth outcomes for all, in practice a selection and deselection process takes place along the structural lines of uneven reproduction, on the basis of language, othering and exoticization, and stereotypes. Necropolitics uncovers how certain bodies are cultivated for life and (re)production while others are systematically marked for death, constructing a constantly shifting borderline between subjects deemed "productive" and "lawful" and non-subjects branded as "illegitimate" or "illegal."[40] In the case of reproduction, this marking for death is not only a power that destroys, but also prevents successful reproduction, or makes reproduction more difficult. Through the effectuation of uneven reproduction through obstetric racism by deploying linguistic racism, othering, and stereotypes, the reproduction of people of color is differentiated and treated separately from the reproduction of white women in the Netherlands, resulting in higher mortality and morbidity rates.

Uneven reproduction is a concept that captures the investments and disinvestments in reproduction more broadly than just within obstetrics—Chamber et al. have brought to the fore nine domains that are influenced by systemic racism in relation to the reproductive lifespan: negative societal views, housing, medical care, law enforcement, hidden resources, employment, education, community infrastructure, and policing Black families.[41] At the same time, obstetric racism has been identified as a major contributor to iatrogenic obstetric care,[42] and it should hence be considered to be an important part of the necropolitical mechanism of uneven reproduction. Through the lens of Mbembe's necropolitics, Williamson shows how the iatrogenic effects of obstetrics are a form of

39 Jasbir Puar, *Terrorist Assemblages* (London: Duke University Press, 2007), 35.

40 Christine Quinan and Kathrin Thiele, "Biopolitics, Necropolitics, Cosmopolitics – Feminist and Queer Interventions: An Introduction," *Journal of Gender Studies* 29, no. 1 (2020), 3.

41 Brittany Chambers et al. "Black Women's Perspectives on Structural Racism across the Reproductive Lifespan: A Conceptual Framework for Measurement Development," *Matern Child Health Journal* 25 (2021): 402–413

42 Kylea L. Liese et al., "Obstetric Iatrogenesis in the United States: The Spectrum of Unintentional Harm, Disrespect, Violence, and Abuse," *Anthropology & Medicine* 28 no.2 (2021): 188-204.

destructive reproductive governance, influencing who reproduces successfully and who does not.[43] One of these iatrogenic harms is, for instance, premature birth, which is a cause of health vulnerability throughout life. Davis showed in her book-length ethnography that premature birth is a severe form of reproductive injustice and is partly caused by obstetric racism (next to systemic racism), which involves the continuously neglect of Black mothers.[44] Obstetric racism seen through the lens of uneven reproduction and necropolitics can hence be understood as "an iatrogenic instantiation of longstanding, systemic racism that leaves painful marks on bodies as well as psyches."[45] This iatrogenic instantiation of uneven reproduction is facilitated in the Netherlands by the othering of marginalized racialized groups through exoticization of, for instance, how babies and bellies look. Exoticization can be understood to be part of European orientalism, through which a specific necropolitics can be deployed towards non-white non-Western European groups, based on a seeming appreciation of a romanticized other in order to establish a "normal" white European self as the counterpoint of the other, thereby effectively othering and dehumanizing non-white people.

Where biopolitics "fosters life or disallows it," necropolitics is the systemic subjugation of life to the power of death, congruent with Gilmore's definition of racism as an organized vulnerability to premature death, resulting in "infinite racializations."[46] Davis's introduction of the concept of "uneven reproduction" to transnationally address "complex patterns of investment and disinvestment that reconfigure reproduction" can be understood as a way of capturing the bio- and necropolitical articulations of power that produce obstetric racism in daily practice and "impede Black women's successful reproduction over time and across space."[47] While, for instance, obstetric violence could still be understood as a byproduct of biopolitics, resulting from over-medicalization with the aim to produce life as safely as possible, even though this might negate the subjectivity of the pregnant person, the willful neglect and under-medicalization that characterizes obstetric racism must be captured in the sphere of necropolitics, as it leads to diagnostic lapses, seriously worse birth outcomes and, thus, to uneven reproduction. Our study shows that the latter is also enabled in

43 Williamson, "The Iatrogenesis."

44 Davis, "Obstetric Racism."

45 Ibid., 7.

46 Achille Mbembe, *Necropolitics*, trans. Steven Corcoran (London: Duke University Press, 2019), 17; Gilmore, *Golden Gulag*, 28.

47 Davis, "Uneven Reproduction."

the Netherlands through linguistic racism, othering and exoticization, and stereotypes around natural birth.

Language becomes a basis for dismissing mothers as deserving of the best care that optimizes life, thereby exposing them to a necropolitical form of neglect, as it makes these mothers more vulnerable for death. Exoticization emerges as an effective form of othering, in which pregnant people of color are at the center of attention, but not in a way constitutive of their humanity, treating them as exceptions that affirm the biopolitical norm of the white pregnant body. This othering process of selection and deselection is reflective of the mechanism of investment and disinvestment central to uneven reproduction. And finally, the usage of contradictory stereotypes functions as the justification for substandard care, where Black women are seen as natural birthers and therefore need less care, while refugees are seen as bad birthers who will end up with a cesarean section anyway and therefore need less care to enable a vaginal birth. In both cases, the necropolitical disinvestment of care in the daily practice of the obstetric institution is facilitated by stereotypes, which makes these mothers more vulnerable to premature death, and is congruent with the uneven disinvestment in the reproduction of marginalized racialized groups.

Following Gilmore's definition of racism as the institutionally and state-sanctioned practices that make particularly designated groups of people vulnerable to harm and premature death,[48] we can now see how uneven reproduction dictates investment and disinvestment in the reproduction of differently racialized groups, carried out through obstetric racism as an institutionally sanctioned necropolitical disinvestment of care facilitated by linguistic racism, othering and exoticization, and stereotypes. As such, uneven reproduction and obstetric racism are directly responsible for the effectuation of vulnerability to premature death, and birth, of marginalized racialized groups. In this chapter, we have conceptualized how Davis's concepts of uneven reproduction and obstetric racism are effectuated in the Netherlands through the daily practice of linguistic racism, othering and exoticization, and stereotypes. By interpreting uneven reproduction as consisting of a bio- and necropolitics that optimizes certain life through investments and negates "other" life through disinvestments, we link the concept of uneven reproduction to daily practices of obstetric racism within the obstetric institution, where a similar logic of selection and deselection, or investment and disinvestment, takes place on a daily basis.

48 Davis, "Obstetric Racism"; Davis, "Uneven Reproduction"; Gilmore, *Golden Gulag*.

3 Obstetric Violence within Students' Rite of Passage: The Reproduction of the Obstetric Subject and its Racialised (M)other

Rodante van der Waal, Veronica Mitchell, Inge van Nistelrooij, and Vivienne Bozalek[1]

Abstract

In this chapter, we argue that the modern obstetric subject (doctor or midwife) representing the obstetric institution engulfs the (m)other in a typically modern way as othered, racialized, affectable, and outer-determined, in order to constitute itself in terms of self-determination and universal reason. We amplify students' curricular encounters in two colonially related geopolitical spaces, South Africa and the Netherlands, and in two professions, obstetric medicine and midwifery, to highlight global systemic tendencies that push students to cross ethical, social, and political boundaries towards the (m)other they are trained to care for. The embedment of obstetric violence in their rite of passage ensures the reproduction of the modern obstetric subject, the racialized (m)other, and institutionalized violence.

Keywords

Obstetric racism, reproductive violence, medical education, midwifery training, Denise Ferreira da Silva, Achille Mbembe

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Waal, van der, R., *Birth Justice. From Obstetric Violence to Abolitionist Care*. Amsterdam: Amsterdam University Press 2025
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Introduction

> *Women who perceived that they had experienced traumatic births viewed the site of their labor and delivery as a battlefield. While engaged in battle, their protective layers were stripped away, leaving them exposed to the onslaught of birth trauma. Stripped from these women were their individuality, dignity, control, communication, caring, trust, and support and reassurance.*
>
> —Cheryl T. Beck[2]

In 1987, Robbie Davis-Floyd described obstetric training as a "rite of passage," an initiatory process of transition into a technological model of childbirth.[3] Doctors, on their way to become professionals who ought to provide support

2 Cheryl T. Beck, "Birth Trauma, in the Eye of the Beholder," *Nursing Research* 53, no. 1 (2004): 34. Contrary to Beck, we use the term "mothers," not women, unless it is specifically about women as a class, to identify a social economical gendered subject category, *not* a biological sex determination. We choose to use this gendered term because we consider obstetric violence to be a form of gender-based violence and reproductive violence specifically directed against the maternal. To support the use of the word mother as a social, economic, gendered subject category, we follow Silvia Federici, *Caliban and the Witch: Women, the Body, and Primitive Accumulation* (New York: Autonomedia, 2004), 14: "[…] [I]f 'femininity' has been constituted in capitalist society as a work-function masking the production of the workforce under the cover of a biological destiny, then 'women's history' is 'class history,' and the question that has to be asked is whether the sexual division of labor that has produced that particular concept has been transcended. If the answer is a negative one (as it must be when we consider the present organization of reproductive labor), then 'women' is a legitimate category of analysis, and the activities associated with 'reproduction' remain a crucial ground of struggle for women." We group "mothering" under gendered reproductive labor, but at the same time, as it refers to the practice of mothering, we regard it as a more open and less biologically determined category than "women": anybody can do the reproductive labor of mothering that is traditionally gendered as women's work, including giving birth.

Furthermore, in this paper we understand the (m)other as a subject position that is reproduced during childbirth in the obstetric institution. In this, we want to follow Johanna Hedva's usage of the term woman as a subject-position in her *Sick Woman Theory*: "To take the term 'woman' as the subject-position of this work is a strategic, all-encompassing embrace and dedication to the particular, rather than the universal. […] I choose to use it because it still represents the un-cared for, the secondary, the oppressed, the non-, the un-, the less-than. […] The Sick Woman is anyone who does not have this guarantee of care." Johanna Hedva, "Sick Woman Theory," accessed February 22, 2020, http://www.maskmagazine.com/not-again/struggle/sick-woman-theory. We believe that the same counts for the subject position of the (m)other, who is uncaringly constituted and reproduced during childbirth in the obstetric institution, as we will elaborate upon in this paper. This does not mean that people with a uterus who do not identify as "mothers" are not victims of obstetric violence; on the contrary, their refusal of this gendered subjectivity typically leads to more, not less, violence.

3 Robbie Davis-Floyd, "The Technological Model of Birth," *The Journal of American Folklore* 100, no. 398 (1987): 479–495; Robbie Davis-Floyd, "Obstetric Training as a Rite of Passage,"

in the challenging process of giving birth, attain an alienated objectified distance to the laboring human, fragmenting her body into different parts and mechanisms, failing to conceive of the emotional, spiritual, and psychological dimension of giving birth. As a result, they become professionals in the medicalization of childbirth, instead of in caring for people in childbirth physically and emotionally. Davis-Floyd conceptualized obstetric training as a forceful rite of passage consisting of a disciplinary integration into the common values and beliefs of the obstetric institution through techniques that resemble the military. She opened her article with the following citation of Stephen Saunders, MD:

> Why is medical school the way it is? I think it's part of the idiocy that goes on with the good ol' boy approach—"we did this back in my day, by God, and you've got to do the same thing"—it's like the Marine Corps and that sort of thing. It's a crazy thing that's gotten in the habit of perpetuating itself.[4]

Now, more than 30 years later, we have to conclude that neither the institution of obstetrics nor obstetric training has changed much. Birthing facilities in both South Africa and the Netherlands, the two geopolitical locations of our study, remain complex environments filled with tensions and obstetric violence, which we define as violence during pregnancy, childbirth, and/or the postpartum period at the hands of healthcare workers in the obstetric system.[5] Learning in the clinical space of obstetrics brings a level of excitement together with anxiety, as students develop a sense of becoming "real" midwives and doctors. What they confront in their training and internships is at times very different to their expectations, leaving them unsettled, confused, and traumatized. In our engagements with students of both obstetrics and midwifery, they report the same persistent, almost invisible culture, as Davis-Floyd wrote of in 1987, that keeps reproducing itself:

As students you don't necessarily see it at this stage, but you go on and you keep seeing these things, and at some stage you're going to pick it up and

Medical Anthropology Quarterly, New Series 1 no.3 (1987): 288–318; Robbie Davis-Floyd, *Birth as an American Rite of Passage* (Los Angeles: University of California Press, 2003 [1992]).

4 Davis-Floyd, "Obstetric Training as a Rite of Passage," 288; Davis-Floyd, *Birth as an American Rite of Passage,* 252.

5 Rachelle Chadwick, *Bodies that Birth: Vitalizing Birth Politics* (London: Routledge, 2018); Marit van der Pijl et al., "Left Powerless: A Qualitative Social Media Content Analysis of the Dutch #breakthesilence Campaign on Negative and Traumatic Experiences of Labour and Birth," *PLOS ONE* 15, no. 5 (2021): e0233114.

you're going to internalize it. I think that's the biggest danger in that they're actually breeding students who end up being just like the doctors that we don't want to be. (*SA, 2015*)[6]

In the Netherlands, midwives in training say that:

[...] *students among each other are acting cool, like they do not care, they're just acting tough, and the competition is unbearable.* [...] [*T*]*he problem is this whole macho culture that is there from the start.* (*NL, NO, 2020*)

This contributes to:

[...] *a vicious circle: you can't draw your own boundaries, because they* [*the midwives*] *have transgressed their boundaries long ago and continue to do so.* (*NL, MV, 2020*)

Students conclude:

It's like the military. It's hazing. You're made to be complicit to the system. (*NL, MB, 2020*).

Students of obstetrics and midwifery in both South Africa and the Netherlands point to the same structures that pressure them to become somebody they do not want to be: (group) pressure from both their peers and their teachers. The comparison with the military shows that the experience of obstetric training as a forceful initiation rite is still a reality.

One thing has changed, though. There is increasing public awareness, also among students, about topics such as obstetric violence and obstetric racism, and acknowledgement of the influence of colonialism on the institutions that were founded in modernity. The students' conscious feminist and anti-racist assessment of their training tells us that they feel forced to collude in obstetric violence and racism in order to become a doctor or midwife. This makes transparent that obstetric training should not merely be understood as a rite of passage into a technological model of childbirth as Davis-Floyd[7] has argued, but as an initiation into a misogynistic, heteronormative,

6 We first refer to the country (SA for South Africa and NL for the Netherlands), then to the students (either anonymously or with their initials), and then to the year the quote from the student is from. The students participating in this research in South Africa were all medical students and in the Netherlands they were all midwives.

7 Davis-Floyd, "The Technological Model."

colonial, and racialized institution, and thus as an initiation into practices of reproductive injustice through obstetric violence. Why is obstetric violence a necessary part of the initiation into the obstetric institution? Why does the obstetric subject need obstetric violence to constitute and affirm itself? And why does it seem so difficult to treat mothers with respect, something that is so obviously necessary in childbirth?[8]

Obstetric violence is a term originating from the early 2000s, introduced by South American activists to raise awareness about mistreatment of people during childbirth.[9] It consists of, but is not limited to, unconsented procedures, neglect, gaslighting, shaming, racism, and discrimination.[10] Subsequently, obstetric violence has been recognized and acknowledged in almost every country globally, leading to more and more international recognition of this form of gender-based violence, culminating in a 2019 United Nations' report.[11] Although it is widely accepted among scholars and activists that obstetric violence is gender-based violence, it is less recognized that it is race-based violence as well, as Dána-Ain Davis has argued, coining the term "obstetric racism."[12] Not only are maternal and neonatal morbidity and mortality rates globally worse for people of color, obstetric violence is also reported to be more prevalent among people of color globally, especially in postcolonial countries.[13]

8 Elselijn Kingma, "Harming One to Benefit Another: The Paradox of Autonomy and Consent in Maternity Care," *Bioethics* 35, no. 5 (2021): 456–464.

9 Michelle Sadler et al. "Moving Beyond Disrespect and Abuse: Addressing the Structural Dimensions of Obstetric Violence," *Reproductive Health Matters* 24, no. 47 (2016): 47–55; C.R. Williams et al. "Obstetric Violence: A Latin American Legal Response to Mistreatment during Childbirth," *BJOG: Journal of Obstetrics and Gynaecology* 125, no. 10 (2018): 1208–1211; Stella Villarmea, Ibone Olza, and Adela Recio, "On Obstetrical Controversies: Refocalization as Conceptual Innovation," in *Normativity and Praxis: Remarks on Controversies*, ed. Ángeles J. Perona (Milan: Mimesis International, 2015).

10 Meghan A. Bohren et al. "The Mistreatment of Women During Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review," *PLoS Medicine* 12, no. 6 (2015): e1001847, discussion e1001847; Chadwick, *Bodies that Birth*; Sara Cohen Shabot, "We Birth With Others: Towards a Beauvoirian Understanding of Obstetric Violence," *European Journal of Women's Studies* 28, no. 2 (2020): 1–16; Sara Cohen Shabot and Keshet Korem, "Domesticating Bodies: The Role of Shame in Obstetric Violence," *Hypatia* 33, no. 3 (2018): 384–401; Dána-Ain Davis, "Obstetric Racism: The Racial Politics of Pregnancy, Labor, and Birthing," *Medical Anthropology* 38, no. 7 (2019a): 560–73; Villarmea & Guillén 2011.

11 Dubravka Šimonović, "A Human Rights-Based Approach to Mistreatment and Violence against Women in Reproductive Health Services with a Focus on Childbirth and Obstetric Violence. Note by the Secretary-General," *Report of the Special Rapporteur on Violence against Women* (New York: United Nations, 2019). https://digitallibrary.un.org/record/3823698.

12 Davis, "Obstetric Racism."

13 Davis, "Obstetric Racism."; Dána-Ain Davis, *Reproductive Injustice: Racism, Pregnancy and Premature Birth* (New York: NYU Press, 2019); Bohren 2019, 2015; Gita Sen, Bhavya Reddy,

Although we live in a postmodern, postcolonial society, the obstetric institution can still be regarded as fundamentally modern and as a locus of coloniality, due to its refined biopolitics concerning racialized reproduction and its strong roots in modern rationality.[14] Denise Ferreira da Silva critiques the modern, post-Enlightenment European subject as the transcendental master of universal reason, and shows how postmodern scholarship in anthropology and sociology tries to critique the white male modern subject but typically ends up defending its position.[15] The problem is, as Silva points out, that we are tempted to think that we should solve the logic of exclusion of the subaltern subject through emancipatory inclusion. We are then blind to the fact that it is not possible to simply include those who are excluded, since their exclusion has a vital function in the constitution of the dominant subject. The subaltern subject, Silva explains, cannot be included into modern subjectivity, because it is itself as much a product of modernity as the modern subject, and was thus never "'forgotten" or "'excluded." It was rather engulfed in the foundation of modern subjectivity as its necessary other. In this chapter, we follow Silva's argument by showing that the mother cannot be included as an equal subject in obstetrics, since she is the necessary (m) other of modern obstetric subjectivity.

By recognizing the obstetric rite of passage as "technological," we understand Davis-Floyd's call for change as a revaluing of the mother over technology, aimed to win back the autonomy or self-determination taken from her by the machine. However, this critique fails to challenge that, in fact, the dominant subject position of the obstetrician or midwife is dependent on the existence of the mother as an oppressed subject, independent from technology. The mother cannot simply be included as a subject within

and Aditi Iyer, "Beyond Measurement: The Drivers of Disrespect and Abuse in Obstetric Care," *Reproductive Health Matters* 26, no. 53 (2018): 6–18; Myra L. Betron, Tracy L. McClair, Sheena Currie, and Joya Banerjee Betron, "Expanding the Agenda for Addressing Mistreatment in Maternity Care: A Mapping Review and Gender Analysis," *Reproductive Health* 15, no. 1 (2018): 143; Andrea Solnes Miltenburg et al., "Disrespect and Abuse in Maternity Care: Individual Consequences of Structural Violence," *Reproductive Health Matters* 26, no. 53 (2018): 88–106.

14 Alys Eve Weinbaum, *Wayward Reproductions: Genealogies of Race and Nation in Transatlantic Modern Thought* (London: Duke University Press, 2004); Alys Eve Weinbaum, *The Afterlife of Reproductive Slavery: Biocapitalism and Black Feminism's Philosophy of History* (London: Duke University Press, 2019); Khiara M. Bridges, *Reproducing Race: An Ethnography of Pregnancy as a Site of Racialization* (Berkeley: University of California Press, 2011); Deirdre Cooper Owens, *Medical Bondage: Race, Gender, and the Origins of American Gynecology* (Athens: University of Georgia Press, 2018).

15 Denise Ferreira da Silva, *Toward a Global Idea of Race* (Minneapolis: University of Minnesota Press, 2007).

the obstetric institution through a devaluation of technology, since her oppression is not tied to technology, but to the obstetric subject itself. To address this, we focus on a more fundamental transition that becomes manifest in the many instances of obstetric violence in students' rite of passage. We lay bare a movement of violent engulfment of the (m)other that constitutes the obstetric self, consisting of the appropriation of the mother as other, subaltern, and affectable, "stripped from [...] individuality, dignity, control, communication, [...] [and] trust."[16] Therefore, the rite of passage should be understood not merely as a transition into a technological model of birth, but as an initiation into an active, assertive, and responsible subject position that is founded on (m)others' oppression. Following the critique of modern biopolitical institutions of Achille Mbembe,[17] we furthermore argue that the rite of passage of students is one into a modern *necropolitical* institution that engulfs the mother of color through a negation, instead of affirmation, of life.

In order to make visible that obstetric violence and obstetric relationality characterize the obstetric rite of passage globally, we locate our study in two different colonially related geopolitical spaces, namely South Africa and the Netherlands. These countries share a colonial past and as such represent a linkage that can be deemed exemplary for the global distribution of wealth, subjectivity, bio- and necropolitics, and—our focus—obstetric violence. We present this linkage as exemplary to make manifest a modern and colonial continuance in obstetrics between contexts that are usually perceived as radically different, one being African and one European. As such, we are able to locate a more fundamental level of the rite of passage that is exposed by obstetric violence and obstetric racism. Hypothetically, this rite of passage can thus be found in obstetric institutions worldwide, since becoming an obstetric subject requires an engagement with the modernity and coloniality of the institution, which are present globally.[18]

The Modern Obstetric Subject and Its Affectable (M)other

Modernity is foundational for contemporary science and impossible to disentangle from the coloniality of power, the conceptualization of gender, and the

16 Beck, "Birth Trauma," 34.

17 Achille Mbembe, *On the Postcolony* (Johannesburg: University of Wits Press, 2001); Achille Mbembe, *Necropolitics*, trans. Steven Corcoran (London: Duke University Press, 2019).

18 We wish to thank our first reviewer for this specific phrasing.

history of slavery.[19] It gave rise to a specifically modern onto-epistemological configuration, that is, the simultaneous constitution of subjects and knowledge of man, establishing who counts as human, differentiating people through racializing and gendering science. Regarding obstetric practice and science specifically, the onto-epistemological configuration of subjectivity became mutually exclusive with having a uterus and/or being of color.[20]

Modernity is furthermore characterized by a switch in power from sovereign to biopower.[21] Biopower rules through disciplinary medical, criminal, military, educational, and policing institutions.[22] This concept has been heavily critiqued for its purely European focus, and it is argued that it cannot grasp another related power responsible for the construction of racially differentiated people. Mbembe understands this as "necropower," mitigated not through the disciplinary production of life, but through a negation of life.[23] Obstetrics can be regarded as a bio-necro collaboration, as it relies on the knowledge gained of the female body during colonial rule and slavery and applies both bio- and necropower to onto-epistemologically produced differentiated, racialized subjects of unequal standing and vulnerabilities.[24]

In her ground-breaking work *Towards a Global Idea of Race*, Denise Ferreira da Silva[25] traces the history of European self-consciousness. She determines the constitutive moment of modern reason to be the self-identification of the European subject with universal reason, constituting itself as universal reason. Thereby, the modern subject was established as transcendental (above the "matter" or the laws of nature), interior (undetermined by external laws), and transparent (without a body).[26] But this position of the transcendental "I" of universal reason could not be attained solely by the European subject itself. It is built on a constitutive movement of othering

19 Walter Mignolo and Catherine Welsh, *On Decoloniality* (London: Duke University Press, 2018); Aníbal Quijano, "Coloniality and Modernity/Rationality," *Cultural Studies* 21, no. 2 (2007): 168–178; María Lugones, "Heterosexualism and the Colonial/Modern Gender System," *Hypatia*, 22, no. 1 (2007): 186–209; Federici, *Caliban and the Witch*.

20 Stella Villarmea, "When a Uterus Enters the Room, Reason Goes Out the Window," in *Women's Birthing Bodies and the Law: Unauthorised Medical Examinations, Power and Vulnerability*, ed. Camilla Pickles and Jonathan Herring (Oxford: Hart, 2020); Owens, *Medical Bondage*.

21 Michel Foucault, *Society Must Be Defended. Lectures at the Collège de France 1975–1976*, trans. David Macey (Picador, New York, 2003); Quijano, "Coloniality."

22 Foucault, *Society Must Be Defended*.

23 Mbembe, *Necropolitics*.

24 Mbembe, *Necropolitics*; Puar, *Terrorist Assemblages*; Ruth Wilson Gilmore, *Golden Gulag: Prisons, Surplus, Crisis, and Opposition in Globalizing California* (Berkeley: University of California Press, 2007).

25 Silva, *Toward a Global Idea of Race*.

26 Ibid., 255.

whereby its relation to the outside world is captured by what Silva calls "the scene of engulfment" of modern science, characterized by the colonization and appropriation of "everything else."[27] In Hegel or Darwin, for instance, everything exterior to the transcendental subject is taken up in a universal movement of progress of the evolution of the Spirit or the natural laws. The transcendental subject is located at the end of progress, as the final outcome of evolution, being the only one with insight into the evolution of natural laws, while remaining undetermined by them. As such, it engulfs "everything else" that is part of the movement that led evolution to itself, leaving everyone else behind, in so-called different stages of development.

Since universal reason was "located" in Europe, "Europe's others" were engulfed into the European self in an unbridgeable difference, established by modernity, as its subaltern other.[28] In contradiction to the modern subject, the subaltern subject is affectable and fully outer-determined (instead of self-determined), without self-consciousness (thus only knowable by the white man instead of by itself), exterior (with primarily a body), and in particular, constituted by being somewhere outside of Europe (instead of being universal).[29] Written in affectability, the subaltern subject is positioned between subject and object, not completely objectified, but influenceable, educatable—but too influenceable, non-self-determined, and passive to really count or be understood as a modern subject.[30]

Through the construction of the post-Enlightenment European male subject as the only one endowed with universal reason, the scene of engulfment was able to contain all land and people outside of Europe as part of the same (universal reason, evolution theory, progress, emancipation, etc.), while grounding them in irreducible difference—an onto-epistemological configuration of globality and subjectivity still responsible for the continuous reproduction of racialized subjects.[31] Whiteness became a marker of universal reason, as the representation of European roots that keeps on writing people into an "analytics of raciality."[32]

In the case of obstetrics, this expressed itself in scientific discussions in Europe that revolved around whether having a uterus meant a causal exclusion from reason[33] and life-threatening and non-anaesthetized ex-

27 Ibid.
28 Ibid.
29 Ibid., 117, 255, 257–259.
30 Ibid., 199.
31 Ibid.
32 Ibid., 3.
33 Villarmea, "When a Uterus."

perimentation on Black enslaved women in the United States, which gave doctors unlimited access to the female body in a way they never had before.[34] These practices began after the closing of the transatlantic slave trade, when slave owners and doctors focused on practices of "slave-breeding" as an alternative,[35] marking the birth of modern obstetrics. The existence of modern obstetric subjectivity is hence dependent on the engulfment of Black enslaved women and European women in universal reason, while they were being written in affectability and exteriority.[36] As white women were engulfed through a biopolitical confinement focused on the enhancement of safe reproduction, Black women were engulfed as a "public (non-European or non-white) place produced by scientific strategies where their bodies were immediately made available to a transparent male desire."[37]

European women, with some exceptions such as the Irish, were biopolitically engulfed and racialized as white, while non-European women were racialized as non-white, leaving them more "vulnerable to premature death" within the practice of obstetrics.[38] The engulfment of women of color can therefore be understood as necropolitical, leading to death through experimentation and exploitation, contributing to medical progress that would primarily serve white women. These practices racialized, gendered, and engulfed pregnant people in universal reason as objects of knowledge, while at the same time excluding them from being subjects of universal reason themselves. They became affectable, outer-determined subjects, bodies that could be studied, while constituting the obstetrician in the same movement as the one endowed with universal reason, self-determination, and as the active agent in birth; the one who *delivers her*. This self-understanding as active on the part of the obstetrician instead of the mother is still commonly used in obstetric training, counting how many deliveries one should *do* in order to graduate.

In postcolonial, post-slavery societies, the onto-epistemological dependency on the analytics of raciality resulted in the racialized nation state through a double logic of "exclusion" and "obliteration."[39] Exclusion is most visible in forms of apartheid, recognizable in obstetrics in the

34 Owens, *Medical Bondage*.

35 Weinbaum, *The Afterlife*; Owens, *Medical Bondage*.

36 This is what Deirdre Cooper Owens argues throughout her book *Medical Bondage*, in which she makes a case for the acknowledgement of the Black enslaved woman as the mother of modern obstetrics, in addition to its infamous fathers.

37 Silva, *Toward a Global Idea of Race*, 266.

38 Gilmore, *Golden Gulag*, 28.

39 Silva, *Toward a Global Idea of Race*.

medical apartheid of accessibility, as well as the division of public and private healthcare. Obliteration is the "emancipatory" engulfment, the "inclusion" of the other, that actually effaces the other as becomes apparent in the denial of obstetric racism—despite vast differences in mortality and morbidity outcomes. It is also apparent in the (re)production of group-differentiated vulnerabilities, as well as the continuation of obstetric violence, unconsented eugenic practices, and reproductive injustice against mothers of color.[40] By practicing within the logics of obliteration and apartheid, the obstetric subject still constitutes itself through the violent engulfment of the maternal body, as the autonomous, self-determining agent of birth that delivers the racialized (m)other of her child. Hence, obstetrics is still onto-epistemologically reproducing the violence that is the groundwork of its rationality and institution, accounting for the epistemic and reproductive injustice equated with obstetric practice.[41]

Two Geopolitical Locations: Data Collection and Analysis

Our research in two colonially related geopolitical spaces, South Africa and the Netherlands, highlights a congruence with the obstetric institution globally. Since obstetric violence is a global phenomenon, we aim to substantiate our argument that obstetric training produces the modern obstetric subject through the engulfment of its affectable (m)other, racialized in logics of apartheid and obliteration, and bio- and necropolitics, by investigating differently located obstetric traineeships.

South African Context

Reproductive health in South Africa is haunted by the legacy of a double logic of exclusion and obliteration during the apartheid regime. For instance, Depo-Provera injections became a tool of power for the apartheid government

40 Loretta Ross and Rickie Solinger, *Reproductive Justice. An Introduction* (Oakland: University of California Press, 2017); Gilmore, *Golden Gulag*.

41 Stella Villarmea and Brenda Kelly, "Barriers to Establishing Shared Decision-Making in Childbirth: Unveiling Epistemic Stereotypes about Women in Labour," *Journal of Evaluation in Clinical Practice* 26 (2020): 515–519; Rachelle Chadwick, "Practices of Silencing: Birth, Marginality and Epistemic Violence," in *Childbirth, Vulnerability and the Law*, ed. Camilla Pickles and Jonathan Herring (Routledge, New York, 2020).

to control Black population growth.[42] Black women of child-bearing age, many of whom worked at white-owned farms and factories, were subjected to these three-monthly contraceptive injections. This follows the logic of obliteration, as they are prevented from reproducing. Also, they were written in complete outer-determination since consent was not even in question.

The logic of apartheid expresses itself in terms of institutional arrangements: separate facilities were built for the white, European population and the so-called non-Europeans that included racialized groups categorized as Black, Colored, Indian, and Asian. Post-apartheid, the logic of exclusion and white supremacy largely remain, albeit more invisibly. The economic wealth of the white minority provides access to private healthcare, supported by corporate medical aid structures. Rachelle Chadwick points to the "bifurcations and binaries" reflected in birth narratives from "privileged (often white) South African mothers birthing in high-tech settings"[43] in the private sector as opposed to marginalized Black mothers birthing in underresourced public health settings. It remains a problem for the poor Black majority to even access public healthcare.[44]

For undergraduate medical students in South Africa, clinical internships take place in the public health facilities. Medical training is mostly six years in duration. Midwives learn their skills amidst a four-year general nursing education. After training in public hospitals, many graduates then move across to the private sector, capitalizing on the necropolitical engulfment of Black (m)others while building their own professional subjectivity. From within the public sector, obstetric violence is relatively well documented as a human rights violation, with increasing visibility revealing numerous forms of mistreatment.[45] In the private health setting, obstetric violence is less well documented, but presents as more "gentle," normalized violence.[46]

42 Judith A. M. Scully, "Black Women and the Development of International Reproductive Health Norms," in *Black Women and International Law: Deliberate Interactions, Movements and* Actions, ed. Jeremy I Levitt (Cambridge: Cambridge University Press, 2015).

43 Chadwick, *Bodies that Birth*, 7.

44 Achille Mbembe, *Apartheid Futures and the Limits of Racial Reconciliation* (Johannesburg: Wits Institute for Social and Economic Research, 2015); Mhlange & Garidzira 2020.

45 Šimonović, "A Human Rights-Based Approach"; Jessica Rucelle et al., "Submission on: Obstetric Violence in South Africa. Violence against Women in Reproductive Health & Childbirth," in "A Human Rights-Based Approach to Mistreatment and Violence against Women in Reproductive Health Services with a Focus on Childbirth and Obstetric Violence. Note by the Secretary-General," *Report of the Special Rapporteur on Violence against Women* (New York: United Nations, 2019), ed. Dubravka Šimonović (New York: United Nations, 2019); Camilla Pickles, "Eliminating Abusive 'Care': A Criminal Law Response to Obstetric Violence in South Africa," *South African Crime Quarterly* 54 (2015).

46 Chadwick, *Bodies that Birth*.

Veronica Mitchell's doctoral research project is on the learning experience of medical students, who differed in ethnicity, age, social class, and religion, at the University of Cape Town. She drew on data collected from three focus groups with medical students, and semi-structured interviews with 3 medical students, 13 midwives, 12 clinician educators, and 3 departmental administrators, all of whom were also asked to complement the discussions with drawings.[47] Moments that "glowed" were brought to the fore and studied through relational ontology, rather than through coding with themes in a conventional structured analysis.[48]

The Netherlands Context

As postcolonial theorist Gloria Wekker argues, the Netherlands is an exemplary country for the pervasiveness of the European myth of "white innocence" where racism continues to be denied in terms of "color-blindness" and a national self-image characterized by tolerance.[49] Contrary to countries such as South Africa, race and racism remain topics that are rarely openly discussed, thereby establishing the idea of an innocent self that cannot be responsible for things their forefathers did so far away. This contributes to the idea that race is not a problem in Europe, as it is in countries such as South Africa or the United States.[50]

In such a context, racism in obstetric care remains unacknowledged. Also the influence of the colonial past on obstetric care is unaddressed, while the plantations of Suriname were infamous for being particularly brutal for women who had to submit to reproductive duties.[51] These possibly included practices of "breeding" (similar to those in the US) after the closing of the transatlantic slave trade in 1814.[52] There were also attempts to implement colonial obstetric medicine in Indonesia and traditional Indonesian midwives' knowledge was appropriated and ridiculed in the context of

47 For this paper, we refer mostly to the transcribed texts from engagement with the undergraduate medical students.

48 Maggie MacLure, "Researching without Representation? Language and Materiality in Post-Qualitative Methodology," *International Journal of Qualitative Studies in Education* 26, no. 6 (2013): 658–667.

49 Gloria Wekker, *White Innocence. Paradoxes on Colonialism and Race* (London: Duke University Press, 2016).

50 Ibid.

51 Anton de Kom, *Wij slaven van Suriname* (Amsterdam: Atlas Contact, 2020 [1934]).

52 Rosemary Brana-Shute, *The Manumission of Slaves in Suriname, 1750–1828* (PhD diss., University of Florida, 1985), 233.

obstetric science.[53] Students hence train in the unacknowledged afterlife of a colonial past that characterizes the obstetric institution through adverse outcomes for marginalized communities, something we can understand as the logic of obliteration, following Silva.[54]

Although obstetric violence in the Netherlands is not extensively documented, the existence of the activist movement de Geboortebeweging (The Birth Movement), the *#GenoegGezwegen* (#Breakthesilence) campaign, and research linking traumatic experiences to the behavior of healthcare workers, show the widespread practice of mistreatment in both midwifery and obstetric care.[55] The Netherlands is one of the last countries in Europe to have a strong, independent primary care midwifery system, although it is continuously under pressure. While independent midwifery care has its own philosophy with its own values and practices (woman-centered relational care focused on the physiology of childbirth), and while some midwives are highly critical and resistant, independent midwifery overall can be regarded as part of the modern obstetric institution. Because of the discrepancy between the ideals of midwifery and the reality of the internships, and because students are not taught to critically understand this discrepancy as the curriculum lacks education in feminist and critical race theory, students often feel that the midwifery philosophy is a "myth" (NL, MV, 2020). The existence of this myth, as something that one keeps hoping for but never encounters, is exhausting, frustrating, and confusing:

In the academy they stimulate you to develop your own vision on midwifery, but in practice it is almost impossible to have the freedom to practice how you want to practice (*NL, MV, 2020*).

There are three Dutch midwifery academies. Unlike in South Africa, midwifery is an independent Bachelor program of four years, with no link

53 Hilary Marland, "Midwives, Missions, and Reform: Colonizing Dutch Childbirth Services at Home and Abroad ca. 1900," in *Medicine and Colonial Identity*, ed. Mary P. Sutphen and Bridie Andrews (London: Routledge, 2003); Liesbeth Hesselink, *Inheemse dokters en vroedvrouwen in Nederlands Oost-Indië 1850–1915* (Amsterdam: Amsterdam University Press, 2009).

54 Silva, *Toward a Global Idea of Race*; J. M. Schutte et al., "Rise in Maternal Mortality in the Netherlands." *BJOG* 117 (2010): 399–406; Noor C. Gieles et al., "Maternal and Perinatal Outcomes of Asylum Seekers and Undocumented Migrants in Europe: A Systematic Review," *The European Journal of Public Health* 29, no. 4 (2019): 714–723; Johanna de Graaf et al. "Living in Deprived Urban Districts Increases Perinatal Health Inequalities," *The Journal of Maternal-Fetal and Neonatal Medicine* 26, no. 5 (2013): 473–48; Gilmore, *Golden Gulag*.

55 Van der Pijl et al., "Left Powerless"; Martine Hollander, F. van Hastenberg, Jeroen van Dillen, M. G. van Pampus, Esteriek de Miranda, Claire A. I. Stramrood, "Preventing Traumatic Childbirth Experiences: 2192 Women's Perceptions and Views," *Arch Womens Mental Health* 20 (2017): 515–23.

to nursing. Rodante van der Waal conducted interviews and organized one focus group in 2020 with the same five midwifery students, who were enrolled in Amsterdam and Rotterdam: 1) NO, a white middle-class mother of a young daughter and an artist who is in the final year of her midwifery training; 2) MV, a Black middle-class woman who is in the final year of her midwifery training; 3) AM, a woman of color and mother who is in the third year of her midwifery training; 4) EH, a white higher middle-class woman who is in the third year of her midwifery training; and 5) MB, a white heterosexual middle-class woman in the final year of her midwifery training.[56]

The semi-structured individual interviews lasted approximately two hours each. They were analyzed thematically using grounded theory, after which the established themes provided the basis for further elaboration in a focus group of three hours, which was again thematically analyzed. The participants were given the chance to read and give feedback on the final research analysis and their quotations used in the paper.[57]

How the Contexts Talk to Each Other

South Africa and the Netherlands are deeply connected through their colonial past. The convenient positioning of South Africa on the shipping route between the East and West enabled the establishment of the Dutch East India Company's power base at the Cape of Storms in the seventeenth century, making them the first colonizers of South Africa. After Britain took over imperial rule, the Dutch established themselves as the "Afrikaner" community, a powerful white actor in the development of the ideology of white supremacy, to which the Dutch word *apartheid* bears testimony.

Our linkage between South Africa and the Netherlands indicates that the affectability of (m)others, and especially (m)others of color, is not only written in the global South but is still fundamentally linked to, as well as produced within, Europe. The continuance of a similar kind of obstetric violence as part of the obstetric training shows that there is a global colonial continuity within the obstetric system regarding obstetric violence and obstetric training. We have identified the rite of passage in the Netherlands in midwifery training and in South Africa in obstetric training, but our hypothesis would be that a similar rite of passage might be identified in

56 Rodante's participants were asked how they identified and how they wanted to be referred to.
57 Veronica's research findings were anonymized; with time and curricular pressures there was no opportunity to return to the research participants.

obstetric institutions elsewhere, both within and outside of Europe. This linkage of South Africa and the Netherlands is hence meant to show the continuance of the universality of the obstetric institution as carried by the modern obstetric subject in two traditionally juxtaposed continents whose relationship is constituted by colonialism.

The Rite of Passage

Drawing further on the theory of the obstetric bio- and necropolitical engulfment of (m)others established above and based on Silva and Mbembe, we elaborate on the obstetric rite of passage which reproduces obstetric subjectivity through this continuous engulfment, by forcing students to collude in obstetric violence.

Davis-Floyd understands a rite of passage as: a) "a patterned, repetitive, and symbolic enactment of a cultural belief or value";[58] that is b) "transitional" in nature, always involving "liminality";[59] and c) as demanding a "retrogression of participants to a lower level of cognitive functioning [...] and extreme redundancy combined with heightened affectivity" to ensure and facilitate "unquestioning acceptance" of the institutional norms and values,[60] having as its goal to d) "mould the belief system of the individual into coherence and symmetry with that of the larger group or society."[61]

Three stages can be distinguished in the rite of passage. First, there is a stage of separation of the participants from their preceding social surroundings. Second, there is a stage of transition in which they have neither one status nor the other. And third, there is a stage of integration in which they are absorbed into their new social state.[62] Drawing on Davis-Floyd's definition of the rite of passage, we will use the same characterization of the three stages of separation, transition, and integration. With the help of our theorization of the obstetric institution and obstetric subjectivity, following the work of Mbembe and Silva, we have identified seven instances of obstetric violence that indicate the engulfment of the (m)other by the obstetric subject-to-be within the three stages of the latter's rite of passage. All these instances consist of implicit or explicit obstetric violence that point

58 Davis-Floyd, "The Technological Model," 480.

59 Davis-Floyd, "Obstetric Training as a Rite of Passage," 289; Davis-Floyd, *Birth as anAmerican Rite of Passage*, 60

60 Davis-Floyd, "Obstetric Training as a Rite of Passage"

61 Ibid., 291.

62 Ibid., 288.

towards a more fundamental level of becoming, namely the constitution of obstetric subjectivity through engulfment of the racialized (m)other.

We identify the following instances. In the stage of separation: 1) emotional isolation; and 2) having to adapt the goals, norms, and values of the obstetric institution that instrumentalize the (m)other. Then, in the stage of transition: 3) establishing subjectivity through assertiveness, competition, and learning at the cost of (m)others; 4) colluding in explicit obstetric violence, obstetric racism, and sexual violence; and 5) traumatic experiences. Finally, in the stage of integration: 6) complicity, balancing guilt with numbness; and 7) responsibility at the cost of (m)others.

Despite the differences between South Africa and the Netherlands, as well as between an obstetric and midwifery education, we identify a similar trajectory in both contexts. Below, we elaborate on these instances of violence and show how much obstetric violence is ingrained in students' training.

Separation

Obstetric and midwifery training in both South Africa and the Netherlands consists of intense internships within the obstetric institution. As Davis-Floyd points out, "one result of such overload is the increasing isolation it creates."[63] Social isolation makes students less capable of reflexivity and more distanced from the ideals that motivate their education choice and their emotional engagement:[64]

To be able to do this training, you have to distance yourself, block your empathy and not feel what somebody else feels, only then you can do what you have to do (*NL, MV, 2020*).

According to Davis-Floyd, isolation is "a prerequisite to the achievement of the necessary cognitive retrogression;" necessary to ensure the internalization of the institutional routine.[65]

Resilience has become a key objective in medical training.[66] When students address problems of workload, stress, burnouts, or worries related to

63 Ibid., 299.
64 Ibid.
65 Ibid., 299, 300.
66 Liselotte Dyrbye and Tait Shanafeltm, "Nurturing Resiliency in Medical Trainees," *Medical Education* 46, no. 4, (2012): 343.

obstetric violence or guilt to teachers, it is not the system that is questioned, but the students themselves:

When I addressed my concerns to the teachers, I was told that I was probably too sensitive for the job (*NL, NO, 2020*).

Or:

they told me that I also have to be able to do it in the normal [*i.e., violent*] *way* (*NL, MV, 2020*).

The fact that they are not taken seriously can be seen as an effective way to cut ties to exteriority, laying the groundwork for an individualized and interior modern subjectivity that is rational instead of emotional, and is tough instead of vulnerable, unaffected by what is "outside." Hence, students emotionally isolate themselves from their peers, their teachers, and, most importantly, the mothers they serve.

A technique reflective of the separation from one's former self and previously held norms is the necessity to adopt the goals of the obstetric institution that tend to instrumentalize mothers:

[*The violence is*] *just repeated and repeated and repeated to the point where it becomes the norm* (*SA, 2015*).

Mandatory numbers of medical practices contribute to the instrumentalization of mothers:

The logbook forces a student to focus on numbers rather than people [...], *students are held at ransom for the signatures* (*SA, 2015*).

Such pressures to reach curricular goals force students to be strategic, finding shortcuts to acquire the logbook signoffs that represent achieving the required numbers of curricular tasks such as deliveries and episiotomies. For instance, clinicians in South Africa notice students going off to do something else, then arriving back just in time to perform the delivery because it is the logbook tick that counts rather than their relationship with the birthing mother.

In the Netherlands it is difficult, for instance, for midwifery students to attain the necessary number of episiotomies (a cut in the perineum, vagina, and pelvic floor to quicken delivery) because midwives typically

avoid this controversial intervention that has a wide range of variability in usage within the country.[67] Consequently, students sometimes have to do an additional two-week internship before they are able to graduate. This is commonly referred to as a "cutting internship" (*knipstage*). The inherent violence embedded in the goals and values of the training is revealed in referring to an internship in which one supposedly cares for people as "cutting" into the most intimate body part. This not only objectifies people's bodies, but also appropriates vaginas as something that should be cut as this is so clearly stated as the goal and essence of the internship. Such processes force students to repeat the scene of engulfment, in which (m)others are being taken up as part of the development of their obstetric subjectivity:

We should learn to never see someone as a means to reach your goals. But we're taught exactly the opposite, namely, to be happy when we can cut, because we need those episiotomies to graduate. (*NL, NO, 2020*)

A consequence is that students soon become complicit with the system, even when they are aware of the power dynamics, hierarchies, and violence embedded within the system:

If I didn't want to be an accomplice, I should've walked out of so many rooms [...] *I mean, those five cuts that you have to make, I think that's one of the worst forms of obstetric violence. And that is literally legally expected of you. Legally.* (*NL, MV, 2020*)

Transition

Professional subjectivity is developed either through competition, being assertive, or being pro-active regardless of the mother. A midwife in South Africa shared how one student assaulted another because the other one "stole her delivery" (SA, Midwife Sibela, 2016). Learning based on these values can be understood as effectively establishing a subject position at the expense of mothers. When students object in defense of the mother, they often get scolded:

The midwife scolded me for not using my opportunities to learn, telling me I will never be a midwife [...]. *I don't agree. My learning process is not more important than her birth experience.* (*NL, AF, 2020*)

67 Anna Seijmonsbergen-Schermers, "Intervene or Interfere? Variations in Childbirth Interventions and Episiotomy in Particular" (PhD diss., Amsterdam: Vrije Universiteit, 2020).

Hence, even for students, their own interest and the interests of the people giving birth are constituted as conflicting realities, instead of being brought together in relationality:

I can now confess that it makes me feel deeply guilty and ashamed that I let myself be pressured into those things—I was trying to be assertive and to learn. (*NL, EH, 2020*)

Students reported instances in which they felt that they had to collude in obstetric violence, such as "helping," or more explicitly "forcing" to keep the legs of non-compliant mothers open for an unconsented episiotomy, unconsented vaginal examinations, or unconsented pelvic floor support. A student remarked that obstetric violence is simply part of their training:

It's like it's just a part of it, if I'm being very honest [...] *to just continue to press deeper with one's fingers into the woman's vagina when she screams stop. You are taught to say "No, I really have to feel further! You have to be strong now!" and then you continue. It seems like becoming a midwife means learning how to cross somebody else's boundary, to learn how to just push a bit further to get what you want.* (*NL, AF, 2020*)

As a student said, we are

made to be complicit [...]. *I have blood on my hands because I participate in institutional violence against women* (*NL, MB, 2020*).

In South Africa, after seeing how deeply obstetric violence was ingrained in the training, a student decided to quit:

It changed my whole outlook with regards to obstetrics (*SA, 2015*).

In both countries, students practice their clinical skills more on people of color. This is a classic characteristic of both obstetric racism and medical apartheid, as it has always engulfed people of color to practice and experiment on.[68] In the Netherlands, the majority of the population is white, and everybody with Dutch citizenship should be enrolled in public healthcare.

68 Owens, *Medical Bondage*; Harriet A. Washington, *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present* (New York: Harlem Moon, 2006).

The students state, however, that supervisors let them practice more on mothers of color:

Those women do not know that it is not normal to always have two vaginal examinations after each other, and they do not know that they can refuse, while Dutch women would probably know that, so with them they do not dare to try. (*NL, EH, 2020*)

Note that unconsented vaginal examinations can be seen as sexual assault and would be a criminal offence in any other context.[69] Another student said: "I thought I noticed that she did not want to be examined twice. So, I didn't do it. The midwife commanded me: just do the internal examination" (NL, AF 2020). Although 'practicing' has an innocent ring to it, in obstetrics this involves highly intimate unconsented procedures by multiple people and should be considered as a clear case of obstetric violence, driven by obstetric racism. This is not only possibly traumatizing for mothers, but it also reconsolidates the idea that the bodies of mothers of color are more publicly available than white mothers' bodies and can be more easily violently engulfed.[70]

Students also report prevalent prejudices regarding the loudness and level of pain of Asian, Black, and Arabic mothers. In both our studies, we heard about the joking and gossip in team rooms among midwives regarding marginalized mothers, as something through which students get conditioned to take their pain and personhood less seriously.

Additionally, students claim that marginalized mothers are less informed and are treated with more normalized violence, effectively continuing to write them in affectability:

Even if people thank you a lot, I feel like, hmmm, we have actually kept everything a secret from them, like we purposefully kept them stupid, leaving them with the feeling that it's probably normal how we've treated them. (*NL, EH, 2020*)

In South Africa, a pattern of learning on Black people is perpetuated in the public/private divide, as students practice within the public obstetric institutions where patients are mostly Black lower-class people who tend to be kept less well informed and treated disrespectfully:

69 Camilla Pickles and Jonathan Herring, eds., *Women's Birthing Bodies and the Law: Unauthorised Intimate Examinations, Power and Vulnerability* (London: Hart, 2020).

70 Silva, *Toward a Global Idea of Race*.

They [*mothers in public health facilities*] *don't know anything* [...] *and it's not fair because why should they get less of a respectful and accommodating health system just because they can't afford private care?* (*SA, FG, 2015*)

Racial discrimination alongside different professional practices is rife, as indicated by a midwife saying:

I will treat a Black person like that, but if you put me with say another race on that bed, my attitude will change and my behavior will change. (*SA, 2016*)

Students practicing on mothers of color without consent, perpetuates the scene of engulfment of the maternal body as the other that is included into obstetric subjectivity as an outer-determined, affectable subaltern subject. This reproduces the logic of apartheid determining the quality of different obstetric facilities, and the logic of obliteration that racializes and (re)creates 'group-differentiated vulnerabilities' within the same obstetric system.[71]

The students also make a connection between obstetric violence and sexual violence, a well-known association:[72]

Sometimes I think, when a supervisor asks me something, what you're asking of me is if I can rape that woman. To me, that is traumatic. Once, I refused, I said I'm not going to do it. If you want it to be done, then you do it yourself. And then she became extremely angry with me in the hallway. (*NL, MV, 2020*)

Having to participate in a practice that students perceive as sexually violent not only forces them to engulf the maternal bodies violently but can also trigger their own past experiences of sexual violence:

It was so recognizable that it kept me awake at night. [...] [*T*]*o witness that they just come in, don't say their name, and put their fingers in. For me that's horrible to see, because I've experienced how that is, and it's horrible. And if you see that with others, I feel it again myself.* (*NL, EH, 2020*)

71 Gilmore, *Golden Gulag*.

72 Van der Pijl et al., "Left Powerless"; Sara Cohen Shabot, "Making Loud Bodies 'Feminine': A Feminist-Phenomenological Analysis of Obstetric Violence," *Human Studies* 39, no. 2 (2016): 231–247; Shea Richland, "Birth Rape: Another Midwife's Story," *Midwifery Today* 85 (Spring 2008): 42–43.

For some students, both in South Africa and the Netherlands, witnessing and colluding in obstetric violence is hence a traumatic experience:

I think the one thing that people don't realize is that what you encounter there as a student [...] *can be traumatic, it doesn't sit well with you, and it can be something that eats you up.* (*SA, 2015*)

You ask me, what precisely is traumatic? Well, all the things that you see, that fact that you have to contribute to this system, that you are literally complicit in somebody else's trauma. (*NL, MV, 2020*)

Trauma can be understood as a destruction of the self, after which it must be rebuilt,[73] and therefore functions as an effective equation in the rite of passage.[74] Students become obstetric subjects through colluding in what they perceive as obstetric, racist, and sexual violence. The trauma caused by this violates their sense of self, and thus functions as grounds to constitute obstetric subjectivity.

Integration

Students learn that accompanying childbirth responsibly and being respectful cannot be practised at the same time:

Their [*the teachers*] *response to my questions always has to do with responsibility. That I do not fully understand it right now because I do not have the responsibility yet. This indicates that if you have principles, you are naïve, like I only now have the luxury to have ideals because I do not have responsibility yet. Like responsibility makes all those other things* [*like empathy, relationality*] *impossible.* (*NL, NO, 2020*)

This establishes a paternalizing responsible obstetric subject, while in the same movement excluding the maternal subject from the possibility to take responsibility.

In South Africa, medical students take up their professional responsibility in clinical settings earlier than the midwives in the Netherlands. Anxiety, apprehension, and fear are felt by many, as well as a high level of excitement:

73 Susan Brison, *Aftermath: Violence and the Remaking of the Self* (Princeton: Princeton University Press, 2003).

74 Davis-Floyd, "Obstetric Training as a Rite of Passage," 300–301.

I don't think that's really appropriate for someone of that age, of that experience level, to be dealing with those situations alone. You're calling for help and no one's coming (*SA, 2015*).

A fearful and paternalistic sense of responsibility that is incompatible with respect, relationality, and the mother taking responsibility for herself (which means that she might do something different than expected of her), characterizes one of the final instances of necessary violence in the rite of passage of becoming a modern obstetric subject, that cannot but write mothers as affectable and unequal others without self-determination:

When a fellow midwife in training asked the mother for consent during an emergency training, they made it super difficult for her to pass the training: The actress [*playing the mother*] *said no to the intervention in an extremely exaggerated way, and almost died. The student failed. So, I thought, okay, I should not ask for consent if I want to pass this test.* (*NL, MV, 2020*)

Through years of training within a bio- necropolitical obstetric system, students not only become part of the institutional violent engulfment of the (m)other, but they are pressured to build their subjectivity on it. For the individual student, it is therefore almost impossible to resist this, as one needs to give in to graduate. Midwifery students express that they wish they would have been more naïve in terms of feminism, women's rights, and anti-racism. They think that their education would have been easier to handle without a critical consciousness. Students need to find a balance between their feelings of guilt and numbness in relation to their curricular needs which has them develop strategies to 'stop thinking' or being 'too critical' but just get through it "without being driven insane [...] in such a way that you can still live with yourself" (NL, MV and NO, 2020). With this complicity, the initiation is fulfilled: "We just carry the stick with us" (SA, 2015).

Conclusion

Students' obstetric and midwifery training can be theorized as a rite of passage in which obstetric subjectivity is constituted. In this process the identity of the student is molded so that the student becomes part of the institution. Robbie Davis-Floyd[75] has criticized the obstetric rite of passage

75 Ibid.

to be too 'technological' in nature, which is the reason, according to her, that obstetrics lost sight of the mother as a subject. In this chapter we have argued that the problem with obstetric training is more fundamental than that. We have determined instances of violence as part of the rite of passage, indicating that it is not merely an initiation into a technological model of childbirth, but one into obstetric subjectivity that occurs through the engulfment of the (m)other through obstetric violence, racism, and trauma. The obstetric rite of passage thereby constitutes obstetric subjectivity not through technology, but through the appropriation of the pregnant body as a (less worthy) part of the obstetric self, thereby engulfing the maternal as othered: as an affectable, outer-determined subject excluded from autonomy, rationality, and self-determination.

This becomes manifest in that students are from early on conditioned into a position in which they are endowed with responsibility over mothers' and babies' bodies, pressured to decide what should happen with the mother's body even if this includes violating her—pushed to fight for their own interests over the backs of mothers. This is (re)productive of both the modern obstetric subject and, necessarily in the same movement, its affectable (m)other, rendering the laboring body always in passivity, writing her in affectability through obstetric violence, thereby preventing relational connection and care.[76] By understanding the problem of the rite of passage as merely technological, this subjectification of students through the appropriation of the maternal body remains unchallenged. Therefore, in order to arrive at the more fundamental problem of the obstetric rite of passage, we have focused on the question why obstetric violence and obstetric racism are an essential part of obstetric and midwifery training, thereby revealing the structural appropriation of the maternal body on which obstetric subjectivity is constituted.

Answering this question, we have shown that the reproduction of obstetric subjectivity follows the logic of the reproduction of the modern, post-Enlightenment European subject, the subject of coloniality and globalization.[77] We have developed this argument by showing how obstetrics should be understood as a global modern institution through the linkage of two colonially related geopolitical places, namely South Africa and the

76 As suggested by one reviewer, it would have been interesting to juxtapose what students say about obstetric violence with what mothers themselves say about their experiences. We will consider this idea for further research, as multiple voices and perspectives might be brougth into dialogue to paint a more complete and complex picture.

77 Silva, *Toward a Global Idea of Race*.

Netherlands. In both places, the obstetric subject can only constitute itself through engulfing the maternal body as its other, thereby reproducing her racialization and oppression. The birthplace of the obstetric institution can be understood as having its foundation in the necropolitical engulfment of Black women and marginalized people, further developing this through a biopolitical engulfment of white women in the Global North. All remain, in different ways, excluded from the position of power and subjectivity within the obstetric institution, as all are appropriated into the obstetric subject that constitutes itself through othering the mother.

The exclusion of the (m)other within the obstetric institution, then, rests upon her *inclusion* as othered, engulfed, and appropriated. As such, she is excluded *through* her inclusion, and obstetric subjectivity and the position of the mother as other are thus fundamentally tied together. Her oppression, therefore, can only be truly challenged by dismantling obstetric subjectivity. For it is not so that the pregnant subject is not already included in the institution, she is in fact a fundamental part of it, but in an affectable, outer-determined way through which she is excluded from autonomy, rationality, and self-determination by merit of existing *within* the obstetric configuration. Attempts at emancipating the pregnant subject, trying to endow her with more modern subjectivity without dismantling obstetric subjectivity and its rite of passage, are therefore doomed to fail as obstetric subjectivity is made up of her inclusion as a lesser part of itself, again and again established by the obstetric rite of passage.

As Silva[78] argues, because of the scene of engulfment, we cannot solve the logic of exclusion through which the modern subject is forced to constitute itself through programs aimed at inclusion. In obstetrics these would, for instance, be striving for informed consent and shared decision making. However important this is, without undoing obstetric subjectivity and its rite of passage, the obstetric subject will continue to rest upon the included exclusion of (m)others from modern subjectivity. Informed consent will then become another box to check and shared decision making an illusion masking unequal power relations, and thus masking her actual exclusion.

The goal should not be to attain modern subjectivity for the pregnant subject, since this is also an emancipatory project of inclusion, because we must not forget that universal modern subjectivity always already rests upon differentiation between groups of people and their included exclusion. The emancipatory conquering of modern subjectivity for one group often means the stricter exclusion of another group. Regarding obstetric violence, we see

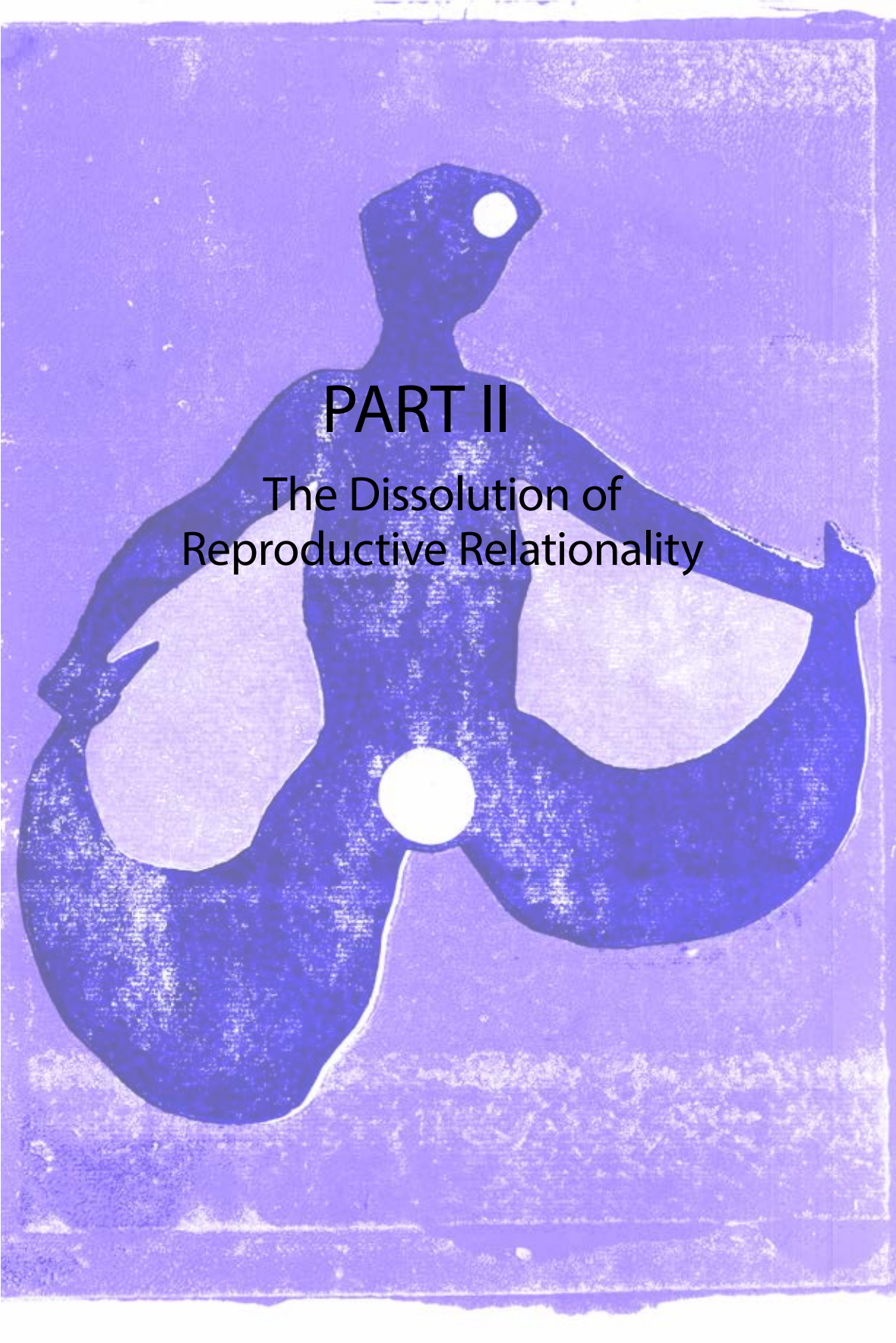
78 Ibid.

that the fight of white cisgender women in the Global North for autonomy in the labor room does not at all mean that the global subaltern subject profits from this fight. Quite the opposite: problems that white cisgender women in the Global North strive to counter are not the same problems Black people, people of color, trans and non-binary people have with reproductive care, and the former again constitute their liberation by leaving others behind. Continuing in this way, we would only attempt to solve the biopolitical engulfment of white women, leaving the necropolitical engulfment of the reproduction of the subaltern subject to exist in the trenches of racial capitalism.

As a direct descendent of the founding fathers of obstetrics at the height of modernity, the obstetric subject will persist globally as long as its institution refuses to be anything else but modern, continuously dismissing intersectional feminist and post- and decolonial critique. Instead of striving for the emancipation of the biopolitically engulfed white pregnant subject, we must therefore work on the dismantling of obstetric subjectivity and its rite of passage. A first step would be to resist the obstetric rite of passage by providing education for future midwives and obstetricians that affirms and enhances their critical thought, by using a Reproductive Justice framework throughout their education.[79] Furthermore, echoing the philosophy of Sylvia Wynter,[80] we must undo the obstetric rite of passage of which obstetric violence and racism are constitutive parts, by writing a new narrative of fertility, birth, and care that can generate new rites of passage that are able to unearth the relational and plural potential of pregnancy, birth, and midwifery care to figure out, in praxis, how to *disrupt* modern subjectivity and be human together *otherwise*. Only new rites of passage aimed at this disruption will make it possible for us to be, once again, in safe relationships with each other. Instead of turning to pleas of inclusivity and emancipatory subjectivity, we should work towards dismantling obstetric subjectivity and trying to figure out, through the potency of the transgressive event of childbirth, how we can give birth through caring for birth, intimately and safely, in equal relationship with one another.

79 Ross and Solinger, *Reproductive Justice*.

80 Sylvia Wynter and Katherine McKittrick, "Unparalleled Catastrophe for Our Species? Or, to Give Humanness a Different Future: Conversations," in *Sylvia Wynter, on Being Human as Praxis*, ed. Katherine McKittrick (London: Duke University Press, 2015).



PART II

The Dissolution of Reproductive Relationality

Intermezzo. Abortion Scene from *Portrait de la jeune fille en feu*

Céline Sciamma's movie *Portrait de la jeune fille en feu* is set in the second half of the eighteenth century—between 50 and 100 years after the last reprint of the *Malleus Maleficarum*, the 1486 treatise on the prosecution of witches. It translates as "The Hammer of Witches," with the hammer referring to the administration of justice by a judge. "Justice" was reached on matters concerning reproduction, such as abortions, mothers having a child from the devil, or the practices of satanic midwives. The last person convicted of being a witch in Europe was prosecuted in 1792.

Imagine, then, how scared of the authorities the protaganists must have been when they had to visit a midwife because their maid was in need of an abortion, as the lovers in Sciamma's movie do. Midwives were understood to be the most dangerous of witches because they could interfere with fertility. As accomplices of the devil, they could force abortions and kill babies. This is why, in the *Malleus Maleficarum*, whole sections are devoted specifically to midwives and their methods, such as question 11: midwives who work harmful magic kill fetuses in the womb in different ways, procure a miscarriage, and, when they do not do this, offer newly born children to evil spirits:

> when they do not kill the little children, they curse them and offer them to the evil spirits in the following manner: As soon as the child is born [...], the midwife carries the child out of the room as though she were going to set about reviving it, and, lifting it up to the prince of evil spirits (namely Lucifer), they offer it as a sacrifice to all the evil spirits. (This takes place in the kitchen above the fire).

The witch hunts were used to regulate and try midwives, and to force them to be complicit in the prosecution of women who have an abortion. They were obliged to make pregnancy registries, a practice that is returning now in states were abortion is highly criminalized, such as Poland and certain states in the US, and look for signs of abortion when someone was not pregnant anymore. Consequently, some midwives became complicit, while others continued to perform abortions in secret, establishing an underground network of secret abortionists that would last for centuries. These underground networks preserved the knowledge of abortion and contraception. Today, we use abortion

methods that were first developed by illegal abortionists and reproductive justice activists. And also today, there are still networks of feminists that work very hard to ensure everyone gets the abortions they need.

In the movie, the midwife is part of such an underground network, which is shown very literally by staging the abortion almost underground, in a low, dark house, without visible windows. When the daughter of the midwife opens the door, it is as if they are invited into a secret world.

Still from Céline Sciamma's *Portrait de la jeune fille en feu*, 2019

The abortion scene that unfolds inside the house resists a current and frequently perpetuated idea about abortions, namely that illegal, underground abortions are necessarily bad or unsafe. Underground abortions can be done safely and in a loving and caring environment. In the scene, multiple women gather together in a room lit by a fire and the children of the midwives are around, helping the maid undress and assisting with the abortion itself. When one of the two lovers, the painter, turns away, the main character tells her to look—a significant detail in a movie about the female gaze—stressing the importance of looking at the reality of abortions. What the painter then sees is not something horrifying, but, although it is painful, is a caring scene in which the midwife carries out the abortion calmly, while her children surround the maid and comfort her—with the lovers bearing witness, the midwife taking care of her, and the children providing comfort; a community of care comes into view.

During this underground abortion, not only is there a strong relationality between the pregnant person and their community of care, but the relationship between the pregnant person and their capacity for pregnancy is also

reconfigured in a particular way. The very fact that she could have an abortion is reflective of this relationship, in that the abortion was made possible by her community of care, in the process giving her the relational autonomy and self-determinacy to relate to her fertility and pregnancy on her own terms. But the scene subtly goes even further. While many configurations of abortion are represented as a dichotomy between child and non-child, and having an abortion is often interpreted as amounting to a negation of motherhood, many people who have an abortion either already have children or experience the potential they carry within themselves to have children as something meaningful and as something this pregnancy gave them, although it was aborted. This relationship with fertility is represented in the scene by the baby of the midwife comforting the girl having an abortion by stroking her face. And she receives the caress almost smilingly, while clinging to the baby's hand.

Still from Céline Sciamma's *Portrait de la jeune fille en feu*, 2019

In the second part of this book, the dissolution of reproductive relationality — the separation between the potentially pregnant person and their fertility, or child, as well as that with their community of care – is traced to three historic moments: to the story of Solomon's Judgment in the Old Testament, to the witch hunts in early modern Europe, and to the postmodern criminalization of abortion and the problem of obstetric violence in the 1960s and 2020s. The abortion scene in Sciamma's movie serves to avow that, despite this continuous dissolution of reproductive relationality, there have always been underground resistance, resistant relationships, and feminist hacks.

4 Hacking Reproductive Justice: Solomon's Judgment and the Captive Maternal

Rodante van der Waal and Stella Villarmea[1]

Abstract

In this chapter, we identify the biblical story of Solomon's judgment as an origin story which constitutes an understanding of justice in matters of reproduction that is still hegemonic today. "Reproductive justice" is a popular, strong, and important activist concept, but it is important, for any feminist reappropriation, that the concept is truly liberated from any form of maternal capture constituted by a patriarchal configuration of justice in matters of reproduction. Working with Joy James's concept of the captive maternal, a "hack" of Solomon's judgment is orchestrated, in order to reimagine reproductive justice within a *feminist* mythology.

Keywords

Obstetric violence, polymaternalism, playing the dead baby card, feminist mythology, Sylvia Wynter, Denise Ferreira da Silva.

1 Another version of this chapter is published as Rodante van der Waal and Stella Villarmea, "Hacking Reproductive Justice: Solomon's Judgment and the Captive Maternal," *Hypathia* (2024) forthcoming: https://doi.org/10.1017/hyp.2024.90.

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Of Discursive Origin Stories, Feminist Mythology, and Hacking Ourselves to the End of the World

Two women with
the same claim
came to the feet of
the wise king. Two women,
but only one baby.
The king knew
someone was lying.
What he said was
Let the child be
cut in half; that way
no one will go
empty-handed. He
drew his sword.
Then, of the two
women, one
renounced her share:
this was
the sign, the lesson.
Suppose
you saw your mother
torn between two daughters:
what could you do
to save her but be
willing to destroy
yourself—she would know
who was the rightful child,
the one who couldn't bear
to divide the mother.
—Louise Glück, *A Fable*[2]

Chiara Bottici's *Feminist Mythology* makes a start with the rewriting of femininity; not through theory, law, or critique, but through stories. More specifically, through an insertion of new stories in age-old myths, such as those of Sherazade, Ariadne, and Europa.[3] According to the Caribbean

2 Louise Glück, "A Fable," in: *Ararat* (New York: Harper Collins Publishers, 1990).

3 Chiara Bottici, *Feminist Mythology* (New York: Bloomsbury Academic, 2021).

philosopher Sylvia Wynter, the stories we tell each other about being human define who we are.[4] These stories are so naturalized and deeply engrained in our epistemology and ethical-juridical understanding of the world, that certain narratives define the limits of who are and who we can be. Wynter names these myths "origin stories" as they contain, in that sense, the origin of our being.[5] Both Bottici and Wynter agree that it is only through changing these myths that we can change our world and ourselves. This is the promise of humans as "*bios/mythoi* enacted orders of supraindividual consciousness," meaning that humans are constructed through the intersection of biology and mythology in our collective lifeworld.[6] It is hence the praxis of storytell-

4 Sylvia Wynter, "Unsettling the Coloniality of Being/Power/Truth/Freedom: Towards the Human, after Man, Its Overrepresentation–An Argument," *CR: The New Centennial Review* 3, no. 3 (2003): 257–337.

5 Of course, Michel Foucault had already coined the notion of discursivity by then, which was expanded upon through the development of theories of subversivity and performativity by Judith Butler, most notably in *Gender Trouble*. Denise Ferreira da Silva points out, however, in what ways Wynter diverges from Foucault, namely by fundamentally introducing the notion of coloniality and race as the story that shapes the origin of both the modern and the classical episteme. Foucault's flaw of not seeing how fundamental coloniality is to the constitution of the classical and the modern episteme, is not merely superficial ignorance to which we can now add the logic of racism, but it in fact pushed him towards a couple of misconceptions, as Silva following Wynter shows: 1) that the emergence of universal reason was only possible through the rewriting of the medieval spirit/flesh dichotomy in a rational/irrational dichotomy, particularizing Europe and the white cisgender man; and 2) taking into account coloniality would have enabled Foucault to see the "outside" to hegemonic discourses and understand the classic and modern episteme not simply as versions and reproductions of the human as the Same, but in fact as only one very specific form of the human, namely Man. As a consequence, Wynter is able to conceive, in contradiction to Foucault and more closely aligned for instance to David Graeber, of the shifts in episteme not simply as contingent power/knowledge/truth shifts but as shifts in the "politics of being'; that is, as a politics that is everywhere fought over what is to be the descriptive statement, the governing sociogenic principles." She hence conceives the shifts in origin stories, i.e., the shifts in knowledge and truth as ontological questions that "unearth a struggle (rewriting Marx's class struggle) between *different* "descriptive statements of the human [...] about whose master code of symbolic life and death each human order organizes itself." See: Wynter, "Unsettling the Coloniality of Being," 319, 317. Also quoted in Denise Ferreira da Silva, "Before Man: Sylvia Wynter's Rewriting of the Modern Episteme," in: *Sylvia Wynter. On Being Human as Praxis*, ed. Katherine McKittrick (Durham: Duke University Press, 2015), 96, 98–99.

6 This does not mean, however, in an Arendtian or Heideggerian way, that we must tell our own stories in order to differentiate ourselves authentically from *das Man*. Wynter understands humans always-already as a "referent-we": "we are no longer, as individual biological subjects, primarily born of the womb; rather, we are both initiated and reborn as fictively instituted inter-altruistic kin-recognizing members of each such symbolically reencoded genre-specificity referent-we." Our aim must therefore not be to individualistically differentiate ourselves from the we, but to change our world and way of being together through the change of our hegemonic stories that we tell each other. See: Sylvia Wynter and Katherine McKittrick, "Unparalleled Catastrophe for our

ing that is the praxis of being human together, and the key to deconstructing the way we are so that we can become human together *otherwise*.

In five essayistic steps, we rewrite a particular origin story, namely that of justice in reproduction and the construction of a captive and isolated maternal. The claim to, and administration of, justice is a practice that is, both currently and historically, rife with patriarchal ideology and racializing state interference. Since our hegemonic conceptualization of justice defines what the moral good is in sexual reproduction, often this implicit understanding makes a normative and discursive claim about the form sexual reproduction should take. Behind the patriarchal, racializing, eugenic formation of sexual reproduction through state policy lies an implicit moral claim, namely that it is "good" and "just" to structure kinship-making in nuclear and white supremacist ways. While reproductive justice as a concept is relatively new, coined by Black feminists in the United States to fight for a holistic ethics when it comes to reproduction,[7] the claim to reproductive justice as the implicit justification of invasive policy regarding sexual reproduction is very old and is fully integrated in Western thought on femininity, kinship, genealogy, motherhood, family, and patriarchy.

If we want to reappropriate reproductive justice in feminism, and reimagine what reproductive justice might come to mean in a feminist world, we must start deconstructing the hegemonic myths about reproductive justice that are still inherent in the law on fertility, birth and abortion, and in the institutions that govern pregnancy, birth, and childcare. For this "moral" conceptualization of reproduction happens not only through law, policy, and ethics, but also through ideology and stories. As Bottici points out, however, we cannot simply get rid of myth by rationalizing it, as Theodor Adorno and Max Horkheimer have shown in *Dialectic of Enlightenment*—the mythical will come back to haunt us in destructive, repressed, and rationalized forms.[8] "Overcoming mythology," according to Bottici, instead means that

Species? Or, to Give Humanness a Different Future: Conversations," in *Sylvia Wynter. On Being Human as Praxis*, ed. Katherine McKittrick, (Durham: Duke University Press, 2015): 34–35.

7 Reproductive justice is commonly defined by three principles (the right to have children, the right not to have children, and the right to raise children in safe and dignified environments), but Sister Song adds the principle of bodily autonomy: the right to control our bodies and futures, the right to have children, the right to not have children, the right to parent the children we have in safe and sustainable communities.

SisterSong 2023, https://www.sistersong.net/visioningnewfuturesforrj accessed on May 13, 2023.

8 Adorno and Horkheimer famously laid bare the dialectic of Enlightenment as a dialectic between myth and rationality. While we understand Enlightenment as the progression of rationality and the dismantling of myth and superstition, the Enlightenment is in fact the suppression of myth by rationality, and, eventually, the coming back of myth in naturalized

we must go "through its retelling because only by traversing the fantasy can one hope to reach a different place."[9] What we must do, is work with the scraps of stories that we have inherited and start rewriting reproductive justice through a feminist mythology: "We become wo-men by endorsing, embroidering, rejecting, modifying, rehearing and rehearsing, in sum, by retelling the myths we have inherited, as well as those we have ourselves created."[10] And by seeing what the concept, set free, might come to mean.

Wynter understands this "becoming" as defined by the hybrid relation between bios and mythos, with a concept borrowed from Frantz Fanon; the "sociogenic principle."[11] For Wynter, the sociogenic principle is not an object of knowledge, but a manifested site of enunciation that makes explicit, for instance, that race is not a biological but a social construct that nevertheless forms us so fundamentally that we can now speak of racial differences within the body that have socially constructed, rather than biological, origins.[12] Humans are literally "words made flesh, muscle and bone animated by hope and desire, belief materialized in deeds, deeds which crystallize our actualities."[13] The sociogenic, or storytelling, principle thus

and seemingly rational versions that are, because of that, much more violent and dangerous than superstitious myths ever were, their prime example being German fascism.

Theodor Adorno and Max Horkheimer, *Dialectic of Enlightenment* (Redwood City: Stanford University Press, 2007 [1947]).

9 Bottici, *Feminist Mythology*, 1.

10 Ibid., 7.

11 Sylvia Wynter, "Towards the Sociogenic Principle: Fanon, Identity, the Puzzle of Conscious Experience, and What It Is Like to Be 'Black,'" in *National Identities and Sociopolitical Changes in Latin America*, ed. Mercedes Durán-Cogan (London:Routledge, 2001), 30–67.

12 Walter Mignolo, "Sylvia Wynter: What Does It Mean to Be Human?" in *Sylvia Wynter. On Being Human as Praxis*, ed. Katherine McKittrick (Durham: Duke University Press, 2015), 116.

13 The problem, however, is that it is difficult for subjects of the hegemonic subjectification practices that propagate only one genre of the human, namely "Man" (Western European white cisgender man), to make the naturalized myths that shape us explicit. But it is only when we make these stories, and their inherent logic, explicit, that we can change them. This is where Frantz Fanon's sociogenic principle is of use, which is able to identify the hegemonic stories that govern our being as "masks" that we wear. Fanon, as a Black man, was in a better position to identify these stories, due to the "double consciousness" of his position, and he was hence able to see how—similar to the other DuBoisian concept of "the color line"—skin color and coloniality fundamentally shape and determine who and how we can be. Wynter takes this sociogenic principle one step further, working through the ways in which our masks, i.e., our *mythoi* or stories, are discursive; in which ways they are "linked in semantically activating causal terms, with the bios phenomena of phylogeny/ontogeny." See: Wynter and McKittrick, "Unparalleled Catastrophe," 11; Sylvia Wynter, "The Pope must have been Drunk, the King of Castile a Madman: Culture as Actuality, and the Caribbean Rethinking Modernity," in *Reordering of Culture: Latin America, the Caribbean and Canada in the Hood*, ed. Alvina Ruprecht (Ottawa: McGill Queen's University Press, 1995), 17–42.

materially organizes and shapes our world, and is consequently something that we can work with, in the sense that we can use feminist mythology to change the world and ourselves for the better. As Bottici writes: "myths are self-fulling prophecies: they do not wait for reality to prove their truth, they just go ahead and build it."[14] It is, consequently, through taking charge of these origin stories with Wynter, and through the appropriation of myth for the writing of a feminist mythology with Bottici, that the "we" that we are and reproduce together according to implicit ideas on what justice is in reproduction can be reimagined and reinvented *otherwise*.[15]

In a similar vein to Sylvia Wynter and Chiara Bottici, the Brazilian philosopher Denise Ferreira da Silva in her article "Hacking the Subject: Black Feminism and Refusal beyond the Limits of Critique" proposes the "hacking" of stories as a way to deconstruct the "arché-subject"—the archetype of the human constructed in hegemonic narratives that defines the limits of who we are and can be—in order to liberate the plurality of ways of being human *otherwise*.[16] For Silva this is not so much done through rewriting the narrative of the story, but through laying bare the code underneath the story—what Bottici would call the "logos" of "mythos"; the "reason of myth"—and hack it, in order to change it and, again with Bottici, bring forth the logos of mythos *otherwise*.[17] "Hacking," Silva writes,

> moves to transfigure "woman" (and with her the female and the feminine), to deface her, and release her to accomplish what she alone can perform, which is the dis/ordering of the modern grammar in which the patriarch remains the presupposed bearer of self-determination in its ethical and juridical renderings, respectively liberty and authority.[18]

For Silva, hacking is, like for Bottici, the "way through," and is hence used to move beyond critique towards the end of the world as we know it; a praxis of decolonization, which is, as she points out, the only way to achieve

14 Bottici, *Feminist Mythology*, 3.

15 Wynter understands this as fulfilling the potential of the "Third Event." She roughly theorizes history as consisting of three foundational events: the origin of the universe, the explosion of all forms of biological life, and the "origin of the human as hybridly auto-instituting, language cum storytelling species." The fulfilling of the potential of the Third Event, would be to create the world we desire through telling different stories. See: Wynter and McKittrick, "Unparalleled Catastrophe," 31.

16 Denise Ferreira da Silva, "Hacking the Subject: Black Feminism and Refusal beyond the Limits of Critique," *PhiloSOPHIA* 8, no. 1 (2018): 19–41.

17 Silva, "Hacking the Subject"; Bottici, "Feminist Mythology," 9.

18 Silva, "Hacking the Subject," 22.

"justice"—as in the quote above for instance, where hacking is used to untie self-determination from the patriarch, a case in point when it comes to reproductive justice.[19] Hacking is a way to write a feminist mythology that can, in Wynter's words, fulfill the potential of humans as hybrid storytelling species, namely by building another world out of the ashes of this one. Having "hacked" something hence means that we have managed to dissolve the code that gives rise to the patriarchal arché-form of the subject, which is either invisible or unconsciously deemed to be necessary, and that we have managed to generate a different code, a different origin story, a different feminist mythology.[20] The praxis of hacking is envisioned by Silva as follows:

> Hacking here is de\ composition, or a radical transformation (or imaging) that exposes, unsettles, and perverts form and formulae. It is an active and purposeful mis-understanding, mis-reading, mis-appropriation. Hacking is a kind of reading, which is at once an imaging (in Benjamin's sense, in reference to the work done by the dialectical image) and a composition (as description of a creative act), but also recomposition of elements, in the sense the term has in alchemy.[21]

To be able to lay bare "form and formulae" of the patriarchal claim to reproductive justice in order to expose, unsettle, and pervert it, to make a "recomposition," we start with the attempted hack of one particular origin story about sexual reproduction and its intersection with justice and maternal captivity: the story of Solomon's judgment from the Old Testament.[22]

19 Ibid., 22, 25.

20 Ibid., 27. This is what Wynter would call fulfilling the potential of the Third Event, see footnote 12.

21 Silva, "Hacking the Subject," 27.

22 Solomon's judgment has been the object of critique by feminist theorists when it comes to ethics and epistemology, but, to our knowledge, not so much from the perspective of reproductive studies or the philosophy of birth, apart from some feminist critiques on the image of motherhood in the story. It was hence already recognized as a foundational story for ethics and patriarchal epistemic authority, and perhaps even as a foundational story for "good motherhood" but never, to our knowledge, as a foundational story for the eugenic understanding of reproduction or reproductive justice. See, for instance: Celia Amorós Puente, *Salomón no era sabio* (Madrid: Fundamentos, 2014); Marie Ashe, "Abortion of Narrative: A Reading of the Judgement of Solomon," *Yale Journal of Law and Feminism* 4 (1991): 81–92; Esther Fuchs, "The Literary Characterization of Mothers and Sexual Politics in the Hebrew Bible," in *Feminist Perspectives on Biblical Scholarship*, ed. Adela Yarbro Collins (Chico: Scholars Press, 1985).

The Captive Maternal: How Birth Is Concealed by a Patriarchal Claim to Justice

According to Wynter, at this moment in time, the hegemonic origin story about who we are is an evolutionary one, both in an economic and a biological sense; it is responsible for a racialized, gendered, neoliberal, and individualistic understanding of "Man." Humans are "storytellers who now storytellingly invent themselves as being purely biological."[23] But while the biocentric perspective is overrepresented as the only narrative through which the possibilities of human life are articulated and envisioned, tellingly, the biological events of fertility, pregnancy, and giving birth stay severely underrepresented in our modern cultural scripts and existential thought. We do have the Heideggerian understanding of being as "being in light of death," and the Arendtian understanding of being as defined by natality, but there is much less philosophy, art, or literature in modernity that takes the *capacity or the act of giving birth* (rather than being born) seriously as a story that could tell us something about ourselves, let alone as a story that shapes us.[24] Rather paradoxically, our biological origin hence remains an empty signifier within our biocentric origin story.

At the same time, eugenics and the disciplining of reproduction play an essential role in the reproduction of society, the nation state, and the subject as we know it. The philosopher Édouard Glissant identifies the origin story of Western culture as one of genealogy and the purity of affiliation, in such a way that it justifies atavistic violence: "The retelling (certifying) of a 'creation of the world' in a filiation guarantees that this same filiation—or legitimacy—rigorously ensues simply by describing in reverse the trajectory of the community, from its present to this act of creation."[25] In other words, it is a story about reproduction, focused on blood, purity, and genealogy, through which the community understands itself, that is recast as justice. Consequently, forms of imperialism and exclusion, and a strong hold on sexual reproduction, are justified to keep on ensuring the "origin" of the community as the same blood, the same race, as belonging to the same chain of filiation. It is thus the origin story of the community that is understood in Western culture as one of reproductive filiation,

23 Wynter and McKittrick, "Unparalleled Catastrophe," 11.

24 Martin Heidegger, *Being and Time*, trans. John Macquarrie and Edward Robinson (Oxford: Blackwell, 2001[1927]); Hannah Arendt, *The Human Condition* (Chicago: University of Chicago Press, 1998[1958]).

25 Édouard Glissant, *Poetics of Relation* (Ann Arbor: University of Michigan Press, 1997), 47.

which is tied to a claim on justice when it comes to ensuring the future of that community through the reproduction of the "same"; consequently structuring sexual reproduction through cultural ideology, taboo, and rule, according to an appeal to what is reproductively just (which is protecting the chain of affiliation). It is therefore no surprise that, as Glissant points out, many canonical tragedies in Western culture are constructed precisely around the "threat" of reproductive miscegenation.[26] Justice in reproduction becomes constructed as a moral praxis aimed at the protection of racial purity, while miscegenation is constituted as a moral evil. Through this *mythos* around rightful reproduction, effectuating the obsessive European *logos* with bastards, inheritance, birthright, and race is constituted. This mythos, with its specific logos, takes hold of our imagination when it comes to sexual reproduction, at the cost of the development of stories about the messy, chaotic, creolizing, fleshy event of fertility, birth, abortion, and stillbirth. Our absent origin story on our biological origin, namely the event of childbirth, is hence concealed by a biocentric origin story about genealogy, blood, kinship, and, consequently, coloniality, race, and reproductive futurity.[27]

The question would thus be how to untie justice in reproduction from a patriarchal preoccupation with policing lineage, kinship, and affiliation that determines how we should behave, reproductively speaking. And how to unleash the reimagination of reproductive justice when it comes to the care for, and experience of, un-policed reproductive events, such as birth, abortion, pregnancy, and motherhood. The concealment of the event of birth by questions of lineage in the hegemonic myths around reproductive justice not only has consequences for the way we understand ourselves, but also for the way in which sexual reproduction and the material event of childbirth themselves take place, i.e., that they have, as we saw with Wynter, biological consequences, such as the way we organize sexual reproduction and its colonial and misogynous effects in (neo)eugenics, the criminalization of reproduction or forced sterilization and abortion according to race, enhanced morbidity and mortality rates for people of color in pregnancy

26 Ibid., 50.

27 Lee Edelman coined the concept of reproductive futurity or reproductive futurism to capture the cis heterosexual tendency to place all our hope in the future, in the form of the children yet to come, rather than dealing with or affirming our current situation. It is, in other words, an obsession with the reproduction of the future subject, and doing that in a just and rightful way, so much so that life, the future, or indeed, justice, becomes dependent upon reproductive futurity rather than being realizable now. See: Lee Edelman, *No Future: Queer Theory and the Death Drive* (Durham: Duke University Press, 2004).

and childbirth, and the saturation of the event of giving birth with obstetric control, violence, and racism.[28]

At the same time, the concealment of the event of birth by questions of lineage has consequences for the modern material praxis of childbirth, as it has existed since the patriarchal biomedical script became dominant. Pregnancy and birth (but also abortion and other forms of reproductive health) are seen in the Global North as purely biological affairs that we cannot, however, safely manage by ourselves, but for which we need the authority of a doctor, and, on a deeper ethical-juridical level, also state and institutional policy and intervention. This supposed need for patriarchal authority within childbirth is often motivated by the possible death of the child, which is understood as a severe injustice.[29] In earlier times the justification for patriarchal interference was the need to secure the genealogy and heritage of the child by making sure it has a registered father and is baptized, otherwise it would, again, be considered an injustice with regard to the child.[30] It is hence both the threat that the death of the child poses as well as the possible miscegenation of the child and the consequential threat to conservative reproductive futurity, i.e., the threat to the future as a continuation of the world as we know it, that, as Joy James has it, captures the maternal in the carcerality of and disciplining by the state, through an implicit claim on what is reproductively *just*.[31] This story on genealogy, blood, affiliation, and risk aversion, constructed through a certain conception of justice in reproduction, conceals the ambiguous and messy existential, experiential, and ontological dimensions of the events of stillbirth, aborted birth, and childbirth (and thereby erases all subjective dimensions of the mother who is supposed to do the reproductive labour), replaced with myths on kinship, blood, race, good motherhood, promiscuity, hysteria, or affiliation that strengthen the hold on the captive maternal. What is left of the event of birth is almost nothing. And even that little that is left over has to be managed in highly risk-aversive and often violent ways,

28 For more information, please search for obstetric violence, obstetric racism, weathering, racial mortality and morbidity differences, neo(eugenics).

29 Silvia Federici, *Caliban and the Witch. Women, the Body, and Primitive Accumulation* (New York: Autonomedia, 2004).

30 Trudy Dehue, *Ei, foetus, baby. Een nieuwe geschiedenis van zwangerschap.* (Amsterdam: Atlas Contact, 2023).

31 Infanticide, miscarriage, and stillbirth have a history of being the primary ethical justification to control women's bodies. It was the primary justification for the witch-hunts, and is still the main reason for invasive child protective services and the reproductive disciplination of reproductive bodies through anti-abortion laws. See: Federici, *Caliban and the Witch*.

or negated or prevented completely, depending on what sort of human life is created, in terms of gender, racialization, and class.[32] The captive womb, that ensures the reproductive futurity of the Western world, is what Joy James calls the "womb of Western theory"—merging precisely the biological and the mythological/philosophical origin of the world as we know it.[33]

In this chapter, we take Solomon's Judgment, a famous story from the Old Testament, as one of the origin stories of justice in matters of reproduction and captive motherhood. Solomon's judgment explicitly inscribes state authority and patriarchal violence into the narrative code of reproductive justice, concealing the event of childbirth by questions of genealogy, and effectively separating and capturing the maternal, based upon accusations and threats of infanticide. The story constitutes the need for ethical and juridical wisdom of a patriarchal, institutionalized power in the form of the king, and is still considered one of the foundational examples of ethical-juridical wisdom—although it is actually an early, and of course patriarchal, myth on "reproductive justice."

Matthias Stom, *The Judgement of Solomon*, 1640

32 Francoise Vergès, *The Wombs of Women: Race, Capital, Feminism* (London: Duke University Press, 2020).

33 Joy James, "The Womb of Western Theory: Time, Trauma, and the Captive Maternal," *Carceral Notebooks* 12 (2016): 253–296.

It is a story about the genealogical lineage of the child, hence of affiliation, which is based on a naturalized ethical judgment on what a good mother should be like. At the same time, the story conceals the actual event of childbirth itself; childbirth is written as a natural given without the event itself actually taking place in the story. Childbirth is written as dangerous without patriarchal embedment, while it is coded with the problematic of affiliation and good motherhood. Solomon's judgment can hence be regarded as one of the foundational stories on institutional patriarchal authority over pregnancy, birth, and motherhood. Not only because it is a foundational story within the Jewish and Christian tradition and exists in different forms in different cultures around the world, but also since it shows one of the ways in which James's captive maternal was captured and because it very clearly lights up the narrative that Glissant identifies as typical of Western culture, namely its preoccupation with the chain of filiation; it marks the eugenic moment when a patriarchal institution decides, based on a normative descriptive claim on justice, what the biological affiliation *is* (rather than should be), and thus the moment when, as characteristic of eugenics, patriarchal conceptions of the "good" in matters of reproduction become biology. As such, the story clearly brings James's womb of Western theory and Wynter's sociogenic principle to the fore; it tells how "words" are "made flesh," how the discursive capacity of the "moral" arché-form of sexual reproduction ensures reproductive futurity.

The Captive Maternal and the Threat of Infantice: Solomon's Justice

The story of Solomon's judgment, as recounted in the Old Testament, goes as follows:

> Two women who were harlots live in the same house and gave birth to two children, three days apart, together in the house—no one else was present. One woman's child was smothered by its mother. This mother switched the children and claimed the alive child as her own.
>
> They go to Solomon, and both say: "The living one is my son, and the dead one is your son." Solomon says: "Bring me a sword and divide the living child in two, and give half to one, and half to the other." Then one woman says: "O my lord, give her the living child, and by no means kill him!" But the other says, "Let him be neither mine nor yours, but divide him."
>
> Solomon answers "Give the first woman the living child, and by no means kill him; she is his mother." And all Israel hears the judgment

> which the king had rendered; and they feared the king, for they saw that the wisdom of God was in him to administer justice.[34]

We will first closely read the story, cut into seven steps, to bring to the fore some details and alternative possibilities of interpretation as opposed to those inherited by tradition.

*Step 1. "Two women who were **harlots** live in the **same house** and **gave birth to two children**, three days apart, together in the house—**no one else was present**."*

The situation before the women went to the king could be interpreted as one of queer kinship where two sex workers lived together, took care of each other, and perhaps even midwifed each other's births. This queer family structure is no coincidence, the genealogical heritance can only come into question because there is no father, i.e., no patriarchal family, or authority, or family name, which is why they come to rely on another patriarchal authority.

A second thing worthy of note in this opening sentence of the story is that it is an essential element of the story that it figures *two* women; only therefore can the story be played out along the dichotomous lines of mother and whore, good (meaning, sacrificial) and evil (meaning, crazy/hysteric/narcissistic/murderous/talking back). And exactly because the women are unnamed, and it is unclear who is who—they are continuously only referred to as "the one" or "this" woman/mother—the dangerous end of the dichotomy is always at risk of being extrapolated to all mothers, meaning to any mother; no mother is truly safe from the potential madness of "the one" when she lives and reproduces outside of patriarchal regulation.

*Step 2. "One woman's child was **smothered** by its mother. This mother **switched the children** and claimed the alive child as her own."*

This is the first time in the story that one of the children dies or is at risk of dying. Interestingly, in the myth, the infanticide (either on purpose or accidental) is constructed as having happened in the past, not in the real-time of the narrative. It is thus an assumed or a "given" infanticide. Then the mother who supposedly killed her child switches the children, drawing both

34 There are multiple versions of the story in different religious traditions. This is the story told in the most straightforward way—see: Hebrew Bible, 1 Kings 3: 16–28—and this is the one most similar to the Dutch National Bible from the nineteenth century; *Nederlandsche Staatenbijbel*, (Arnhem: Uitgeverij Swaan, 1864), 328-329.

the alive child into her dangerous hands, and replacing the alive child with a dead one. This can be read as installing a potential repetition of supposed infanticides: where there was an alive child, there now is a dead one, and where there was a dead child, another child is now in danger. This move ascribes potential moral evil and reproductive injustice on the part of both women, as both children are no longer safe, and thereby extrapolates the murderous madness or fatal accident of one particular mother to a danger on the part of the maternal as a whole, which is congruent with the fiction of the maternal as dangerously life-giving *and* life-taking. The women, who were already morally ambiguous due to their profession, and perhaps also their relationship, are now read as urgently in need of the regulation of their kinship by the patriarch: due to the threat of reproductive injustice in the form of infanticide by the potentially murderous maternal, justice must be installed by the king by securing the chain of filiation, circumscribing who the good mother is, and hence protecting the child from the dangerous maternal. The supposed event of infanticide, and the subsequent theft of the other child thus justifies patriarchal authority—imprinting a life-threatening danger into the maternal. So much so, that the women supposedly hand over their authority and ethical judgment to the patriarch *themselves*—even they supposedly see that they are in need of patriarchal regulation.

*Step 3. "**They go to Solomon**, and both say: 'The living one is my son, and the dead one is your son.'"*

It is rather dubious, and therefore important to note in a story written and read in a patriarchal scheme, that two queer, independent, feminine, single (as in: without a male partner), potentially lesbian, sex-working, probably polyamorous, mothers decide to go to a patriarchal authority to resolve their conflict, rather than solving it either together or within their own community. It must be remembered that the story constructs the narrative in such a way that there is no apparent community to which they could turn, which is why the state/institution/king is needed to intervene. In the story, there is no commons to which they belong, there are no elders, no friends, seemingly no other people rather than the patriarch to solve their situation. These lines therefore read as a classic justification for authoritative power; still pertinent in modern times when it comes to policy making, criminal law, and the prison industrial complex. Property logic on part of the maternal is assumed since, rather than regarding *both* children as their own, since the mothers were living in the same house as potential lovers or partners, so that the children would grow up closely together like siblings, they both claim one child as *their* child, which is a narrative that only

makes sense within a property logic where questions of care and kinship are dominated by genealogy and filiation. It is interesting that it is the question of property and affiliation which is attributed to the maternal (through a kind of bitch-fight) that justifies the mothers needing patriarchal help. The patriarchal obsession with affiliation is thus transposed to the maternal, while the patriarch is constructed as not having much to do with it; he just needs to keep order and ensure their fight over property and affiliation get out of hand. We could also imagine, for instance, that the two mothers where friends, and when one child died by accident and the mother, mad with grief, replaced it with the other child, that the other mother would understand, and they would raise the remaining child together. Instead, the maternal is again circumscribed, not by female competition, making any form of polymaternalism a fiction.

Step 4. "Solomon says: 'Bring me a sword and ***divide the living child in two,*** *and give half to one, and half to the other.'"*

It is worth to first emphasize that, contrary to popular opinion, threatening infanticide is a very violent rather than a wise move—it is a fiction that there was no other way to come to justice. Here, justice in reproduction becomes tied to the violent manipulation of parents through threatening the child's life, something that is still one of the most common forms of obstetric violence, and anti-abortion manipulation and intimidation, currently termed "playing the dead baby card." It is a form of shroud waving in which mothers are manipulated to accept obstetric policy, or to justify obstetric violence, by warning of an exaggerated threat to the fetus's life, implying that if the mothers do not yield to institutional policy, the death of their child will be on their heads. In anti-abortion activism, the accusation is even more explicit, namely that if you have an abortion, you are responsible for the murder of your child.

While the first moment of infanticide happened in the past (effectively functioning as a presupposed unproven threat and not told in the story in real-time), the second moment of infanticide is a real-time threat, i.e., an infanticide that might happen in the close future; the sword is already drawn. It is this patriarchal violence that is constructed around the image of the dead baby that represents the second moment of infanticide in the story. It is hence the (imagined/assumed/fear of/attempted control of) the first infanticide in the past and consequential the (threatened) second infanticide in the real-time future which places the baby's life in the king's hands for the 'just' administration of its biological lineage. Note also that this moment in which both infanticides are present—the first one being the justification of the second one which is about to happen—captures

the maternal through her guilt for both: the second infanticide is not the responsibility of the king but presented as the consequence of the crazy mother who killed the first child, although it is the king who could have used a different strategy to come to his administration of justice.

Step 5. "Then one woman says: 'O my lord, ***give her the living child****, and by no means kill him!' But the other says, 'Let him be neither mine nor yours, but* ***divide him****.'"*

The response from both mothers begs many questions. Why does the second mother say something evil, while she also wanted the child? She could have simply accepted the child, but instead she decides to say something that fully discredits her being the mother. Could she be fighting back, provoking the institution that has threatened her? And if the child was so easily given away by the first one upon a threat of patriarchal violence, and by the second one out of a refusal to sacrifice herself, why did they not simply resolve the matter on their own? Here, the ambiguity and implausibility of the story installs a good mother/bad mother dichotomy that only works when it is uncritically accepted. Only because there are, supposedly, "good" and "evil," i.e., fully sacrificial and fully murderous mothers—the implication of the story is that the murderous mother would kill twice: first by smothering a child and then by splitting another child in half, thus again establishing the murderous threat of the maternal for which patriarchal supervision and control is needed—is Solomon even able to "reveal" who the real, that is, the good, that is, the sacrificial mother, is. What is justice in reproduction is tied in this scene to a traditional good mother/bad mother (and consequently, good woman/whore, sacrificial mother/narcistic mother) dichotomy. Compliance of the reader with these dichotomies is essential to make the story work. At the same time, we must remember that because of their lack of names, the dichotomy always extrapolates to both women, and thus to the maternal in general: the mother is always at risk of slipping from good to bad motherhood.

In this scene, mother and child are separated, to have a third party, the patriarch, decide both their futures, and both maternal positions are captured in a mutually exclusive situation of either being with their child or talking back. This is the moment where one woman, the (supposed) mother, sacrifices herself, for she sacrifices what she knows to be true; her own truth, her own word, and her own desire, to save her child. Here the maternal becomes a captive; losing her knowledge, authority, and right to truth and self-determination, for the care and nurturance of the child—a condition that will be continuous since precisely this moment of capture will

return the child to her, and thus also return her duty to care and love even though she has lost her agency and authority. Through both being forced to lie and sacrifice her knowledge, *or* through being provoked to talk back and lose the child forever—we must understand the plurality of mothers in the story as a merging of multiple iterations of the maternal that function as expanding towards each other rather than as idiosyncratic separate entities—the maternal is captured as having no liberty, no authority, no right to self-determination, while the mother still be the one who, bound by love, will nurture and care for the child depending on what the king will decide. As James says: "The captive maternal is one who is tied to the state's violence through their non-transferable agency they have to care for another."[35] For both mothers, there is no relationality anymore, either with their polymaternal community or with their child, that is not controlled and mediated by the patriarch.

*Step 6. "Solomon answers '**Give the first woman the living child**, and by no means kill him; **she is his mother**.'"*

First, it is important, and perhaps redundant, to note that there are many reasons why Solomon's judgment is unjust and untrue: the story does not actually "prove" the first woman to be the mother; this is Solomon's subjective assessment based on his conception of good motherhood, and hence it is a moralistic fallacy—in other words: "justice" turned flesh. What is important here, however, is not so much the question of whether this judgment is true, which is only interesting if we were to share the Western obsession with affiliation, but the fact that because of the moralistic fallacy, the judgment and the patriarchal conception of justice take on a eugenic character. The patriarchal authority decides what the best conditions for the reproduction of future subjects are—a mother that sacrifices her own truth, authority, and ethical judgments, one who fully succumbs to the threats of patriarchal authority rather than talks back—and consequently makes this judgment biology. Solomon does not say, for instance, that the child is best raised by the one woman because she would be a better mother; no, the point of the story and of Solomon's divine wisdom lie precisely in the presented fact that this woman *is* the biological mother. Solomon thus "reveals" or "proves" biology through an ethical judgment, and pretends to serve justice by revealing the truth, while in fact he turns his conception of justice into the truth, and hence

35 Joy James, "The Captive Maternal and Abolitionism," *TOPIA: Canadian Journal for Cultural Studies* 43 (2021): 9–23.

into biology. Here, the authority to eugenically constitute reproductive futurity through the regulation of kinship and sexual reproduction is attributed to the patriarch, concealed as, and based on conceptions of, justice in matters of reproduction. A justice that, in the end, is not even safeguarded by the king himself, for he actually was about to kill the child with a sword, but by the care work of the captive maternal through her sacrifice of her subjectivity and truth.[36]

*Step 7. "And **all Israel** hears the judgment which the king had rendered; and **they feared the king**, for they saw that **the wisdom of God was in him to administer justice**."*

In this last sentence, the story is connected to the greater political body, namely "all Israel." The judgment is hence avowed by this broader societal body, tying the question of good motherhood and kinship to the state. The ethical judgment and the authority over the maternal are inscribed within the ideas of reproduction of the society as a whole, and the maternal thus becomes immanent to the reproduction of the people, as an instrument, rather than a subject in and of itself.[37] In the same breath, the patriarch is accepted as the one who indeed has the wisdom to administrate reproductive justice, based on his eugenic move of turning justice into biology and back again. The rendering of "justice" in reproduction is furthermore an act with which the king apparently establishes authority—the judgment installs "fear" for the king into the community—through a newly won affiliation with the wisdom of God *through* his assumed capacity to reveal biology, which is, as we know now, his capacity to *make* biology, i.e., his judgment turning flesh. The establishment of Solomon's jurisdiction in the realm of justice in general, through his control over sexual reproduction by his, what is currently known as, "playing of the dead baby card," connects the reproductive and political realms, and thus the future of the kingdom and the future subject, tying justice in reproduction to affiliation, the broader societal body, and to futurity. It is thus via the control of reproduction through seemingly rendering justice in reproduction that the ultimate, threatening, and divine authority of the king is constituted—underscoring once more that, indeed, all politics are reproductive politics.[38]

36 James, "The Womb of Western Theory"; James, "The Captive Maternal and Abolitionism."

37 Simone de Beauvoir, *The Second Sex*, trans. Constance Borde (New York: Vintage, 2011 [1949])

38 Laura Briggs, *How All Politics Became Reproductive Politics: From Welfare Reform to Foreclosure to Trump* (Berkely: University of California Press, 2017).

How to Untangle King and Kinship: Revealing the Code

For Denise Ferreira da Silva, hacking consists of three moves: "translation," "transposition," and "transformation."[39] The first move, translation, consists of exposing a logic or code in a certain story or societal structure that functions as what she calls, the "arché-form of the subject." The second and third move are to transpose this code and transform its elements to dismantle the arché-form of the subject as we know it. In what follows, we start with the first step, translation, which involves translating the story of Solomon's judgment, and its former interpretation, to expose the elements that constitute its "code," specifically focused on how the code of the story makes up the arché-form of, in our case, two subjects, namely mother and child.[40] Below, we will show how the arché-form of the captive maternal, on the one hand, and the child as the subject of reproductive futurity on the other hand, are constituted through an overarching code that ties them together through the concealment of the real events of childbirth, love, home, family life, and death, by a patriarchal conception of justice in reproduction.

Four main things that are effectuated by the story are: (1) the event of childbirth itself is concealed by a question of biological lineage embedded in property logic. (2) Reproduction is institutionalized by having the question of lineage resolved by a patriarchal institution, namely the king, *through* two moments of infanticide—it is the constructed narrative of the event of infanticide in the story that gives the authority to administer justice to the patriarch.[41] (3) The story establishes that questions of justice regarding reproduction should be resolved by the patriarchal authority, establishing the maternal as possibly dangerous to justice, i.e., it places the capacity to administer justice *in* the hands of patriarchal state institutions, thereby capturing the maternal and depriving her of liberty, authority, self-determination, and ethical judgment. (4) The story establishes a logic in which it is the administration of justice which engulfs the maternal subject, as being merely sacrificial, into the subject of the child; meaning that justice in matters of reproduction and free maternal subjectivity become mutually exclusionary, since the maternal is, in fact, enclosed *through* the administration of "reproductive justice"—for any feminist reimagination of reproductive justice it would

39 Silva, "Hacking the Subject."

40 Silva, "Hacking the Subject," 27–28.

41 This logic can be seen as deeply entrenched in modernity when it comes to sexual reproduction in other dichotomies such as hysteria on the part of women vs. reason on the part of medical men, female irrationality vs. male rationality, wild nature vs. civilized state, and so on.

hence be of essential importance that reproductive justice is truly untied from any form of capture of the maternal and is deeply non-matricidal.[42]

Let us now take a closer look at the "code," at what is driving the *logos* of *mythos* here. We can identify the two infanticides as the events that set the story in motion. It is these infanticides that are responsible for the mothers going to the institution, the consequent sacrifice of maternal subjectivity, the related eugenic establishment of biological kinship, and finally the establishment of the king as the authority to administer justice over a whole people. Since infanticide is literally murder, and hence the negation of life, the infanticides can be understood as two moments in which life is negated, or where life is threatened by negation. It is hence two negations that drive the logic of the story; they are therefore part of the code that constitutes institutionally mediated life, in the sense that they constitute biological lineage that is determined by patriarchal authority. It is these two negations that make the free maternal into a captive maternal. Together, these negations constitute the reproductive futurity in which new life should be embedded, i.e., *not* in a queer lesbian community, but in a clear patriarchally constructed biological lineage. There is a code present, therefore, that consists of a basic form of logic, in which the two negations of a thing constitute the thing itself (as far as, in logic, the opposite of the opposite is the thing itself):

First negation. The first infanticide (*-1*)
This factor reveals the supposed infanticide resulting in a dead child without lineage. It is the "given" infanticide functioning as the reason why patriarchal authority in matters of reproduction is needed.

Second negation. The second infanticide (*-1*)
This factor reveals the threatened future infanticide that makes one mother sacrifice her truth. This is the potentially "real" infanticide, because it is this infanticide that *could* happen in real time in the story, and could hence also still be prevented, which is why it is this second infanticide that is used to manipulate and therefore capture the mother.

Code. (*-1*) * (*-1*) = (*1*); (*first infanticide*) * (*second infanticide*) = (*a living child with a biological lineage*)
This calculation represents the logic present in the story that constitutes the child embedded in a biological lineage by the patriarch as the positive

42 Laura Green, "Myths, Matricide and Maternal Subjectivity in Irigaray," *Studies in the Maternal* 4, no. 1(2012): 1–22.

outcome, based on two moments of infanticide that drove the story to this culmination. This code can be taken as the arché-form of the subject of reproductive futurity that is given by the myth.

As becomes clear in the code above, what constitutes the arché-form of the future subject is that its production of life is mediated by past/presupposed/haunting death, or the threat of future death. The first negation represents the threat of the death of *both* children, one dead and the other replaced by the dead child, which dissolves the polymaternal maternal community, pushing them to an external authority in search for justice. Infanticide is thus instrumentalized as the justification for administering justice by the patriarchal institution—a logic that is also present in the witch hunts, in abortion debates, and in obstetric violence. And it is due to the threat of the second infanticide that the child is consequently eugenically (i.e., through an ideologically motivated repurposing of biology) inscribed in a chain of filiation.

If we switch our lens to the arché-subject formation of the maternal, we see that the same two moments of negation add up to its isolation and capture. They represent the dissolution of relationality from both her child and her maternal community, as well as the sacrifice of her own subjectivity. Together, this constitutes a new maternal position that is not so much that of a subject itself, but a position that is held captive by the patriarchal institution, engulfed, to use another Silvaen concept, by the arché-form of the subject of reproductive futurity that is the child.[43] Following a similar logic as before, the maternal is constituted as institutionally mediated, isolated, individualized, and sacrificial to the child, rather than possessing her own differentiated subject position. If we now apply the correspondent factorization and calculation, we obtain the following:

First negation. The separation of the community relationship: the dissolution of polymaternal sociality (*-1*)
This factor refers to the supposed infanticide which breaks up the polymaternal community into fear and suspicion. Rather than solving

43 According to Silva, the scene of engulfment is characteristic of the subject of European modernity that establishes his own imperialist subjectivity by engulfing "everything else". For an exploration of how the scene of engulfment plays out in the relation between the state and the pregnant mother, see: Rodante van der Waal et al., "Obstetric Violence within Students' Rite of Passage: The Relation of the Obstetric Subject and Its Racialised (M)other," *Agenda* (*Durban, South Africa*) 35, no. 3 (2021): 36–53. See also: Denise Ferreira da Silva, *Towards a Global Idea of Race* (Minneapolis: University of Minnesota Press, 2007), 255.

the problem together within their own community, the polymaternal household breaks up, and its members turn to the patriarchal institution for justice as separate and competing individuals, rather than turning to forms of transformative or healing justice. The negation here consists of the breaking up of a maternal community of othermothers, and the absence of a broader community of family, lovers, partners, the whole polymaternal "village" that is constitutive of the maternal, since no mother can raise a child truly alone.

Second negation. The separation of the mother-child relationship; the sacrifice of maternal subjectivity (*-1*)
This factor refers to the threat that the second infanticide poses to the relationship between mother and child, as the child is about to die, which leads to the sacrifice of the mother as a subject. The child can only be saved by giving up the mother, who is either provoked to talk back and lose the child or give up her child and her truth by herself. The negation here consists of the installment of an either-or logic between mother and child, which negates the idiosyncratic and ambiguous "two-in-oneness" relationality of pregnancy, birth, postpartum, and early motherhood, since her child cannot be kept by keeping herself intact. Only by sacrificing herself can she win back the child. Only by maternal sacrifice itself can the child be saved, and can the relationship between mother and child consequently be reinstalled. But this relationship is now mediated by the institution through a threatened infanticide, on the one hand, and the matricide of the maternal subject on the other.[44]

Code. (*-1*) * (*-1*) = (*1*); (*first relational separation*) * (*second relational separation*) = (*captive maternal*)
If the maternal is inherently relational, it is the double negation of relationality that constitutes her, but as captive. Congruently, and driven by, the two moments of infanticide, two negations that dismantle the relational whole that the maternal subject is, eventually add up to her establishment as a captive womb that ensures the reproductive futurity of the kingdom headed by the patriarch. It is the patriarch who, based on the sacrifice of the mother, establishes the future subject of the child

44 This can indeed be read as an Irigarayan foundational matricide, and thus, in the rewriting of the myth of Solomon as an origin story of Reproductive Justice, it would be of detrimental importance to do that in a non-matricidal way, as developed by Laura Green in "Myths, Matricide and Maternal Subjectivity in Irigaray."

> in the nurturance of a new mother-child relationship, one consisting of an engulfed, captive mother. The arché-form of the mother should hence be understood as captive, i.e., as sacrificially engulfed, by the eugenically constituted arché-form of the child.

The above formulas amount to the code through which justice in reproduction is administered, and which engulfs the maternal by the institutionally mediated eugenic reproductive futurity of the child as a matter of justice. The code inherent in this origin story of justice hence justifies *and* constitutes eugenics, altering biology in such a way that it ensures reproductive futurity through the reproduction of the captive maternal. The code hence reveals how the hegemonic administration of justice in matters of reproduction can, in fact, never be "just." For it is exactly the keeping intact of two forms of relationality (polymaternal community and mother-child) that is the precondition for true feminist "reproductive justice."

The Polymaternal Affirmation of Childbirth/Stillbirth/Aborted Birth

How do we proceed now? How can we hack this story and turn it into feminist mythology? Where should we interfere? How does the maternal get her truth, word, dignity, and self-determination back? How do we ensure reproductive justice passes into the hands of people who birth, and out of the hands of those who do not need to birth but hold authority over reproduction derived from patriarchal institutions? How to reshape relations of reproduction? One way to hack the story and make it a mythology would be to turn the code around, something Silva terms the "transposition" of the elements of the code by their transformation. Transposition and transformation of the elements of the code of Solomon's Judgment—this is precisely what Louise Glück already does at the end of the poem which is the motto of this paper:

> *Suppose*
> *you saw your mother*
> *torn between two daughters:*
> *what could you do*
> *to save her but be*
> *willing to destroy*
> *yourself—she would know*

who was the rightful child,
the one who couldn't bear
to divide the mother.[45]

By stating that the rightful child is the one who cannot bear to split the mother in two, Glück brings the absurdity of the story to the fore: as if there could be but one rightful child, translating to: as if there could be but one rightful mother. At the same time, Glück addresses in a beautiful and subtle way the violence done to the maternal in the original story with the three final words, "divide the mother," echoing the division of the maternal in the original (through the dissolution of relationalities that constitute her subjectivity). If we indeed understand this poem as a new version of an origin myth on reproductive justice, Glück brilliantly moves the focus from conceiving justice as ensuring that the child has the "good" mother to saving the wholeness and subjectivity of the mother. In a move that counters the logic of infanticide, the infanticide is finally proposed by the child herself, resisting the capture of the maternal by offering to destroy herself.

But at the same time, Glück remains slightly stuck within the eugenic logic that binds an ethical judgment to biology. Here too the "rightful" child, i.e., the deserving child, but also the true, and hence, the "real" child, is the one who is willing to sacrifice herself, which is understood as the moral thing to do, and as that which proves the "true" lineage of the daughter. However, the way in which Glück uses this same eugenic logic which rests upon a moralistic fallacy is mostly to bring to the fore the absurdity of the logic in the first place—it shows that the logic only works when already supported by misogynous dichotomies, as discussed in the section above. Glück's rewriting thus turns the code of the story upside down: she resists the capture of the maternal, but does keep on working with a negative and eugenic logic, albeit it in an absurd and upside-down fashion. The question remains, however, if this is a fundamental enough hack to truly explode the arché-forms of both subjects and hence traverse the "fantasy" of the myth to end up in "a different place."[46] After all, following Denise Ferreira da Silva,

> the second move, *transposition*, is the placing of relevant terms and concepts in equations, which I then proceed to resolve, using a few simple mathematical signs and procedures that allow me to explode the *arché-form* of the subject through a *transformation* of its elementary parts or de\

45 Glück, *Ararat*.
46 Bottici, *Feminist Mythology*, 9

> composition. The symbols used in the equations operate like pieces of an imaging designed to break a code, and not as particles of signification.[47]

While Glück completed both these moves in her retelling of the myth, and she indeed managed to explode the arché-forms of both subjects, we can wonder whether by leaving intact the code that ties justice to "true lineage," the hack protects the maternal enough from being captivated again—what prevents this upside-down logic from being turned upside-down again?—and, thus, whether truly allows us to reimagine reproductive justice in a feminist mythology. Another problem is that the retelling of the myth puts the perspective with the child, rather than the maternal subject, who hence remains passive. It is a rewriting of an origin story of reproduction and reproductive justice that does not put the maternal center stage, but the, now grown, child. The question is whether this is sufficient to liberate justice in reproduction and rewrite an origin story on reproduction.

Let us consider another way of decomposition, of breaking the code that locks the arché-form of the future subject and the engulfed arché-form of the captive maternal together in a eugenic code that claims reproductive justice. What if we could refuse the code altogether by refusing the concealment of birth by questions of reproductive lineage? It would mean to resist both infanticides by affirming the event of birth as the center of the story. Then, perhaps, the story could be about two women who are sex workers who assist each other's freebirths. These could be two births that happen in a sequence, installing a new repetition in place of the repetition of infanticide. This would work even if we stick to the narrative that one child died, since sometimes birth does go wrong. Perhaps our new feminist myth could even affirm that the death was on purpose as a radical affirmation of on-demand abortions—affirming that any reproductive justice politics must be both pro-abortion and pro-humane childbirth. In other words, we could affirm the first infanticide not only as an acceptance of death as a risk that could be part of life, but indeed as something that we can do, and that we sometimes want to do.

The latter would mean rewriting the story in such a way that yes, indeed, the first child was killed by the mother, but not as a negation of a life that needs patriarchal disciplining, but as an affirmation of other life (the other life that becomes possible when one aborts one's child). If both, the birth *and* the infanticide, could be an affirmation of life, then we would have dismantled the way in which the arché-form of the subject of reproductive

47 Silva, "Hacking the Subject," 27–28.

futurity is constituted through negativity. There would be no need to go to the king, no justification for the patriarchal administration of reproductive justice, and reproductive justice could be reimagined as expressed within the event of childbirth, aborted birth, or stillbirth, outside of any patriarchal institution. Reproductive justice would be reimagined as a form of abolitionist "healing justice."[48]

This would mean to affirm both births with the same autonomous and self-determined conviction, but without separating them. For instance, the mother who gave birth to the live birth would have gone to the village to get the spices needed for the abortion, and would have given them to the other mother, and she would have been her doula in the process. The mother who had the abortion, in turn, would have gotten everything ready for the live birth of the baby, assisting the other mother as her midwife. The mourning mother who aborted her child would have been taken care of by the other mother, while she in turn would have helped her to raise the baby, reconstituting a healing polymaternalism as well as an autonomous relation to fertility in the place of the otherwise proposed captive isolated motherhood:

A Fable
Two women with
the same claim
came to the feet of
the wise king. Two women,
but only one baby.
The king knew
someone was lying.
What he said was
Let the child be
cut in half; that way
no one will go
empty-handed. He
drew his sword.

A Fable
Two lovers in
the same condition
came to the event of
birth. Two sex workers,
but only one baby.
The lovers knew
they could not raise
both children.
What they said was
Let one child be
born and let us abort
the other. We will raise
the one together, that way

48 Healing justice was developed by the Kindred Collective as an abolitionist intervention to policing. It responds to intergenerational trauma and is an effort to transform systemic oppression and make collective healing possible. It honors collective and ancestral wisdom, wellness and joy as essential tools of liberation, our fundamental interdependence and the value of all bodies. See: The Kindred Collective, "Values," accessed on May 17, 2023, http://kindredsouthernhjcollective.org/values/.

Then, of the two
women, one
renounced her share:
this was
the sign, the lesson.
Suppose
you saw your mother
torn between two daughters:

what could you do
to save her but be
willing to destroy
yourself—she would know
who was the rightful child,
the one who couldn't bear
to divide the mother.

no one will go
empty-handed. They
induced the abortion
and waited for the birth.
Then, the two
women both birthed
gloriously—one child lived,
the other died:
this was
the pain, the loss.
Suppose
you could put
your aborted child
for one night
in the arms of your lover

so you wouldn't
have to carry it alone,
and you could take
her baby, which would also
be yours, for a walk that stills
grief, for a nighttime feed
with the milk you
had extra.

In this transposition and transformation, the story of the Solomon's judgment, the events of the abortion and the birth take center stage as two life-affirming episodes that can be true at the same time: one can abort and birth a baby out of love, out of self-love, and out of love for one's community. Now, we can start exploring the possibilities for justice that the experience of abortion and giving birth—as an experience of circlusion, transgression, intuitive and/or calculated rationality, communal pushing, screaming, pain, awe, etcetera—offer us. Rather than concealing these events by the logic of affiliation, infanticide, and separation, we release the captive maternal from the engulfment by the arché-form of the child, and we hack the arché-form of the child by taking out its eugenically mediated constitution, replacing it instead with the polymaternal relational event of birth as the proliferation of messy and creolized life within a community. As such, with birth and abortion center stage, we open up *the origin story* of "reproductive justice" to practices of care: of aborting and giving birth, of polymaternal kinship,

and consequently of being human together in an abolitionist *otherwise*, having dismantled the grip of the patriarchal institution. We let reproductive justice come to life in a polymaternal practice of care in a rewritten feminist mythology.

5 The "Dead Baby Card" and the Early Modern Accusation of Infanticide: Situating Obstetric Violence in the Bio- and Necropolitics of Reproduction

Rodante van der Waal[1]

Abstract

In this chapter, I argue that playing the dead baby card echoes the accusation of infanticide, which was prominent in the early modern witch hunts as the most common verdict for which women and midwives were executed, and, since then, has run through the whole of Western modernity. The playing of the dead baby card can similarly be understood to have the negation of the pregnant person as its effect, so that the maternal subject cannot be conceptualized as part of the biopolitical production of subjects. This chapter differentiates the playing of the dead baby card from both bio- and necropolitics as a form of *matricide* as the condition of the biopolitical project of the accumulation of life.

Keywords

European witch hunts, primitive accumulation, matricide, Silvia Federici, obstetric racism

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Introduction

I notice the risk of transgression in my work as a midwife when I slip into it, as if there is a darkness looming behind my practice, behind the event of birth. I am continuously balancing on the border between trust, confidence, and empathy on the one hand, and, on the other, a neurotic regard for safety that is perhaps a front for fear—fear that my approach, a feminist, empathetic, respectful approach—might get us all in danger.

This chapter is an examination of this fear.

When I give into it, I might do an internal exam "too enthusiastically,"[2] as the Scottish midwife Mary Cronk described it: briskly command that the one who is giving birth assume a certain position, or insert my fingers into their vagina without real consent as the baby's head is crowning to help speed up the birth. In the field, these are considered mild violations, if they are considered violations at all. But their manifestation even in my critical practice as an independent midwife, which is grounded in the belief in pregnant people's capability to birth, points to a pervasive logic in obstetrics.

The logic in question is based on a threat that resides in the background of obstetric practice, where the belief in a birthing person's capability and knowledge on how to give birth is suspicious to obstetric rationality. Self-determination is not only incompatible with what is deemed necessary, but almost conceived as a specific danger to safety by itself. Taking people in childbirth seriously is something so subversive that I, as a midwife, am worried to be on the wrong side, to be accused of irrationality, made out to be a witch, held responsible for the death of a child. When I am not resistant enough to overcome my worries, I step out of the practice of trusting, of waiting, of sitting in patience, into the battleground, into that playing field that all too quickly switches from being the origin of life to a triangle of violence, marked by both knees and sacrum. I start telling the one giving birth what to do, *how* to give birth, and match what I am saying with a "hands-on" approach—the threat, "listen to me now, otherwise your baby might die," never uttered, but lying closely behind my lips. WHO data shows that the abuse of birthing people occurs most often when birth is most stressful: 15 minutes before up tp 30 minutes after the baby is born.[3]

2 Mary Cronk, "Mary Cronk MBE Midwife," filmed 2011, video 1:51, https://www.youtube.com/watch?v=UV2EXzsSRKQ.

3 WHO, "New WHO Evidence on Mistreatment of Women during Childbirth," October 9, 2023, https://www.who.int/news/item/09-10-2019-mistreatment-of-women-during-childbirth.

In this chapter, I aim to show that the denial within obstetric care of the capability of pregnant people to give birth themselves is a direct consequence of a negation of maternal subjectivity.[4] The persistence of this negation is remarkable when one considers that childbirth in the Global North is very safe, albeit not equally so for everyone: racism and concomitant neglect are, in the United Kingdom and the United States for instance, responsible for a four to five times higher mortality rate for Black women and babies.[5] In rich countries it should be possible, one would think, to create the conditions in which all pregnant people can birth their child safely and in the way they want, to trust and empower their capability. Yet, as I have already begun to suggest, my own fear attests to the pervasiveness of the tendency to "handle" birthing people, make them passive, tell them what to do. An injurious logic is embedded in obstetric care, one that denies pregnant people their subjecthood—their relational autonomy, rationality, freedom, responsibility, relationality, and bodily integrity—and actively constructs the maternal as a passive, potentially dangerous place from which the child must be saved. A systemic violence haunts the maternal subject, while paradoxically aiming to save her and her child's life. What is the nature of this logic of saving and traumatizing, of security and violence, of wanting her alive while denying her existence?

4 In this article, I understand "maternal" to be gender-neutral, pointing towards a symbolic, discursive configuration of the place of mothers within Western modernity. Following Sara Ruddick's maternal thinking, this concept is not tied to a gender-essentialist notion of motherhood or pregnancy (1989). I furthermore sometimes use the terms "women" and she/her pronouns when I speak about historically situated people with the capacity for pregnancy. In modernity, pregnancy is tied so closely to the configuration of the maternal and to the oppressive category of womanhood, that it is sometimes necessary to use these less gender-neutral terms in the argument, in order to illuminate the specific gender-based violence that is obstetric violence and the playing of the dead baby card.

5 Emily E. Petersen et al., "Racial/Ethnic Disparities in Pregnancy-Related Deaths. United States, 2007–2016," *Morbidity and Mortality Weekly Report* 68 (September 2019): 762–65; Marian Knight et al., *Saving Lives, Improving Mothers' Care: Lessons Learned to Inform Maternity Care from the UK and Ireland. Confidential Enquiries into Maternal Deaths and Morbidity 2014–16, MBRRACE-UK Report* (Oxford: National Perinatal Epidemiology Unit, University of Oxford, 2018), https://www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202018%20-%20Web%20Version.pdf; Marian Knight et al., *Saving Lives, Improving Mothers' Care: Lessons Learned to Inform Maternity Care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018–20, MBRRACE-UK Report* (Oxford: National Perinatal Epidemiology Unit, University of Oxford, 2022), https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2022/MBRRACE-UK_Maternal_MAIN_Report_2022_UPDATE.pdf. See chapter 2 for an elaboration on this topic in the Netherlands.

Rachelle Chadwick, Sara Cohen Shabot, and Stella Villarmea all analyze this form of systemic violence, termed "obstetric violence," as an injustice that intersects with other forms of oppression, such as sexism, racism, and classism, as well as a specific form of epistemological negation specifically tied to the laboring subject and its configuration as irrational, abject, and vulnerable.[6] I attempt to contribute to the understanding of the negation of the maternal subject as a logic both inherent to the practice *and* a justification of obstetric violence. I understand this pattern of negation, present within obstetrics and society more broadly, as effectively carried out by the expropriation of the relationships the maternal subject needs to thrive, namely the relationship between the person and their (capacity for) pregnancy and the (pregnant) person and a community of care (such as the midwife).[7] As such, I continue the effort of other scholars in understanding obstetric violence not merely as a violation of autonomy and self-determination, but as a violation of the relationality central to maternal subjectivity and essential to birthing freely.[8] I will do so by tracing what I argue is an exemplary form of this violence, namely the "playing of the dead baby card": a mode of manipulation in which the mother is told by a midwife or doctor that if she does not comply with institutional policy, her baby may die, thus rendering her responsible for the death of her child if she is not compliant.[9] The playing of the dead baby card is exemplary of

6 Rachelle Chadwick, *Bodies that Birth: Vitalizing Birth Politics* (New York: Routledge, 2018); Sara Cohen Shabot, "Making Loud Bodies 'Feminine': A Feminist-Phenomenological Analysis of Obstetric Violence," *Human Studies* 39, no. 2 (2016): 231–247; Sara Cohen Shabot and Keshet Korem, "Domesticating Bodies: The Role of Shame in Obstetric Violence," *Hypatia* 33, no. 3 (2018); Corinne Berzon and Sara Cohen Shabot, "Obstetric Violence and Vulnerability: A Bioethical Approach," *International Journal of Feminist Approaches to Bioethics* 16, no. 1 (2023): 52–76; Stella Villarmea and Francisca Guillén, "Fully Entitled Subjects: Birth as a Philosophical Topic," *Ontology Studies* 11 (2011); Stella Villarmea, "Reasoning from the Uterus: Casanova, Women's Agency, and Philosophy of Birth," *Hypatia: A Journal of Feminist Philosophy* 36, no. 1 (2021).

7 Rodante van der Waal and Inge van Nistelrooij, "Reimagining Relationality for Reproductive Care: Understanding Obstetric Violence as 'Separation,'" *Nursing Ethics* 29, no. 5 (2021): 1186–1197; Rodante van der Waal, Inge van Nistelrooij, and Carlo Leget, "The Undercommons of Childbirth and Their Abolitionist Ethic of Care: A Study into Obstetric Violence Among Mothers, Midwives (in Training), and Doulas," *Violence Against Women* 0, no. 0 (2023).

8 Sara Cohen Shabot, "We Birth With Others: Towards a Beauvoirian Understanding of Obstetric Violence," *European Journal of Women's Studies* 28, no. 2 (2020): 213–228.

9 Chadwick, *Bodies that Birth*; Christine Morton et al., "Bearing Witness: United States and Canadian Maternity Support in Workers' Observations of Disrespectful Care in Childbirth," *Birth: Issues in Perinatal Care* 45, no. 3 (June 2018): 1–2.

practices of obstetric violence since it illuminates both the logic behind most forms of this violence, namely the prioritization of the baby over the mother, as well as its moral justification—bringing to the fore that justice in matters of reproduction is still very much understood as the protection of the child at all costs.

Western culture is rife with accusations of mothers killing their children. One only has to look at the ideological war over abortion, in which "murder" is still the most common accusation against pregnant people. Silvia Federici elaborates extensively on how the accusation of infanticide played a key role in the early modern witch hunts, which, she argues, should be considered part and parcel of the process of primitive accumulation that was foundational for capitalism. The often-overlooked trauma of the witch hunts in Western European history, at the birth of modernity, was the foundation of a repetition of violence against women within the logic of capitalism, modernity, and biopolitics.[10] In this chapter, I trace the present-day playing of the dead baby card back to the early modern accusation of infanticide that played a key role in the process of primitive accumulation. My argument is that the accusation of infanticide lies at the heart of the foundation of a biopolitical power over reproduction and the consequent reconfiguration of reproduction in the modern era, which has the negation of the maternal subject as a consequence. To make sense of this negation, I follow the work of Silvia Federici, Achille Mbembe, Éric Alliez, and Maurizio Lazzarato, who have argued that biopolitics has always functioned upon the negation of certain life in favor of the proliferation of other life.[11] Below, I will first elaborate on obstetric violence, the maternal subject, and biopolitics, before I discuss three different ways in which the dead baby card is currently played, and its relation to necropolitics. Then I trace the dead baby card back to the accusation of infanticide during the witch hunts and discuss how reproduction was primitively accumulated through this accusation. Finally, I will conceptualize the negation of the maternal from both biopolitics and necropolitics as a continuous matricide that is the condition for the biopolitical fostering of new life.

10 Silvia Federici, *Caliban and the Witch: Women, the Body, and Primitive Accumulation* (New York: Autonomedia, 2004).

11 Ibid.; Achille Mbembe, "Necropolitics," trans. Libby Meintjes, *Public Culture* 15, no. 1 (2003); Achille Mbembe *Necropolitics*, trans. Steven Corcoran (London: Duke University Press, 2019); Éric Alliez and Maurizio Lazzarato, *Wars and Capital*, trans. Ames Hodges (South Pasadena: Semiotext(e), 2016).

Situating the Maternal Subject, Obstetric Violence and the Playing of the Dead Baby card in Bio- and Necropolitics

Biopolitics

While it can be argued that reproduction and the disciplining of the maternal subject play an important role in the exertion of biopower, the maternal as a subject did not take up a prominent place in the modern biopolitical project of the subjectification of life. Instead, she became strongly equated with nature and was used as that against which the Enlightened masculine subject could be differentiated. Biopolitics, or biopower, is the Foucauldian concept essential to our understanding of the way modern power works, which shows that "power does not repress subjects," but produces them.[12] The stronger the hold of biopolitics on the maternal, however, the more the maternal as a subject disappeared throughout modernity. This is not to say that pregnant people or parents did not have any subjectivity, but to point out that the figure of the maternal cannot be recognized as a subject in full capacity in Western modernity, and was hence not part of the biopolitical production of subjects.[13] Feminists such as Simone de Beauvoir considered pregnancy a danger to the exertion of subjectivity, and it was not until the end of the twentieth century that the argument was proposed, by Sara Ruddick, that mothers have a distinct subjective practice of thought that can be differentiated from the epistemic standpoints of other subjects.[14] It is no coincidence that very few famous female writers and artists were mothers, and that if they were, it was particularly difficult for them to align their motherhood with their artistically strongly developed subjecthood.[15] When it comes to motherhood or even (the capacity for) pregnancy, there seems to be an impossibility present in Western modernity to be something that others, or even the self, recognize as a subject. While this might no longer be surprising, it remains remarkable since the biopolitical project specifically concerns the exertion of power via the subjectification of life. While the maternal herself falls outside of the scope of subjectification, she remains essential for the proliferation of subjects, as she gives birth to future subjects, and/or raises them. Although she is not granted subjectivity herself, she is

12 Catherine Mills, *Biopolitics* (London: Routledge, 2018), 25.

13 Villarmea, "Reasoning from the Uterus," *Hypatia* 36, no.1 (2021): 22–41.

14 Simone de Beauvoir, *The Second Sex*, trans. Constance Borde (New York: Vintage, 2011 [1949]); Sara Ruddick, *Maternal Thinking: Toward a Politics of Peace* (Boston: Beacon Press, 1989).

15 Julie Phillips, *The Baby on the Fire Escape: Creativity, Motherhood, and the Mind-Baby Problem* (New York: W.W. Norton & Company, 2022).

vital for the effectuation of biopolitics in the general population: while the biopolitical project of the fostering of life runs, so to say, through her, her own life is not fostered through subjectification, but instrumentalized or merely something from which other things are to be extracted.

Biopolitics established and sustained modern society and disciplined human life through the production of certain kinds of subjects. It is "a power whose highest function was no longer to kill, but to invest in life through and through."[16] As a consequence, excessive forms of violence used by the state, for instance torture or the death sentence, came into conflict with the construction of the modern nation state as the patron of the life of its population. Exerting direct oppressive power over life became "a limit, a scandal, a contradiction."[17] Thereby, sovereign power, "the ancient right to *take* life or *let* live" developed into a taboo, hidden within a system of biopower that fosters life and operates through the motto "to *make* live or *let* die."[18] The right to kill, the active negation of life, transformed, at most, into the passive neglect of life. In biopolitics, the focus of power switches from an oppressive non-productive power, exerting its rule through the negation of already existent life, to a politics that does not rule over life but *is* life: that defines, literally, what life is, *through* embodying it. As such, biopolitics is the "making sense" of life, the constitution of a certain conception of life, in which "life" instead of "death" becomes the main signifier of power. Biopower is therefore most effectively carried out through institutions, such as schools, healthcare, and prisons, rather than through a sovereign power—contributing to the medicalization of childbirth.[19]

The more childbirth became medicalized, the more the maternal subject lost her place in labor.[20] Obstetrics, as the institution in which childbirth takes place, is partly responsible for the exertion of a form of biopower that does not form but inhibits maternal subjectivity, being productive of the maternal only in the small range of making this subject passive, vulnerable, and docile.[21] Obstetrics is not engaged with the production of a maternal

16 Michel Foucault, *The Will to Knowledge: The History of Sexuality Volume I.*, trans. Robert Hurley (London: Penguin Books, 1998), 139; Michel Foucault, *Society Must Be Defended. Lectures at the Collège de France 1975–1976*, trans. David Macey (New York: Picador, 2003), 241.

17 Foucault, *The Will to Knowledge*, 138.

18 Ibid.; Foucault, *Society Must Be Defended*, 241.

19 Foucault, *The Will to Knowledge*, 144; Foucault, *Society Must Be Defended*, 248.

20 Barbara Rothman, *Recreating Motherhood* (New Jersey: Rutgers University Press, 1989); Barbara Rothman, *A Bun in the Oven: How the Food and the Birth Movement Resist Industrialization* (New York: NYU Press, 2016).

21 Cohen Shabot, "Making Loud Bodies 'Feminine'"; Berzon and Cohen Shabot, "Obstetric violence and vulnerability."

subject capable of effectively and productively *giving* birth, but rather shames her into a passivity that bears little resemblance to a subject in full capacity.[22] She is often forced to lie on her back, causing her pelvic joints to be "virtually immobilized," overriding her possibility to act on instinctive knowledge, resulting in increased pain.[23] At the same time, institutional protocols impose a chronological timeframe onto the process of childbirth, resulting in a serious limitation of the chance to give birth by herself.[24] The violence of forced cesarean sections or vaginal examinations, scolding, gaslighting, neglect, hitting, verbal abuse, or unconsented episiotomies (something that would be without a doubt recognizable as a case of severe violence in any other setting), produce severe trauma.

According to the philosopher Susan Brison, surviving trauma can be understood as surviving a "destruction" or "undoing" of the subject.[25] It is an "outliving" of the self: one does not survive as the same or prior subject, this self is destroyed, or, as Brison puts it, "murdered." Brison's description of her experience of a traumatic event of rape is: "I was murdered in France last summer," making clear that the event destroyed her subjectivity after which it had to be, slowly and painfully, built up again as something new.[26] Violence that can potentially result in serious trauma (even in those cases when it "luckily" does not) can hence be regarded as a negation of subjectivity, a possible murder—in our case, a possible matricide—and hence as exceeding the mere productive disciplining of the subject. Even in cases of discipline, like in Foucault's examples of the prison or the school where physical punishment is replaced with disciplinary tactics, the idea of biopolitics is that power is still productive of subjectivity and does not fully destroy it: subjugation is won through a productive affirmation and formation of life. Such a conception of biopolitics is not tenable with regards to the maternal subject when the treatment at birth is so closely aligned to

22 Cohen Shabot, "Making Loud Bodies 'Feminine'"; Cohen Shabot and Korem, "Domesticating Bodies"; Stella Villarmea, "When a Uterus Enters the Room, Reason Goes Out the Window," in *Women's Birthing Bodies and the Law: Unauthorised Medical Examinations, Power and Vulnerability*, ed. Camilla Pickles and Jonathan Herring (Oxford: Hart, 2020): 63–78; Villarmea, "Reasoning from the Uterus."

23 Margaret Jowitt, "Electronic Fetal Monitoring Is More Important Than Freedom of Maternal Position In Labour," *BJOG* 125, no. 7 (2018): 894.

24 Susan Crowther, Elizabeth Smythe and Deb Spence, "Kairos Time at the Moment of Birth," *Midwifery* 31 (2015): 451; Trudy Stevens, "Time and Midwifery Practice," in *Childbirth, Midwifery and Concepts of Time*, ed. Christine McCourt (New York: Berghahn Books, 2010), 112.

25 Susan Brison, *Aftermath, Violence and the Remaking of the Self* (Princeton: Princeton University Press, 2003), 38–40.

26 Brison, *Aftermath*, xi.

severe trauma that it inhibits one's ability to think, to move freely, to birth, to love one's children, to take care of oneself, or to have relationships with others.

While being forced to lie with one's legs in the stirrups could perhaps still be theorized as a disciplinary form of subjectification (although this is doubtful, since it amounts to an almost full passivity that inhibits thought and instinct in labor), forms of physical abuse in the birthing scene have to be understood as potentially traumatizing in a way that exceeds the biopolitical narrative of medical necessity in service of "life"—at least when it comes to the life of the pregnant person. As such, obstetric violence seems to qualify as "a limit, a scandal, a contradiction" of biopolitics,[27] the contradiction being that, within a politics of subjectification, certain subjects lose their subjectivity and continue to be more prone to a process of de-subjectification, even if masked by dominant narratives of life, health, and medical necessity. As such, the widespread practice of obstetric violence brings to the fore the suspicion that there is another form of power at work that is not productive but destructive, grounded in a violent logic that is distinguishable from, but thoroughly intertwined with, biopolitics.

Necropolitics

Critical theorists such as Silvia Federici, Achille Mbembe, Éric Alliez, and Maurizio Lazzarato understand the structural presence of violence within biopolitical capitalism as a destructive force that has always been part of biopolitics.[28] In *Necropolitics*, Mbembe argues that there is another form of politics at work in addition to biopolitics, which exposes itself exactly in the transgression of the limit: a politics that is "the difference put into play by the violation of the taboo."[29] The taboo of death or "making die" proper to biopolitics is continuously and invisibly violated through the determination of who, that is, what kind of subject, is taken up within the biopolitical project of subject-formation, and who is not; whose lives are fostered and proliferated, and whose are instrumentalized or extinguished in the name of (other) life. Mbembe calls this "other law" of violence at work within biopolitics "necropower" or "necropolitics," in order to emphasize that there is negation, destruction, and oppression present within biopolitics, which is

27 Foucault, *Society Must Be Defended*, 138.

28 Federici, *Caliban and the Witch*; Mbembe, "Necropolitics"; Mbembe, *Necropolitics*; Alliez and Lazzarato, *Wars and Capital*.

29 Mbembe, *Necropolitics*, 16.

essential to its functioning.[30] The addition of necropolitics to the theory of biopolitics provides us with what Jasbir Puar calls a "bio-necro collaboration" that can "conceptually acknowledge biopower's direct activity in death, while remaining bound to the optimization of life."[31] This dual practice of cultivating some life and marking other life for death enables us to examine the relation within the biopolitical institution of obstetrics between the fostering and destruction of life, between its optimization and traumatization.

It is specifically this dual practice of biopolitics and necropolitics that is illuminating when studying the playing of the dead baby card in obstetric violence, and in reproductive violence more broadly. It is clear that the life of the child is fully part of the biopolitical project, indeed the child can be considered the biopolitical subject *par excellence,* as it embodies and represents the future. In biopolitics, the fostering of future life is essential, as is attested to by eugenics, pronatalism, and the criminalization and stigmatization of abortion at the height of modernity. Justice in matters of reproduction became configured as the protection of the life of the child, effectively obscuring that this is often at the cost of the instrumentalization of the mother. This is exactly what we see in the playing of the dead baby card.

In anti-abortion activism, the dead baby card is played to pregnant people, as they are accused of "murder" or of "killing their babies." Plastic embryos are strewn on the ground in front of clinics or "murder" is written over the pictures of aborted embryos. There is a negation of subjectivity implicit in this accusation, namely that pregnant people should be forced to carry out their pregnancies against their will, and hence allowed a full alienation of their bodies and lives, instead of having an abortion. In the biopolitical project of the fostering of life, in which much value is placed on fetal and children's lives, the abortion of that life becomes constructed as the biopolitical taboo, as a moral transgression in the form of "murder." The negation of pregnant people's subjectivity is not understood in similar terms, however, since their lives can be alienated from them, and hence be negated, through forced pregnancy and childbirth. In this current playing of the dead baby card, what comes to the fore is that the accusation of infanticide justifies the negation of pregnant people's subjectivity.

The playing of the dead baby card even transcends anti-abortion activism into explicitly pro-abortion discourse. In the Netherlands, in a recent upheaval over the decline of people using hormonal contraception, many pro-choice feminists were the first to defend this method of contraception

30 Ibid., 14.

31 Jasbir K. Puar, *Terrorist Assemblages* (London: Duke University Press, 2007), 35.

over others since, being more efficacious, it reduces the risk of unwanted pregnancy and thus of abortion. To choose other contraceptive methods and thus allow a higher risk of having an abortion, rather than taking hormones, was criticized as being "unfeminist," "bizarre," "irresponsible," "tricky business," and compared to playing a game of "Russian roulette"—in this metaphor, having an unwanted pregnancy and consequently an abortion was thus equated to the bullet.[32] This again reveals an implicit negation of subjectivity of people with the capacity for pregnancy: despite the pill being an important invention, the fact is that it is a very invasive one, and it cannot be expected of people to take hormones for decades out of a sense of moral responsibility to potential life. Just as with moral debates when it comes to pregnancy or organ donation, the expectation of people with the capacity for pregnancy to use medical interventions for the protection of the (potential) life of someone else, is a serious and far-going moral appeal that cannot be taken lightly. People with the capacity for pregnancy are thus—through the playing of the dead baby card in the metaphorical construction of abortion as a bullet—endowed with such a grand moral responsibility for other potential life that it negates their self-determination, agency, and subjectivity. The playing of the dead baby card hence equals the moral justification of both the negation of the subjectivity of people with the capacity for pregnancy, and the normative appropriation of the reproductive body.

If this is the cultural and political landscape when it comes to abortion and contraception, one can imagine how strong the prioritization of the life of a fully developed fetus is. Taking the slightest risk as a midwife, doctor, or mother, quickly feels like committing a dangerous injustice, just like I felt in the scene with which I started this text. It takes a lot of effort to resist disciplining the behavior of pregnant people that comes with this moral reflex to protect the child. In my empirical research, mothers recount the dead baby card being played multiple times. One participant told of a gynecologist crying out of fear that the child would die if the mother would not consent to induction at 41 weeks, something that would typically qualify as a small risk, but apparently one big enough to scare this doctor to tears. Another example was from a

32 Nicole Hunsfeld, "De anti-pilbeweging op TikTok en Instagram is een zorgwekkende trend," *Volkskrant*, August 22, 2023, https://www.volkskrant.nl/columns-opinie/opinie-de-anti-pilbeweging-op-tiktok-en-instagram-is-een-zorgwekkende-trend~b85a9b3c/; Emma Curvers, "Na abortus is ook de pil doelwit van een conservatieve desinformatiecampagne," *Volkskrant*, July 7, 2023, https://www.volkskrant.nl/columns-opinie/na-abortus-is-ook-de-pil-doelwit-van-een-conservatieve-desinformatiecampagne~b995cedc/; Hester Zitvast, "Bizar – bang zijn voor hormonen, maar een groot risico op abortus voor lief nemen," *De Telegraaf*, July 13, 2023, https://www.telegraaf.nl/vrouw/1793604684/bizar-bang-zijn-voor-hormonen-maar-een-groot-risico-op-een-abortus-voor-lief-nemen.

mother whose doctors insisted that she have a preventative IV, as otherwise the child might die, they said, in a situation that almost does not even qualify as risky. Another mother told of being pressured into using preventative anti-psychotics by her doctor insinuating that she might otherwise harm her newborn child—a playing of the dead baby card in which the accusation of infanticide is barely hidden.[33] These mothers were emotionally blackmailed with the potential death of their children, and with the suggestion that this would be their fault if they did not comply with the proposed course of action. The playing of the dead baby card not only manipulates the pregnant person through what is presumed to be most dear to her; it also functions as a justification for obstetric violence after the fact, uttered as something along the lines of "otherwise your baby would have died." The playing of the dead baby card after the obstetric violence has already happened reveals not only that the life of the baby is deemed to be more important than, and also mutually exclusive with, the wellbeing of the mother, but also that the mother cannot really complain about what she has experienced. To do so renders her a "bad mother," who would put her needs before the very life of her child—as if it were impossible to provide safe *and* respectful care. Importantly, the dead baby card does not really function like a warning or statement of facts, but as a justification of obstetric violence through an accusation: if we do/ had done as you want/wanted, your baby will die/would have died; is that what you want? The dead baby card hence reveals that we expect maternal sacrifice in the form of maternal (self-)negation, and that if the sacrifice is not made freely it is taken, since the subjectivity of pregnant people becomes a moral threat as it is constructed as mutually exclusive with the biopolitical project of fostering and protecting the child's life.

When a dead baby or abortion is constructed as a biopolitical taboo for which the mother is responsible, the negation of the subjectivity of people with the capacity for pregnancy that is effectuated through this accusation is almost invisible and so normalized that it is the opposite of a taboo: sacrifice of subjectivity in the form of effacement is constituted as the moral expectation, thus closer to necropolitics than biopolitical subjectification. Below, I trace this, for the part of the bio- and necropolitics of reproduction that is destructive of the maternal, to the period of primitive accumulation and the early modern accusation of infanticide that was used to trial and execute mothers and midwives during the witch hunts.

33 Rodante van der Waal and Inge van Nistelrooij, "Shroud Waving Self-Determination: A Qualitative Analysis of the Moral and Epistemic Dimensions of Obstetric Violence in the Netherlands," *PLoS ONE* 19(4) (2024).

The Primitive Accumulation of Reproduction through the Accusation of Infanticide during the European Witch Hunts

According to Foucault's analysis, biopower emerged in the eighteenth century and was strengthened in the nineteenth century through the development of liberalism, the emergence of state institutions, demographics, and the production of "knowledge" about evolution, the population, biology, and "race." But theorists such as Federici, Alliez and Lazzarato argue that biopower, which emerged alongside and in relation to capitalism, could never have developed without the processes of primitive accumulation that established capitalism starting in the fifteenth century.[34] The Marxist concept of primitive accumulation refers to the first expropriation of common land into private capital, and work into waged labor, as essential for the further accumulation of capital—primitive accumulation is thus a precondition of capitalism, since capitalism was only able to develop through a primary concentration of labor and capital. This necessarily required the separation of the worker from the means of production, making him dependent on a wage, and thus precarious and prone to exploitation.[35] Understanding capitalism as racial capitalism makes the important addition that an essential element of primitive accumulation was the colonial conquest of land and the enslavement of Black and indigenous people to do unwaged labor.[36] The historical process of primitive accumulation is hence the foundation of present-day relations in racial capitalism.

Federici argues that violence against women effectively tied the development of capitalism and biopolitics together during the witch hunts. She shows that primitive accumulation was only possible when women's positions within the community were destroyed, as they often occupied central functions overseeing "demographic" domains such as reproduction and healing.[37] To break communities, expropriate the commons, and force people into an individualized existence of waged labor, women's knowledge and collective power had to be dismantled. This was done during the witch hunts by striking fear into women, and fear *of* women into men, thereby strengthening the gender dichotomy and gendered power relations. Federici lays bare how the witch hunts amounted to a primitive

34 Federici, *Caliban and the Witch*, 15; Alliez and Lazzarato, *Wars and Capital*, 72.

35 Federici, *Caliban and the Witch*: 62–63.

36 Cedric J. Robinson, *Black Marxism. The Making of the Black Radical Tradition* (Chapel Hill: University of North Carolina Press, 2021).

37 Federici, *Caliban and the Witch*, 63–64.

accumulation, not only of land and labor, but of reproduction—adding to Marx's famous thesis.[38] In the witch hunts, the primitive accumulation of capital as the expropriation of land and labor power through diminishing the power of women, *and* the primitive accumulation of reproductive bodies come together. According to Federici, the primitive accumulation of the reproductive body was hence a pre-condition for the establishment of our distinctly modern mode of economic production that is capitalism.[39] But, as she convincingly shows, the witch hunts did not only function as a foundation of capitalism, but also as the foundation of biopolitics, through the expropriation and instrumentalization of the reproductive body through which the next generation could be produced.

The witch hunts spanned a long three hundred years. Out of the demographic panic that resulted from the plague, in the period between 1435 and 1487, 28 treatises on witchcraft appeared. In 1450, the first witch trials took place in Southern France, Germany, Switzerland, and Italy. The last executions and the last trial took place in 1792 and 1820 respectively—well into the Enlightenment and Foucault's dating of the birth of biopower. There are differing estimates as to the total number of women tried as witches. Brian Levack argues that it could have been no more than 45,000 killed and 90,000 prosecuted,[40] while the feminist historian Barstow argues that it could have been no less than a 100,000 killed and 200,000 prosecuted.[41] The exact number does not indicate the effect that the witch hunts had on women's lives, however, since the suspicion of witchcraft was widespread and effective.

Witches were seen as an existential threat that had to be faced "head-on" with all the "judicial power that European states could muster."[42] Women came under severe state surveillance, being forced to register when they were pregnant, when they miscarried, and when their children were born. While women in general were targeted by the witch hunts, there was a more specific narrative concerning pregnancy and childbearing, in which mothers and midwives played a centrol role.[43] The knowledge and practices of midwives

38 Ibid.

39 Ibid. This is not to say that violence against women did not happen before primitive accumulation, but rather to argue that the witch hunts were an event that engrained violence against women deeply within the capitalist and biopolitical system of modernity.

40 Brian Levack, *The Witch Hunt in Early Modern Europe* (4th ed.; New York: Routledge, 2015), 21.

41 Anne L. Barstow, *Witchcraze: A New History of the European Witch Hunts* (San Francisco: Harper Collins Publishers, 1994), 23.

42 Ibid.

43 Ibid., 15, 19, 41, 62.

and healers regarding contraception and abortion were forbidden, resulting in women having more children from younger ages onwards than had been the case in the Middle Ages.[44] The theoretical discourse surrounding the witch hunts was full of metaphors, ideas, and suspicions concerning the maternal: poisoned breastmilk, pregnancies from the devil, perverse types of infanticide, the evil nature of some children, and extravagant means of devilish conception featured in the myths on witches.[45] The accusation of the killing, cursing, or sacrificing of children to the devil played an essential role in the accusation, conviction, and justification of women put on trial as witches.

Specifically, the accusation of infanticide was the main reason for women *not* tried as witches to be executed: "more women were executed for infanticide in 16th- and 17th-century Europe than for any other crime, except for witchcraft, a charge that also centred on the killing of children and other violations of reproductive norms."[46] In the *Malleus Maleficiarum*, which was the most famous treatise on how to hunt and trial witches, first published in 1486 but reprinted through the whole of Europe until the end of the seventeenth century, whole sections are devoted to midwives, such as: "Question 11: Midwives who work harmful magic kill foetuses in the womb in different ways, procure a miscarriage, and, when they do not do this, offer newly born children to evil spirits":

> when they do not kill the little children, they curse them and offer them to the evil spirits in the following manner: As soon as the child is born [...], the midwife carries the child out of the room as though she were going to set about reviving it, and, lifting it up to the prince of evil spirits (namely Lucifer), they offer it as a sacrifice to all the evil spirits. (This takes place in the kitchen above the fire).[47]

The persecution of witches on the charge of infanticide led to the introduction of severe penalties in the legal codes for reproductive crimes, thus expropriating women's control over pregnancy and childbearing, appropriating reproduction as a matter of state.[48] Around the mid-sixteenth century, European states "began to impose the severest penalties against

44 Federici, *Caliban and the Witch*, 88, 89.

45 Barstow, *Witchcraze*, 61, 62, 65, 69–70, 109; Federici, *Caliban and the Witch*, 88, 179.

46 Federici, *Caliban and the Witch*, 88–89.

47 Heinrich Kramer, *The Malleus Maleficarum*, trans. Peter Maxwell-Stuart (Manchester: Manchester University Press, [1486] 2007): 92–93.

48 Federici, *Caliban and the Witch*, 86–87.

contraception, abortion and infanticide [...] In France, a royal edict of 1556 required women to register every pregnancy, and sentenced to death those whose infants died before baptism after a concealed delivery, whether or not proven guilty of any wrongdoing," including both late and early miscarriages.[49] Infanticide, which included abortion (as provoked and as miscarriage) at the time, became a *crimen exceptum*, punished with the death penalty, even when the child was stillborn.[50] It was regarded as a crime "so dangerous to the civil community that the very accusation acted to suspend traditional procedural protection to the defendant and opened the way for the most ruthless and thorough kind of prosecution, undertaken to protect the state from its most dangerous enemies."[51]

In various European states, women only became legal citizens to be able to charge them for infanticide; in other words, (potential) maternal subjects gained legal subjecthood so that they could be accused of killing their children, thus expropriating the control of reproduction from the maternal.[52] Here, the contradiction forced upon maternal subjectivity clearly comes to the fore: mothers were only recognized as subjects *through* the accusation of killing their children. Women's subjecthood is thus founded upon the accusation of infanticide, revealing modern maternal subjectivity to be dependent on an age-old playing of the dead baby card. Through the charge of infanticide as a matter of punitive justice, the state gained the power to foster life by directly "protecting" the child from the body of its mother. This primitive accumulation of future life destroys that by which the maternal subject is constituted in the same move that grants it its subjectivity: from a relationality able to bring forth life, the maternal subject is constituted as a dangerous and individuated receptacle of life, no longer the one capable of creating life on her own terms, but now living under the threat of execution for potentially revoking life. When the child became configured biopolitically as the life to be fostered *par excellence*, the maternal as a subject with responsibility and autonomy over reproduction became primitively accumulated as a captive: the one from whom life is delivered. The accusation of infanticide hence results in the "capture" and negation of the maternal as instrumental for the new biopolitical aspirations of emerging capitalist society.[53] European mothers gained legal adulthood

49 Ibid., 88.

50 Ibid.

51 Barstow, *Witchcraze*, 135.

52 Ibid., 12, 41.

53 Joy James, "The Captive Maternal and Abolitionism," *TOPIA: Canadian Journal for Cultural Studies* 43 (2021): 9–23.

by virtue of the biopolitical aim to control reproduction, as they entered the public domain of justice through a particular patriarchal configuration of justice in reproduction, in which they became constructed as always criminalizable. The expropriation of the maternal relationship with her potential offspring through the charge of infanticide and the execution of people with the capacity for pregnancy as a matter of justice was the primitive accumulation for the further expropriation of the maternal relationship with her potential child that intensified throughout modernity.

The primitive accumulation of reproduction was not complete, however, if it did not involve isolating the maternal from her other key relationship: the one between her and her community of care and knowledge, such as healers, doulas, and midwives. One of the traits of maternal subjectivity is the capacity to become pregnant and to give birth, and the sense-making and self-determination thereof. This requires a relationality of support and expertise. The midwife (or traditional birth attendant or doula) providing a network of relationships can thus be seen as part of the maternal, since the space and safety she provides are necessary for the maternal to flourish in her capability to give birth and her capacity to abort and control her fertility. During the witch hunts, the first attempts were made to control midwifery, either by accusing midwives of being witches, or, more importantly, by recruiting them to testify against alleged witches and thus carry out the surveillance of the maternal. It is no coincidence that the first witch trials took place in 1450 and that, in 1452, the first regulations on midwifery were enacted in Germany. As mentioned before, the major theoretical work on witches and how to prosecute them, the *Malleus Maleficarum*, contains whole chapters specifically devoted to midwives.[54] The regulation of midwifery was thus intimately connected with the attempt to take hold of the maternal.

In order for biopolitics to succeed, the profession of midwifery (which often consisted of a safe space created during a birth by various wise women healers in a midwifery-like role) had to be controlled: "Midwives' involvement in [...] reporting on illegitimate births, abortion, anticonception and infanticide increased between 1400 and 1800."[55] Midwives became obligated to report infanticide, even if it concerned an early miscarriage, to participate in witch hunt tribunals, to examine women publicly to see if they had extra nipples to feed the devil, and search for the mothers of dead children by

54 Kramer, *Malleus Maleficarum*.

55 Hilary Marland, ed., *The Art of Midwifery. Early Modern Midwives in Europe* (London: Routledge, 1994), 7.

examining which women were lactating.[56] Midwives who remained resistant to this duty of surveillance were vulnerable to prosecution.[57] Just as women only gained legal citizenship in order to be charged for infanticide, midwifery only became an official profession for the very same reason. Professionalization was not primarily to regulate midwives' medical practice, but rather to use midwives for the surveillance, and consequently prosecution, of the maternal—indeed to make midwives carry out reproductive policing. The primitive accumulation of reproduction, achieved through the accusation of infanticide, could thus only be completed through also expropriating a relationship of care essential to the maternal that facilitated her relational autonomy into one of control, surveillance, and complicity in maternal captivity. The severance of these two key relationships for maternal self-determination can be considered the foundation of modern biopolitics, as the start of demographic and reproductive policing.

Death as a Signifier: The Logic of Matricide

This chapter opened with the contention that obstetric violence is an all too irrational, excessive, and unnecessary kind of violence to unproblematically fit a biopolitical framework, since biopolitics is concerned with the fostering of life and subjectivity. Obstetric violence is too violating of maternal subjectivity to be merely understood as a disciplinary violence that is constructive of a (however docile) maternal subject. Instead, obstetric violence can, on the basis of the work of Brison,[58] be understood as destroying maternal subjectivity, often resulting in trauma and Post-Traumatic Stress Disorder (PTSD). In the section above, I traced this pattern of negation of the maternal based upon an accusation of infanticide— which currently comes to the fore most clearly in the playing of the dead baby card—to the primitive accumulation of the reproductive body during the witch hunts, where there was a literal accusation of infanticide followed by a literal threat of matricide in the form of executions. The closing question is now how to understand this pattern in the light of the reproductive bio- and necropolitics of modernity. On the one hand, it is a logic that works through

56 Barstow, *Witchcraze*.

57 Nadia Maria Filippini, "The Church, the State and Childbirth: The Midwife in Italy during the Eighteenth Century," in *The Art of Midwifery: Early Modern Midwives in Europe*, ed. Hilary Marland (London: Routledge, 1994).

58 Brison, *Aftermath*.

two signifiers of death or negation, namely the playing of the dead baby card, corresponding to the accusation of infanticide, and the negation of the mother as a subject, corresponding to the threat of matricide, and that could as such be considered to be a strand of necropolitics, where death is the main signifier instead of life. On the other hand, this logic is a consequence of the biopolitical pronatalist investment in the life of the fetus, that is, the fostering and accumulation of the life of the future subject, which differentiates it from the necropolitics of racial capitalism in which whole racialized marginalized communities, including children, are made vulnerable to premature death.[59]

Federici argues that the promotion and fostering of life in biopolitics can only be understood in relation to a destruction of other life, the one being "a condition for the other."[60] Biopolitical measures such as the registration of pregnancies and natality rates and the institutionalization of midwifery did not happen gently; they were interlinked instances in violent processes that catapulted feudal society and its members into modernity. If Foucault had studied the witch hunts, Federici states, he would have realized that the era of violent primitive accumulation is the condition for the birth of biopolitics, and he "would have recognized that torture and death can be placed at the service of 'life.'"[61] Following Mbembe, it is possible to conceptualize the maternal as a negated subject constituted through a relationship to death instead of to life,[62] or, in Federici words, merely at the service of life.[63] While it is recognized that the maternal is the bearer of life, at the same time she is constructed as the one who could kill that life and must, consequently, be threatened with death in order to prevent her from killing. Life is extractively accumulated through her, while at the same time *her* life is not part of the biopolitical project of fostering life and subjectivity.

Mbembe theorizes how not only life but also death works a signifier in the bio-necropolitics of colonial modernity and its institutions.[64] As elaborated above, both the relationship to the child and to the midwife were expropriated through the accusation of infanticide and the subsequent threat of execution. The accusation of infanticide, as a justification of processes of separation and control, is the expression of a logic that, although embedded within

59 Ruth Wilson Gilmore, *Golden Gulag: Prisons, Surplus, Crisis, and Opposition in Globalizing California* (Berkeley: University of California Press, 2007).

60 Federici, *Caliban and the Witch*, 16.

61 Ibid.

62 Mbembe, *Necropolitics*.

63 Federici, *Caliban and the Witch*.

64 Mbembe, *Necropolitics*.

biopolitics, only makes "sense" through, and is set in movement by, the threat of death. This threat of death can be understood as threefold, encapsulating all subjects involved in the maternal: (1) the accusation of infanticide; (2) the subsequent threat of execution of mothers; and (3) the subsequent threat of the execution of midwives, and/or their forced complicity in the witch hunts and hence in matricide and maternal captivity. More than merely instrumentalizing the maternal, it is the symbolic "making die" of the mother upon the accusation of infanticide, which installed death as the signifier of the politics of her de-subjectification. Relating the current playing of the dead baby card to the early modern accusation of infanticide reveals that the continuous expropriation of maternal relationality through obstetric violence should not be understood as mitigated through a concept of life, and therefore, not as *bio*politics, but as effectuated through the concept of death, closer to Mbembe's necropolitics, albeit in the service of a fostering of (other) life.[65]

The crucial difference with necropolitics, however, is that while certain groups are marked for death and live in a closer proximity to death through colonialism and racism, the life of the European mother once targeted by the witch hunts became very much protected after its initial primitive accumulation. But even where there is no literal making die, the negation of maternal subjectivity persists through a continuous playing of the dead baby card. This logic resulting in the negation of the maternal is reminiscent of French feminist philosopher Luce Irigaray's concept of matricide, in which she understands Western civilization as fundamentally rooted in an appropriation and negation of the maternal, which she terms *original* matricide.[66] In Irigaray's critique of psychoanalytic thought, she problematizes that the subjectification of the child requires a primordial rejection of the mother in Western conceptions of subjectivity.[67] Tracing back the playing of the dead baby card to the witch hunts, a similar pattern becomes visible where the biopolitical subjectification of life also rests upon an "original" matricide in the form of the prosecution and execution of the maternal as part of the primitive accumulation foundational to biopolitical capitalism. The subjectification of future life is constructed as dependent on the original execution of the maternal, still being echoed in the negation of maternal subjectivity during the birth of the future subject.

65 Ibid.

66 Laura Green, "Myth, Matricide and Maternal Subjectivity" *Studies in the Maternal* 4, no. 1 (2012): 3; Luce Irigaray, *Sexes and Genealogies*, trans. Gillian C. Gill (New York: Colombia University Press, 1993), 15.

67 Irigaray, *Sexes and Genealogies*.

Tellingly, in the 1990s, Jo Murphy Lawless said about obstetrics: "If I were to extract only two words whereby to classify the concerns of contemporary obstetric practice, they would include not birth, but risk and death."[68] "Birth" as a former capacity of the woman, is replaced by "risk" and "death." The installation of a logic that uses death, specifically infanticide, as its main referent, still makes reproductive care which is truly affirmative of the maternal hard to come by. The biopolitical fostering of life still rests upon the continuous effectuation of the taboo of death, namely as the accusation of a dead child, upon which the maternal subject is still negated and traumatized. As a result, any assertion of maternal subjectivity seems to threaten the biopolitical project of safely fostering future life since it evokes the threat of death through which maternal subjectivity is negated and controlled—attesting to my own experience as a midwife that taking pregnant people seriously and keeping the fetus safe seem mutually exclusive. The affirmation of the maternal subject in birth, or with regards to abortion or contraception, is already *in and of itself* a biopolitical transgression since the protection of the future subject is bound up with the negation of the maternal. This means that the practice of playing the dead baby card in birth is not only a manipulation technique. It is not only a tactic used to make mothers comply. It is rather the making explicit of the borders of the biopolitical subjectification of life, it is a warning of the taboo of the child's death if you transgress these borders.

Rather than a necropolitics that threatens the lives both of mothers and their children, which would be a "true" necropolitics, matricide can be recognized as part and parcel of the modern bio-necro configuration of reproduction as the constitutive border of the project of biopolitical subjectification, which is the extractive instrumentalization of the maternal body and the negation of maternal subjectivity. Because the death, or the termination, of future life are the direct contradiction, and thus the taboo, the limit, the excess, of biopolitics, the project of subjectification must exclude the maternal in order to be able to accumulate and control reproduction directly, subjecting her instead to a de-subjectifying politics that functions through the signifier of death instead of life. This de-subjectifying politics is a kind of necropolitics that I have differentiated as matricide.[69] Although

68 Jo Murphy-Lawless, *Reading Birth and Death. A History of Obstetric Thinking* (Bloomington: Indiana University Press, 2021), 229.

69 More discussion of the racial stratification of the functioning of matricide as part of the bio- and necropolitics of reproduction is needed, but unfortunately there is not enough space to elaborate on this here.

the playing of the dead baby card no longer consists of the actual threat of matricide as it did during the witch hunts, it still constructs maternal self-determination as a transgression of the biopolitical project of fostering life. As such, the playing of the dead baby card still expropriates and captures the maternal subject, echoing its primitive accumulation through the continuous implicit accusation of infanticide.

6 Reimagining Relationality for Reproductive Care: Understanding Obstetric Violence as "Separation"

Rodante van der Waal and Inge van Nistelrooij[1]

Abstract

In this chapter, we identify a structural form of violence that a care ethical relational approach to reproductive care is up against: that of "maternal separation." Confronted with reproductive and obstetric violence globally, we show that a hegemonic, racialized, instrumentalized, and individualized conception of pregnancy is responsible for a severance of relationalities that are essential to safe reproductive care: (1) the relationship between the person and their child or reproductive capabilities; and (2) the relationship between the pregnant person and their community of care. We pinpoint a dissolution of reproductive relationality in at least two discursive domains, namely, the juridical-political and the ethical-existential.

Keywords

Reproductive violence, midwifery, maternity care, care ethics, abortion, reproductive justice

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Introduction

On August 31, 2021, the State of Texas banned abortion after the detection of a fetal heartbeat. On top of that, the law gave citizens the possibility to sue those who "aid and abet" abortion care seekers, such as friends and families, taxi drivers or information providers and medical professionals.[2] It is the most severe abortion ban since half a century in one of the most powerful nations in the world. It will not be enforced by the state that enables it, since that would be unconstitutional. Instead, enforcing the ban will be the responsibility of individual plaintiffs, giving anti-abortion vigilantes the possibility to sue people they do not know or have never met for a chance at a reward of 10,000 dollars.[3] The ban hence places a bounty on both pregnant people seeking abortion care and those who care for them. The law is not enforced in the traditional way through state, police, patriarchal, or medical violence, but the responsibility of patriarchal racialized violence is handed over directly to fellow citizens.[4] That which has been constitutive of both reproductive disciplining as well as reproductive and obstetric violence here clearly comes to the fore: the structural destruction of potential maternal subjects by the severing the relationalities that define them: 1) their relationship with their reproductive capacity (reproductive relationship); and 2) their relationship with their caring community, what we want to call the "midwifery relationship"—together we term this double severance of relationality "maternal separation."[5]

2 Kate Buchanan et al., "Does Midwifery-Led Care Demonstrate Care Ethics: A Template Analysis," *Nursing Ethics* 29, no. 1 (2021): 245–257; Anita Hallgren, Mona Kihlgren, and Pia Olsson, "Ways of Relating during Childbirth: An Ethical Responsibility and Challenge for Midwives," *Nursing Ethics* 12, no. 6 (2005): 606–621; Adam Liptak, J. David Goodman, and Sabrina Tavernise, "Supreme Court, Breaking Silence, Won't Block Texas Abortion Law," *New York Times*, last modified: September 2, 2021, https://www.nytimes.com/2021/09/01/us/supreme-court-texas-abortion.html; Jennifer MacLellan, "Claiming an Ethic of Care for Midwifery," *Nursing Ethics* 21, no. 7 (2014): 803–811; Elizabeth Newnham and Mavis Kirkham, "Beyond Autonomy: Care Ethics for Midwifery and the Humanization of Birth," *Nursing Ethics* 26, no. 7–8 (2019): 2147–2157.

3 Liptak, Goodman, and Tavernisse, "Supreme Court."

4 Ibid.

5 As we have argued elsewhere, we choose to use the terms "mother" and "maternity" as social economical gendered subject categories, not as an essentialist sex differentiation. See: Rodante van der Waal et al., "Obstetric Violence within Students' Rite of Passage: The Relation of the Obstetric Subject and Its Racialised (M)other," *Agenda* (*Durban, South Africa*) 35, no. 3 (2021): 36–53; Silvia Federici, *Caliban and the Witch: Women, the Body, and Primitive Accumulation* (New York: Autonomedia, 2004), 14; Johanna Hedva, "Sick Woman Theory," accessed February 22, 2020, http://www. maskmagazine.com/not-again/struggle/sick-woman-theory. This does not mean that people with a uterus who do not identify as "mothers" are not victims of reproductive or

In reproductive policy, the law, and in political discourse and activism concerning abortion, the embryo has been individualized and separated from the pregnant body from the start of the debate about the legalization of abortions, using misleading imaginaries from which mother, womb, placenta, and umbilical cord are erased.[6] Fetuses are presented in photographs and materialized in puppets as if they live on and by themselves, lifting them out of the mother. This separation does not stop with the discourse surrounding abortion. Instead, it continues through the full length of pregnancy. Both the prominent place of the "maternal-fetal conflict" in bioethics, which poses the baby as a danger to the mother and vice versa, the maternal body as a danger to the baby, as well as the common view that the baby is "delivered" by a doctor or midwife, reproduce the discursive separation of mother and child, instead of understanding childbirth as an active relational cooperation between mother and child.[7] This severance of the reproductive relationship also effectuates common forms of obstetric violence, such as "shroud waving," where the mother is manipulated into consenting to obstetric policies through the exaggeration of risk to the life of her child, playing mother and child out against each other.[8]

While discussions about the infant's health as well as medical ethical dilemmas in situations of maternal-fetal conflict are justified, the primary focus on these questions in medical ethics is problematic. It disguises other, more pressing issues by singling out the "choice" between mother and child, especially because the active agent imbued with this choice is the doctor, or the ethicist, but not the mother herself. Meanwhile, systemic global problems such as reproductive and obstetric violence and racism

obstetric violence, on the contrary. We understand maternal separation to be a form of violence against all reproductive people (those who identify as mothers and those who do not) as it consists of the severance of relationalities that makes up an existential caring relation present as a capability or possibility of reproduction, a structure of being we identify as "maternal."

6 "Peut-on le tuer? Ceux qui osent dire: Nous sommes tous des avorteurs." *Paris Match*, no. 1241 (February 1973): 39–48.

7 Raymond de Vries, "Obstetric Ethics and the Invisible Mother," *Narrative Inquiry in Bioethics* 7, no. 3 (2017): 215–220; Ashish Premkumar and Elena Gates, "Rethinking the Bioethics of Pregnancy: Time for a New Perspective?" *Obstet Gynecol* 128, no. 2 (2016): 396–399; L.H. Harris, "Rethinking Maternal-Fetal Conflict: Gender and Equality in Perinatal Ethics," *Obstet Gynecol* 97, no. 3 (November 2000): 786–791.

8 Rachelle Chadwick, *Bodies that Birth: Vitalizing Birth Politics* (London: Routledge, 2018); Christine Morton et al., "Bearing Witness: United States and Canadian Maternity Support in Workers' Observations of Disrespectful Care in Childbirth," *Birth: Issues in Perinatal Care* 45, no. 3 (June 2018): 263–274; Giovanni Scambia et al., "'Obstetric Violence': Between Misunderstanding and Mystification," *European Journal of Obstetrics, Gynecology, and Reproductive Biology* 228 (2018).

remain in the periphery of the ethical debate concerning maternity care. An overwhelming focus on both the fetus's safety and maternal-fetal conflict in medical practice and ethics, as well as on the embryo's rights in anti-abortion discourse produce a specific biopolitical framework that determines how we look at, think of, experience, and care for pregnancy and childbirth. The emphasis on the maternal-fetal conflict in ethics, obstetric practice, but also in popular culture, as *the* ethical dilemma and medical problematic of pregnancy not only unjustifiably neglects other issues, but also reproduces the severance of the relationship between mother and child. Instead of trying to understand the relationality of the reproductive subject and the event of childbirth, or the relationality of fertility and abortion, we continuously reinscribe both phenomena in a logic of separation.

In this paper, we identify how reproduction is continuously formulated in terms of separation in both the juridical-political as well as the ethical-existential sphere. We follow theorists on maternity and care ethics such as MacLellan and Newnham and Kirkham, as well as theorists of obstetric violence such as Cohen Shabot and Chadwick, who have theorized obstetric violence as a problem of relationality rather than autonomy.[9] We build further on fundamental insights of feminist care ethicists concerning relationality, dependency, maternity, and vulnerability, such as Joan Tronto, Sara Ruddick, and Eva Feder Kittay, as well as the scholarship on relational autonomy.[10] We aim to illuminate how a discursive tendency of separation continues to *inhibit* the relationality that is needed for both relational autonomy and care ethics in reproductive care. Consequently, we argue for a relational ethics and praxis regarding abortion, pregnancy, and childbirth care through a reimagination of the reproductive, maternal, and midwifery relationalities that can challenge and interrupt individualized subjectivity—acknowledging that in the current climate we do not yet know what these relationalities could possibly entail.

9 MacLellan, "Claiming an Ethic"; Newnham and Kirkham, "Beyond Autonomy"; Chadwick, *Bodies That Birth*; Scambia et al., "'Obstetric Violence.'"

10 Joan Tronto, *Moral Boundaries: A Political Argument for an Ethic of Care* (New York: Routledge, 1993); Sara Ruddick, *Maternal Thinking: Toward a Politics of Peace* (Boston: Beacon Press, 1989); Eva Feder Kittay, *Love's Labor: Essays on Women, Equality and Dependency* (New York: Routledge, 2019); Catriona Mackenzie and Natalie Stoljar, ed., *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self* (Oxford: Oxford University Press, 2000); Catriona Mackenzie, Wendy Rogers, and Susan Dodds, *Vulnerability: New Essays in Ethics and Feminist Philosophy* (Oxford: Oxford University Press, 2014).

Maternal Separation

The Severance of the Reproductive and Midwifery Relationship

In France on a cold winter night in the 1960s, Annie Ernaux had an illicit abortion, the subject of her novel *The Happening* (2000). It was years before abortion was legalized in France in 1975 and the *Paris Match* ran the cover story "Can we kill him?" in 1973, featuring a photo series of embryos floating in empty space.[11]

Paris Match, 1973

11 *Paris Match*, "Peut-on le tuer?"

Ernaux dedicates her book to the woman who performed her abortion, Madame P-R, and to all the women who had helped her along the way—all of whom could now be sued in Texas. Although the society in which she lived was determined to separate her from her community of care, Madame P-R made a deep impression on Ernaux, however meager the actual care she gave was. The relationality of this illegal network of women made what Ernaux calls "the world" possible:

> I have never stopped thinking about her. Involuntarily, this avaricious woman—whose flat was nonetheless poorly furnished—wrenched me away from my mother and into the world. She is the one to whom this book should be dedicated.
> [...]
> Now I know that this ordeal and this sacrifice were necessary for me to want to have children. To accept the turmoil of reproduction inside my body and, in turn, to let the coming generations pass through me.[12]

Her abortion transformed her into a relational subject, forever inscribed by the relationship to the women who helped her and gave her the world, and by the abortion that gave her the possibility to make the relationship of reproduction her own and hence accept the "turmoil of reproduction" inside her body. What this quote illustrates, is that in order to be able to relate to one's fertility on one's own terms, there must be space for both autonomous decisions and meaning-making practices regarding the relational possibility of another within oneself. This, in turn, is only possible within a relational community of care—exactly these two relationships the State of Texas is trying to sever.

When we switch our lens to maternity care, we see that the age-old form of caring for birth, midwifery practice, is also based on these two relationalities, namely, the relational perception of mother and fetus, and the relationship between mother and midwife.[13] A long-term commitment between mother and midwife and a focus on physiological birth and the relational nature of pregnancy are the essence of the art of midwifery. In most Western countries however, midwifery became appropriated into the obstetric institution, even when midwives work independently. Midwives must continuously relate

12 Annie Ernaux, *The Happening*, trans. Tanya Leslie (New York: Seven Stories Press, 2001).
13 Mavis Kirkham, ed., *The Midwife-Mother Relationship* (London: Palgrave, 2010); Sarah J. Buckley, *Hormonal Physiology of Childbearing: Evidence and Implications for Women, Babies, and Maternity Care* (Washington, DC: Childbirth Connection, 2015); Ólöf Ásta Ólafsdóttir, "An Icelandic Midwifery Saga Coming to Light: 'With Woman' and Connective Ways of Knowing" (PhD diss., London: Thames Valley University, 2006).

to and negotiate with the obstetric institution that delivers the dominant discourse and hegemonic epistemology, and functions upon a paternalizing responsibility over the mother and the instrumentalization of the maternal body in favor of the fetus's safe passage.[14] As a result, midwives are being torn between their relational ideals and the reality of having to work in a system characterized by protocols, over-medicalization, time pressure, high workload, and administration.[15]

The separation of mother and child by the obstetric care provider has its consequences for the relationality between mother and child during pregnancy and birth.[16] The midwife or obstetrician has the leading role in delivering the baby and seems to know not only more about the condition of the child but also about what is best for the child. Simultaneously, the mother is constituted as a complicating, instead of enabling, factor in the process of childbirth, whose main role is to somehow get through the painful event in a docile manner.[17] This leaves the mother cut loose from the status of an active subject, whereas she should be the main, active, relationally embedded, subject of reproduction. Disabling the maternal subject from making her own choices actively writes her subjectivity in non-maternal and non-relational terms, making autonomy impossible. Obstetric violence, then, can be understood on a more structural level as "maternal separation" in which the mother is denied relationality both with her child and with her community of care.

Ernaux's illegal abortion gave her "the world" through the relationality with the women who cared for her, and through the autonomous experience of the fecundity of her body. However, legal, institutional, political, and ethical spheres of today's society continue to sever these relationalities, just as in Ernaux's time. A good abortion, pregnancy, childbirth, and parenthood are dependent on an intact relationality between the reproductive subject, the child, and a caring community in which someone can take up a midwifery role. This double relationality is vital for pregnant people to know how to birth and to trust the process of birth, as well as to know how to accept "the reproductive turmoil" inside their bodies and be able to have

14 Van der Waal et al., "Obstetric Violence within Students' Rite of Passage."

15 Newnham and Kirkham, "Beyond Autonomy."

16 Ruddick, *Maternal Thinking*.

17 Sara Cohen Shabot, "Making Loud Bodies 'Feminine': A Feminist-Phenomenological Analysis of Obstetric Violence," *Human Studies* 39, no. 2 (2016): 231–247; Stella Villarmea, "When a Uterus Enters the Room, Reason Goes Out the Window," in *Women's Birthing Bodies and the Law: Unauthorised Medical Examinations, Power and Vulnerability*, ed. Camilla Pickles and Jonathan Herring (Oxford: Hart, 2020); Stella Villarmea and Brenda Kelly, "Barriers to Establishing Shared Decision-Making in Childbirth: Unveiling Epistemic Stereotypes about Women in Labour," *Journal of Evaluation in Clinical Practice* 26 (2020): 515–519.

an affirmative experience of their abortions. The structural tendency to separate reproductive subjects from their caring relationships and reproductive capacity is increasing in anti-abortion stances globally, and in the continuous perseverance of obstetric violence and paternalizing care that induces trauma in these relationships and inhibits relational care for and from the maternal. Below, we will discuss the continuous separation of the maternal in at least two discursive domains, namely, the juridical-political and the ethical-existential.

The Juridical-Political Configuration of the Maternal in Opposition to "Life"

Reproduction is embedded in a societal and political context in which abortion is legally limited across the globe[18] and in which people with the capacity for pregnancy are often framed as being in opposition to the interests of the fetus, the child, or even "Life" itself. "Pro-life" anti-abortion activists are gaining more and more ground in the Western world, in the US, across Europe, to which the European party ECPM attests.[19] Framing maternal subjectivity as a risk to "Life," while the maternal is actually a potential source of life, and the acceptance, or allowance, of this discourse as a valid point of discussion in mainstream politics is the current-day articulation of the traditional grip of nation states over people's reproductive

18 For an overview, see: https://reproductiverights.org/worldabortionlaws.

19 In Oslo, Norway, thousands of people protested against plans to restrict abortion law in 2018, but a restricted abortion law passed parliament in June 2019. Alex Matthews-King, "Abortion Demonstrations Draw Thousands across Norway after Prime Minister Proposes Tightening Laws," The Independent November 17, 2018, https://www.independent.co.uk/news/world/europe/abortion-norway-protest-oslo-storting-womens-erna-solberg-christian-democrats-march-a8638966.html. In Poland, since October 22, 2020, abortion remains legal only in case of rape, incest, or when the life of the pregnant person is in danger. European Parliament, "Poland's De Facto Ban on Abortion Puts Women's Lives at Risk, Says Parliament," *News European Parliament* November 26, 2020, https://www.europarl.europa.eu/news/en/press-room/20201120IPR92132/polish-de-facto-ban-on-abortion-puts-women-s-lives-at-risk-says-parliament. Abortion in case of fetal defects was ruled to be unconstitutional. In Iceland, major protest did not prevent the passing (April 2019) and going into effect (September 2019) of a restricted new abortion law. Andie Sophia Fontaine, Iceland's New Abortion Law Goes into Effect Today," *The Reykjavik Grapevine* September 2, 2019, https://grapevine.is/news/2019/09/02/icelands-new-abortion-law-goes-into-effect-today/. In other countries, an explicit demographic policy has been introduced as part of populist politics. In Hungary, for example, women are rewarded for having many children. They are exempt from income tax for life, after having a fourth baby. Prime Minister Orbán explicitly makes a connection between Hungarian reproduction and a xenophobic and homophobic defense of Hungarian culture. Shaun Walker, "Viktor Orbán: No Tax for Hungarian Women with Four or More Children," *The Guardian* February 10, 2019, https://www.theguardian.com/world/2019/feb/10/viktor-orban-no-tax-for-hungarian-women-with-four-or-more-children

bodies. It repeats the dissolution of relationality between the mother and what she reproduces, making the child into a separate entity that must be protected from the mother.[20] In the Netherlands, for instance, abortion is still part of criminal law and the recent proposal to allow deceased fetuses to be registered as deceased citizens is being used by Christian parties to argue for the rights and personhood of embryos and fetuses.[21]

Even in countries where abortion is legal, reproductive subjectivity remains a taboo, imbued with shame and a sense of irresponsibility when one wants to make use of one's right to self-determination. Schrupp refers to the lawyer Nina Strassner who points out this double standard when arguing that a pregnant woman who says "I am unwantedly pregnant, I do not want to birth this fetus" commits an injustice, but a person who says "I do not want to donate blood, even when someone next to me will die and I would have saved his life with my blood," clearly falls under the right to self-determination.[22] The stigma of injustice that clings to maternal agency reproduces a certain conception of pregnancy. The reproductive relationship no longer belongs to the maternal, but its reproductive capacity is turned against it by taking away its possibility to take responsibility. Establishing a primary relationship of protection between the embryo and a stranger (in the form of the state or, in Texas, a concerned citizen) excludes the pregnant person from this relationship and separates her from it by subjugating her, while she is the only one who can and must decide whether she has the possibility to engage in a long-term care relationship. If she is forced to, the consequences for both her and the child are detrimental.

The discursive tendency of maternal separation instrumentalizes reproductive bodies as vessels instead of relations in which care for themselves, their children, and their reproductive capacities can take place. This instrumentalization is racialized through a history of colonization, slavery, forced sterilization, and eugenics and results currently in higher maternal and neonatal mortality rates.[23] For instance, in the same decade

20 Federici, *Caliban and the Witch*; Barbara Duden, *Disembodying Women: Perspectives on Pregnancy and the Unborn* (Cambridge: Harvard University Press, 1993).

21 Romy van der Burgh et al., "De anti-abortusbeweging in Nederland. 'Voor ons en natuurlijk dankzij de Here God,'" *Groene Amsterdammer* 10–11 (2021): 60–67.

22 Antje Schrupp, *Schwangerwerdenkönnen: Essay über Körper, Geschlecht und Politik* (Sulzbach: Ulrike Helmer Verlag).

23 Loretta Ross and Rickie Solinger, *Reproductive Justice: An Introduction* (Oakland: University of California Press, 2017); Francoise Vergès, *The Wombs of Women: Race, Capital, Feminism* (London: Duke University Press, 2020); Dána-Ain Davis, "Obstetric Racism: The Racial Politics of Pregnancy, Labor, and Birthing," *Medical Anthropology* 38, no. 7 (2019): 560–73; Emily E. Petersen et al., "Racial/Ethnic Disparities in Pregnancy-Related Deaths. United States, 2007–2016," *Morbidity and Mortality Weekly Report* 68 (September 2019): 762–65; Marian Knight et al., *Saving Lives, Improving Mothers'*

as *Paris Match* featured the early "pro-life" photo series, in the French overseas territory La Reunion Island, thousands of Black women were subjected to forced abortions and sterilization without their knowledge or consent.[24] Françoise Vergès discusses in her book *The Wombs of Women* how this practice, designed to deal with "serious demographic issues" and collect insurance money, was able to continue for years without causing public or ethical outrage.[25] The discursive power of maternal separation hence *reproduces* the axes of whiteness, Blackness, marginalization, and privilege.[26] The situatedness of these three events in the same time under the power of the same nation state shows the racial differentiation in bio- and necropolitics, where some people are forced to reproduce while others' reproductive capacities are destroyed.

This grip of the state is effectuated through the appropriation of midwives and doctors by the state. Excessive measures in the United States show the force that policymakers deem necessary to sever the relationality and solidarity between mother and midwife or doctor, such as the new law in Texas, or the attempts by other states to make performing an abortion a felony after 6 weeks of gestation.[27] Also, on the other end of pregnancy, midwives who provide homebirths or follow mothers' wishes against medical advice are faced with prosecution, and indigenous and traditional birth attendants continue to be juridically pushed out of the domain of childbirth.[28] At a more formative level, students in obstetric training must show assertiveness, power, and responsibility over mothers in order to graduate, which is juridically embedded in mandatory numbers of procedures like episiotomies.[29] During the whole period of pregnancy, there is a discursive tendency in both the juridical and the political domain to sever the relationship between the

Care: Lessons Learned to Inform Maternity Care from the UK and Ireland. Confidential Enquiries into Maternal Deaths and Morbidity 2014–16, MBRRACE-UK Report (Oxford: National Perinatal Epidemiology Unit, University of Oxford, 2018), https://www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202018%20-%20Web%20Version.pdf.

24 Vergès, *Wombs of Women*.

25 Ibid., 18.

26 Ross and Solinger, *Reproductive Justice*; Vergès, *Wombs of Women*; Davis, "Obstetric Racism."

27 Liptak, Goodman, and Tavernise, "Supreme Court"; "Louisiana's Democratic Governor Signs Abortion Ban into Law," NBC News, last modified May 30, 2019, https://www.nbcnews.com/news/us-news/louisiana-s-democratic-governor-signs-abortion-ban-law-n1012196; Amaryah Shaye Armstrong, "Surrogate Flesh: Race, Redemption, and the Cultural Production of Fetal Personhood," *Journal of Ecumenical Studies* 55, no. 4 (2022): 518–543.

28 Sheryl Nestel, *Obstructed Labour: Race and Gender in the Re-Emergence of Midwifery* (Vancouver: University of Birtish Colombia Press, 2016); Vergès, *Wombs of Women*; "Hungarian Home Birth Champion Sentenced to Two Years in Prison," *The Guardian*, March 25, 2011, https://www.theguardian.com/world/2011/mar/25/midwife-agnes-gereb-home-births-jailed.

29 Van der Waal et al., "Obstetric Violence within Students' Rite of Passage."

maternal and the one who cares for them, decreasing the power, autonomy, and freedom of pregnant people which must be constituted relationally.

The Ethical-Existential Framing of the Maternal as Maternal-Fetal Conflict or Constraint

Even in countries with policies that guarantee patients' rights, respectful maternity care is under pressure. Ethnographic research reveals that the expectation that professional experts give objective information remains unfulfilled as these experts are not free from prejudice, their assessment of medical risks is biased, and their relationship with the institution they work for is stronger than with the people they care for.[30] Decisions concerning treatments and interventions are not clearly communicated to the mother, nor is she offered the opportunity to give informed consent.[31] In addition, mothers rarely receive continuous and relational care during pregnancy, childbirth, and postpartum, although the beneficial effects of support and care on maternal and neonatal morbidity and mortality have been proven many times.[32] The increase in epidurals is not only caused by a higher demand for pain medication but also by the experts' technocratic values, a fragmented system of maternity care, and a lack of continuous relational support.[33] The absence of both objective information and continuous support attests to the dissolution of the relationality between mother and midwife, leading, again, to a strategic diminishment of their subjectivity. This effectively results in a shift in priority from the mother's best interests to what is understood to be the baby's best interest.[34]

The focus on the baby's life as an entity "captured" inside of the mother, instead of as an entity relationally intertwined with the mother, results in a lack of care for the latter. Mothers express how they are made to feel "less than human," like a "lump of meat," and an "obstacle" surrounding the child.[35]

30 Elizabeth Newnham, Lois McKellar, and Jan Pincombe, *Towards the Humanisation of Birth: A Study of Epidural Analgesia & Hospital Birth Culture* (Cham: Palgrave Macmillan, 2018).

31 Villarmea and Kelly, "Barriers to Establishing"; Newnham, McKellar, and Pincombe, *Towards the Humanization*.

32 Sue Kildea et al., "Continuity of Midwifery Carer Moderates the Effects of Prenatal Maternal Stress on Postnatal Maternal Wellbeing: The Queensland Food Study," *Arch Womens Ment Health* 21. no. 2 (2018): 203–214.

33 Newnham, McKellar, and Pincombe, *Towards the Humanisation*.

34 Newnham and Kirkham, *Beyond Autonomy*; De Vries, "Obstetric Ethics"; Premkumar and Gates, "Rethinking the Bioethics"; Harris, "Rethinking Maternal-Fetal Conflict."

35 Gill Thomson and Soo Downe, "Widening the Trauma Discourse: The Link between Childbirth and Experiences of Abuse," *J Psychosomatic Obstet Gynecol* 29, no. 4 (2008): 268–273;

Kingma describes these misconceptions as the dominating "fetal container model."[36] This model regards the fetus as if it is independently growing within the mother, hence reducing the mother to its container. Rothman traces the conceptualization of the individual fetus to the beginning of medical measurements and visualizations of the fetus, which lifted it as a subject out of the mother's body—recall the *Paris Match* cover story: "The fetus in utero has become a metaphor for 'man' in space, floating free, attached only by the umbilical cord to the spaceship. But where is the mother in this metaphor? She has become empty space."[37] With the differentiation from its mother, the fetus is no longer growing within the mother but, rather, within medical discourse. According to Duden, these developments have "transformed pregnancy into a process to be managed, the expected child into a fetus, the mother into an ecosystem, the unborn into a life, and life into a supreme value."[38] As such, the maternal in the maternal-fetal organism is established as ontologically secondary to the being of the fetus. In the maternal-fetal container model, maternal separation results in a diminished maternal subjectivity, while the child is taken up by the obstetric institution as both a subject and the symbolic representation of "Life" that must be defended.

The traditional lack of thought on relationality in Western philosophy works discursively in its understanding of the relational nature of the maternal as an anomaly. Feminist bodies of knowledge that elaborate upon relationality from care ethics,[39] care-ethical disability studies,[40] critical vulnerability studies,[41] and the social practice of identity formation[42] have not received appropriate attention. In Western thought, one configuration of the human, one that emphasizes identity as differentiation and separation of the individual from others, remains dominant. As Hird writes:

Gita Sen, Bhavya Reddy, and Aditi Iyer, "Beyond Measurement: The Drivers of Disrespect and Abuse in Obstetric Care," *Reproductive Health Matters* 26, no. 53 (2018): 6–18; Rajat Khosla et al., "International Human Rights and the Mistreatment of Women during Childbirth," *Health and Human Rights Journal* 18, no. 2 (2016): 131–143.

36 Elselijn Kingma, *Better Understanding the Metaphysics of Pregnancy: Organisms, Identity, Personhood & Persistence* (Research proposal, University of Southampton, 2015).

37 Barbara Rothman, *The Tentative Pregnancy. Prenatal Diagnosis and the Future of Motherhood* (New York: Penguin Books, 1986).

38 Duden, *Disembodying Women*, 2.

39 Margaret Urban Walker, *Moral Understandings: A Feminist Study in Ethics* (2nd ed.; Oxford: Oxford University Press, 2007).

40 Kittay, *Love's Labor.*

41 Mackenzie and Stoljar, *Relational Autonomy*; Mackenzie, Rogers, and Dodds, *Vulnerability.*

42 Hilde Lindemann, *Holding and Letting Go: The Social Practice of Personal Identities* (Oxford: Oxford University Press, 2014).

> Insofar as Western societies are dependent upon a notion of freedom prior to constraint and inasmuch as the human body is assumed as clearly and cleanly demarcated from others, then pregnancy, birthing and breastfeeding can only exist as uncomfortable anomalies to human subjectivity.[43]

The lack of impact of feminist philosophies of relationality, and of the experience of fertility, pregnancy, and childbirth within philosophy, complicates our understanding of pregnancy and childbirth culturally and politically as the dominant view limits our sense of self, leaving fertility, pregnancy, birth, and early motherhood as an impossibility or problem to our subjectivity that can be easily expropriated into specialized domains beyond the grasp of pregnant people. The continuous expropriation of relationality from the maternal is ensured by a biopolitical discursive reproduction of mother and child, or woman and "Life," as separate entities, effectuated in ongoing obstetric reproductive and obstetric violence that is, at its core, a severance of relationality. This dual severance of both key relationships leaves the maternal not only isolated from a community of care, but also alienates it through the instrumentalization of their reproductive capacities from their fertility as an existential dimension of the self.

Reimagining Maternal Relationality

The Reproductive Relationship (First Key-Relation)

In order to take seriously the turmoil of reproduction, giving birth, and relational reproductive care, we must dare to reimagine the relationality and ambiguity of pregnancy and fertility. Following Audre Lorde's question "What are the words you do not yet have?," we need to reconsider the configuration of the maternal and reproductive relationship and ask freely: What is pregnancy? And giving birth? And fertility? And midwifery care? And how do these relationships restructure our relation to ourselves and the world?[44] Lily Gurton-Wachter writes:

> How will having a baby disrupt my sense of who I am, of my body, my understanding of life and death, my relation to the world and my sense

43 Myra J. Hird, "The Corporeal Generosity of Maternity," *Body & Society* 13, no. 1 (2007): 1–20.
44 Audre Lorde, *Sister Outsider: Essays and Speeches* (Berkeley: Crossing Press, 1984).

> of independence, my experience of fear and hope and time, and the structure of my experience altogether?[45]

Next to the often-theorized existential dimensions of natality and mortality, reproduction must be reimagined if we are going to arrive at reproductive justice. The interwovenness of the fetus with the maternal challenges every conception of subjectivity as singular.[46] The modern idea that the subject is enclosed and confined by the skin, an embodied and singular "I" is no longer valid for a pregnant person. Pregnancy questions these boundaries of the "I," as the pregnant human does not coincide with their own body in which another starts to grow. The boundaries of both identities of mother and fetus are opaque, fluid, and relational to the core. Maternal identity is neither one nor two-in-one.

Maternity is not a passive waiting for an already completed other human being that is merely following the course of its fate, but an active awaiting that will go on and on and transforms the maternal together with the formation of the child. During the year of pregnancy, birth, and maternity, the mother's identity changes fundamentally.[47] The transformation concerns their sense of self (becoming a mother), social status, and activities, but she also transforms on a deeper level from an "I" to the experience of the self as "we."[48] In pregnancy, there is a constant dynamic of questioning who the other is, how the other is, of interpreting and circumventing the child whose limbs are formed in dialogue with the maternal movements of nurturance, of healing, of making milk.[49] The maternal relationship is genealogy

45 Lily Gurton-Wachter, "The Stranger Guest: The Literature of Pregnancy and New Motherhood," Los Angeles Review of Books, last modified July 29, 2016, https://lareviewofbooks.org/article/stranger%20-guest-literature-pregnancy-new-motherhood/#.

46 Amy Mullin, *Reconceiving Pregnancy and Childcare* (Cambridge: Cambridge University Press, 2005); Alison Stone, *Feminism, Psychoanalysis, and Maternal Subjectivity* (New York/London: Routledge, 2012); Jonna Bornemark, "Life beyond Individuality: A-subjective Experience in Pregnancy," in *Phenomenology of Pregnancy*, ed. Jonna Bornemark and Nicholas Smith (Huddinge: Södertörn University, 2015).

47 Tina Miller, "'Is This What Motherhood Is All About?' Weaving Experiences and Discourses through Transitions to Frst-Time Motherhood," *Gender & Society* 21, no. 3 (2007): 337–358; G.A. Hartrick, "Women Who Are Mothers: The Experience of Defining Self," *Health Care Women Int* 18, no. 3 (1997): 263–277; Patricia Hill Collins, "The Meaning of Motherhood in Black Culture and Black Mother-Daughter Relationships," in *Maternal Theory: Essential Readings*, ed. Andrea O'Reilly (Toronto: Demeter Press, 2007).

48 Elizabeth K. Laney et al., "Becoming a Mother: The Influence of Motherhood on Women's Identity Development," *Identity* 15, no. 2 (2015): 126–145; Christina Prinds et al., "Existential Meaning among Frst-Time Full-Term and Preterm Mothers: A Questionnaire Stud," *J Perninatal Neonatal Nurs* 28, no. 4 (2014): 271–279.

49 Lindemann, *Holding and Letting Go*; Bornemark, "Life beyond Individuality."

and generativity: both are embedded in past and future generations, and diachronically the newborn is embedded in "his/her generation."[50] Relationality in pregnancy is both spatial and temporal: throughout pregnancy the maternal body is reshaped, inflated, made to make space for, and increasingly co-possessed by, the other-in-the-self.[51]

Where natality and mortality individualize, pregnancy and fertility make us plural by carrying the possibility of the natality of the other. The possibility of the other's natality is constitutive for our fertility. This means that a relational view of pregnancy and birth forms the foundation of two existential structures that cannot be separated: the specific natality of the fetus that structures fertility and pregnancy on the one hand, and the fertility that enables the specific natality of this fetus on the other hand. The possibility of something new lies less in natality, as Arendt has argued, but is located in the relationality of reproduction, as a sympoetic productive intertwining of fertility, natality, community, and care.[52]

The Midwifery Relationship (Second Key-Relation)

A relational form of abortion and midwifery care would consist of long-term individual or communal relationship-building that allows for freedom of choice, in-depth conversations on pregnancy, birth, and the needs of mother and child after birth to make another ethical, existential, and communal consciousness possible through experience, reimagination, receptivity, and spirituality.

Only tailor-made care can hope to attune to the concrete person. The thought, decisions, and subjectivity of the maternal can be seen as primarily structured within the specificity of their circumstances: it is always about *this mother, this child, in this world*. As such, pregnancy and childbirth should be approached intersectionally.[53] This requires diversity, cultural humility, and conversations about beliefs and considerations concerning morally good and meaningful maternity practices and courses of action with maternity care workers.

50 Christina Schües, *Philosophie des Geborenseins* (Freiburg: Alber Verlag, 2008).

51 Hird, "The Corporeal Generosity"; Julia Kristeva, *Histoires d'amour* (Paris: Denoël, 1983); Inge van Nistelrooij, *Sacrifice: A Care-Ethical Reappraisal of Sacrifice and Self-Sacrifice* (Leuven: Peeters, 2015).

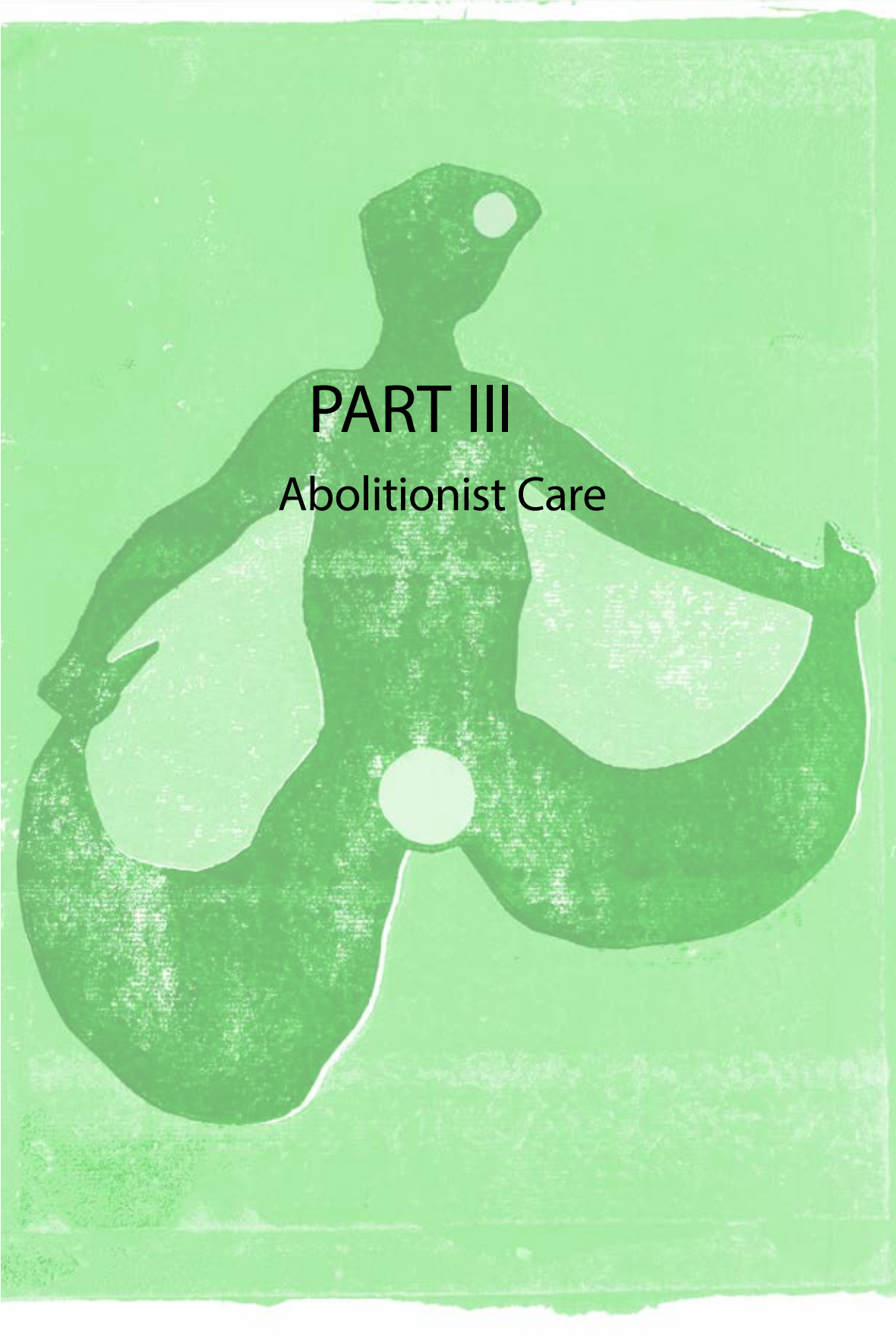
52 Hannah Arendt, *The Human Condition* (Chicago: The University of Chicago Press, 1998).

53 Patricia Hill Collins, "Shifting the Center: Race, Class, and Feminist Theorizing about Motherhood," in *Representations of Motherhood*, ed. Donna Bassin, Margaret Honey, and Meryle Mahrer Kaplan (New Haven: Yale University Press, 1994).

"Everybody is some mother's child," writes care ethicist and disability philosopher Eva Feder Kittay.[54] This shared human condition of a bodily and dependent origin is the foundation of human equality, rather than any individual condition or capacity (such as rationality or autonomy). One can also change the perspective within her famous quote: it takes both a mother *and a midwife caring for a mother* to come into existence. Each human being owes his or her existence to a person who got pregnant, has experienced that pregnancy positively or negatively, has felt this unborn being, fed it, and eventually gave birth to it, *and* those who cared for her. Throughout this process all three—mother, community, and child—can transform and be given "the world," like in the case of Annie Ernaux. Opening the imaginary through philosophy, art, activism, and, most importantly, care, can help us to reconceive relationality for reproductive justice.

We have discussed the discursive structural tendency of the two relationships that are essential for reproductive justice as a cause of reproductive and obstetric violence. This separation racializes and instrumentalizes the reproductive subject and consists of a severance of the double relationality that constitutes the maternal: the relationship between the person and their (capacity for) pregnancy, and the relationship between the (potentially pregnant) person and their community of care. We have identified separation in two domains, the juridical-political and the ethical-existential. This separation ultimately leads to the expropriation of the relationalities that are constitutive of the maternal, thereby violating, isolating, alienating, and instrumentalizing the reproductive subject. For reproductive justice and emotionally and physically safe maternity care to become possible, both the reproductive and the midwifery relationship must be radically reimagined. We underscore the need for care ethics because of its focus on relationality, and relational autonomy in maternity care, as well as to lay bare what inhibits the relationalities necessary for reproductive justice. Furthermore, we aim to shine another light on debates concerning abortion and childbirth leading to ethical questions and problematics that differ from those more commonly raised, centering on interwovenness relationality, community, and solidarity. Consequently, midwifery needs to start including abortion more prominently in its philosophy and reimagination of care to ensure relationality not only surrounding childbirth, but surrounding the whole reproductive justice spectrum

54 Kittay, *Love's Labor.*



PART III

Abolitionist Care

Intermezzo. Cecilia's Story

I met Cecilia when I was starting off my studies and I asked her to participate. During the development of the research, Cecilia's story became more and more inspiring to the theoretical development of the questions propelled by the interviews and focus groups. Her story speaks to many of the different aspects above, as an exemplary case. Before she became pregnant, Cecilia had a psychosis three times. Since she was at risk to develop a psychosis postpartum due to her history, she was advised to take medication, give birth in the hospital, and spend the first postpartum days there as well. This would not only be better for her, as it would reduce the risk of psychosis, she was told, but also for her child. It would be safer this way. Instead of giving birth in a familiar setting, she was hence advised to give birth in an unfamiliar and clinical setting. Her labor would be supervised by people she did not know, and she would be on medication that would flatten her experience of becoming a mother.

Based on her own experience and knowledge of herself and her psychoses, Cecilia was not convinced that this approach would really work preventatively. She knew that the alienation from herself and her environment would make her more, rather than less, vulnerable to a postpartum psychosis. While Cecilia thought that her sensitivity to psychosis increased the need for personal and relational care, more institutionalized and depersonalized care was prescribed. Additionally, this approach also went too far for Cecilia. To her, psychosis was not the worst thing that could ever happen to her. It was not something (and she knew what she was talking about) that had to be prevented at all costs. The care proposed would require her to give up something precious. She wanted to have an experience that she knew would be important for herself and for her relationship with her child. She thought she could learn about the world through that experience. She wanted to be clear, sharp, too sharp perhaps, to celebrate instead of suppress herself, to not be alienated from herself and those around her through a clinical setting, unknown caregivers, and medication while having her child. But all this preferably without flying off the handle.

There was no room for any other form of care, however. The doctors had already decided for her how her pregnancy, birth, and labor would be handled. Cecilia tried to speak to the psychiatrist of the hospital, but there was no room for deviation from the protocol. She was intimidated and paternalized, and it was implied that she was risking the life of her child by not adhering to the care plan advised. At one point, she decided

to take things into her own hand. She arranged for her own care to make the experience of becoming a mother that she was looking for possible. She knew that she needed loved ones and care workers: a known midwife, doula, social worker, maternity nurse, her own familiar psychiatrist. She and her husband gathered a group of people who were committed. They formed a community of care around her, and made a plan, one without preventative medication and without having to spend the first postpartum days in the hospital. In order to become a mother loyal to herself, knowing that the experience would likely be intense and transgressive, given her history, a web of caring relationships had to be organized to make that safely possible.

In the broken nights during the days postpartum, she experienced a radical openness in terms of her senses and connections to others. A social worker, maternity care nurse, midwife, and her own familiar psychiatrist came by frequently in the first two weeks. The openness she experienced was not limited to her, but present in everything, in her whole community of care, and went also beyond purely human relationships. She discovered a physical rhythm between her and her child that was completely in tune, and she felt that they were made of the same matter, days after birth. That was her transgression and her spiritual experience of becoming a mother, within a generative inseparable sociality that was her family.

Cecilia knew it would not be easy, and based on her past experiences she knew as well as anyone could know what kind of risk she was taking. She knew what she needed to experience birth safely and organized this with her husband, despite the opposition of the medical structures. This practice of organizing with each other, of figuring out how to do it all, and then her spiritual experience of childbirth and the postpartum, is political because it constitutes something different from what we know, a different network of relationships, a different rooting of an experience, a different collaboration, a different praxis of care, and a different story of where we come from. That story, as Cecilia knew, can be about an event beyond the obstetric institution, and beyond the normal boundaries of the human, language, time, and the physical.

Cecilia story leads our gaze to three things that are the main questions of this book. First, an experience of transgressive openness that took her beyond the boundaries of subjectivity and was an experience of being human otherwise. Second, her story explicated the relationship between the possibility of that experience and the need for a caring community. This openness was indeed not limited to an individual experience but arose from a relational praxis of radical care. And third, her story showed that enabling such an experience is a political issue. The obstetric violence she

experienced, the carcerality present in the paternalistic approach of the doctors, and their insistence on something that she perceived as an alienated pregnancy, birth, and postpartum experience, as well as the resistance of the medical establishment, made the act of organizing together a different kind of experience and relationality, highly political. Cecilia's story shows that the experience of giving birth has an important political role in reinventing the human, precisely because it involves a *political* organization of a community of care against current configurations of how we should reproduce and the strict policing of these configurations.[1]

1 If anyone wants to contact Cecilia (a pseudonym) it can be done via the author.

7 The Undercommons of Childbirth and Its Abolitionist Ethic of Care: A Study of Obstetric Violence among Mothers, Midwives (in Training), and Doulas

Rodante van der Waal, Inge van Nistelrooij, and Carlo Leget[1]

Abstract

Engaging in dialogue with critical mothers, midwives, midwives in training, and doulas in the Netherlands, this study furthers the theoretical understanding of both obstetric violence and the activist resistance against it. Obstetric violence is understood as part of a process of separation, leaving the pregnant person isolated. The activist resistance against it is consequently theorized as the abolitionist building of an alternative "otherworld" of radical relational care. The themes established are: (1) "institutionalized separation" with the subthemes of "expropriation," "carcerality," and "obstetric violence"; and (2) "undercommoning childbirth" with the subthemes of "fugitive planning," "anarchic relationality," and "obstetric abolition."

Keywords

obstetric carcerality, obstetric abolition, birth, midwifery, Fred Moten, doula.

1 A prior version of this chapter was published as Rodante van der Waal, Inge van Nistelrooij and Carlo Leget, "The Undercommons of Childbirth and Its Abolitionist Ethics of Care: A Study of Obstetric Violence among Mothers, Midwives (in Training), and Doulas," *Violence against Women* 0(0) (2023): https://journals.sagepub.com/doi/10.1177/10778012231205591.

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Introduction

Only a few years ago, obstetric violence was deemed to be an unnecessarily provocative term which would guarantee heated reactions from midwives, doctors, hospital management, and policymakers. Fortunately, during the last couple of years, the problematization of obstetric violence has become more mainstream. With the growth of consciousness around obstetric violence, we tend to hear more about the traumatic birth experiences of victims, however, and less about the knowledge that those affected, such as mothers, doulas, and midwives (in training), have developed—both in the form of critique and of care alternatives. In the study of obstetric violence, or what is often euphemistically called respectful maternity care, we, as care workers, academics, and policymakers, must be careful not to instrumentalize the experiences of traumatic birth for the reform of obstetric services in the way we deem fit and thereby reproduce an active-passive dichotomy on the part of pregnant people as victims on the one hand, and the reforming institutions of healthcare and science as agents of change on the other. For most activists, calling out obstetric violence always went hand in hand with the radical demand for, and practice of, relational continuity of care, oftentimes preferably outside of the jurisdiction of the obstetric institution. But currently, the proposition for obstetric reforms has gotten the overhand over a more radical reimagination of reproductive care. As a consequence, the general difficulty and disappointment that come with the attempt to reform big and powerful institutions can lead to the impression that obstetric violence is a problem that is near impossible to tackle. As such, the attempted reform of the obstetric institution by the institution itself disguises the many solutions to obstetric violence already offered and practiced by mothers, midwives, and activists, such as mutual aid and radical care outside of the obstetric institution—most often this comes down to relational continuity of autonomous midwifery and doula care.

In this chapter, we aim to take seriously the knowledge developed by engaged and activist mothers, midwives, midwives in training, and doulas of both the nature of obstetric violence and of alternative ways of care. We do so by pairing the views of the participants with two critical traditions of thought; care ethics and abolitionist thought as articulated by the Black radical tradition. Both traditions have developed a body of thought on a multiplicity of patterns of racist and misogynous violence. Adhering to a "practicalist conception of truth," this paper engages with the moral and epistemic standpoint of critical and/or activist mothers, midwives, midwives in training, and doulas in the Netherlands with regard to the problem of

obstetric violence and its solutions, aiming to present their thought, analysis, actions, and resistance, rather than merely their experiences of victimhood.[2] As such, this paper is written from the methodological perspective of the "rearguard intellectual" and "scholar-activist," doing intellectual labor in the back seat of the movement, i.e., in support of the knowledge and actions already being developed by the movement itself, documenting, clarifying, and theoretically strengthening its position.[3] As such, this study is a contribution of coalition and solidarity that will hopefully be useful to take our radical care and struggle further.

Although multiple definitions exist, we understand obstetric violence to be the institutionalized appropriation and violation of pregnant people's bodies, expropriating them of their self-determinacy, autonomy, responsibility, community, the right to physically and emotionally safe care, and the choice to birth or not birth their children in the way that they think is best.[4] Examples of obstetric violence in the Netherlands are procedures done without consent, such as vaginal examinations and episiotomies, verbal and physical abuse and mistreatment, and epistemic injustice.[5] In the Netherlands, 54% of parents indicate that they were subjected to one or more forms of mistreatment and abuse, 20% of which to physical violence.[6] Of the people who get an episiotomy during birth, 42% indicate that they were not asked for consent.[7] Another 47% of the people who received medication state that they were not asked for consent for its administration. On top of that, people report being given

2 Sara Ruddick, *Maternal Thinking: Toward a Politics of Peace* (Boston: Beacon Press, 1989).

3 Boaventura de Sousa Santos, *The End of the Cognitive Empire* (Durham: Duke University Press, 2018).

4 Rodante van der Waal et al., "Obstetric Violence: An Intersectional Refraction through Abolition Feminism," *Feminist Anthropology* 4 (2023): 91–114; Rodante van der Waal et al., "Obstetric Violence within Students' Rite of Passage: The Relation of the Obstetric Subject and Its Racialised (M)other," *Agenda* (*Durban, South Africa*) 35, no. 3 (2021): 36–53.

5 Van der Waal et al., "Obstetric Violence within Students' Rite of Passage"; Marit van der Pijl et al., "Left Powerless: A Qualitative Social Media Content Analysis of the Dutch #breakthesilence Campaign on Negative and Traumatic Experiences of Labour and Birth," *PLOS ONE* 15, no. 5 (2021): 1–21; Marit S. G. van der Pijl et al., "Consent and Refusal of Procedures during Labour and Birth: A Survey among 11 418 Women in the Netherlands," *BMJ Quality & Safety* (2023); Marit van der Pijl et al., "Disrespect and Abuse during Labour and Birth amongst 12,239 Women in the Netherlands: A National Survey," *Reproductive Health* 19, no. 160 (2022): 1–16; Rianne van Hassel, Rodante van der Waal, and Inge van Nistelrooij, "Mijn belichaamde kennis is van waarde. Een auto-etnografische, zorgethische analyse van epistemisch onrecht binnen de Nederlandse reproductieve zorg," *Tijdschrift voor genderstudies* (2022).

6 Van der Pijl et al., "Disrespect and Abuse."

7 Van der Pijl et al., "Consent and Refusal of Procedures."

episiotomies, vaginal examinations, and medication despite their explicit refusal: 40% of those who refused an episiotomy got one anyway, and the same counts for 40% of those who refused a vaginal examination, and 60% of those who refused medication. While healthcare workers within the obstetric institution and their allies still tend to react defensively to the term obstetric violence,[8] and while many people still do not know this rather invisible form of gender-based violence—maybe because it is one of those kinds of violence that is too public, too institutionalized, too normalized to be noticed—the problem of obstetric violence is been on the agenda in maternity care ever since the publication of various major studies in high-ranking journals,[9] and a United Nations report.[10] By now, the meticulous analysis of the racist and gender-based nature of this form of violence, both philosophical,[11] sociological,[12] anthropological,[13] juridical,[14] and epidemiological,[15] is being used to battle obstetric violence on juridical and policymaking levels.

8 See for instance: Maura Lappeman and Leslie Swartz, "How Gentle Must Violence against Women Be in Order to Not Be Violent? Rethinking the Word 'Violence' in Obstetric Settings," *Violence Against Women* 27, no. 8 (2021): 987–1000. See also the response to this article: Rachelle Chadwick, "The Dangers of Minimizing Obstetric Violence," *Violence Against Women*, 29 no. 9 (2023): 1899–1908.

9 Roberto Castro and Sonia Frías, "Obstetric Violence in Mexico: Results from a 2016 National Household Survey," *Violence Against Women* 26, no. 6–7 (2020): 555–572; Michelle Sadler et al., "Moving beyond Disrespect and Abuse: Addressing the Structural Dimensions of Obstetric Violence," *Reproductive Health Matters* 24 (2016): 47–55.

10 Dubravka Šimonović, "A Human Rights-Based Approach to Mistreatment and Violence Against Women in Reproductive Health Services with a Focus on Childbirth and Obstetric Violence, Note by the Secretary-General," *Report of the Special Rapporteur on Violence Against Women* (New York: United Nations, 2019).

11 Sara Cohen Shabot, "Making Loud Bodies 'Feminine': A Feminist-Phenomenological Analysis of Obstetric Violence," *Human Studies* 39, no. 2 (2016): 231–247; Stella Villarmea, "When a Uterus Enters the Room, Reason Goes Out the Window," in *Women's Birthing Bodies and the Law: Unauthorised Medical Examinations, Power and Vulnerability*, ed. Camilla Pickles and Jonathan Herring (Oxford: Hart, 2020); Elselijn Kingma, "Harming One to Benefit Another: The Paradox of Autonomy and Consent in Maternity Care," *Bioethics* 35 (2021): 456–464.

12 Rachelle Chadwick, *Bodies that Birth: Vitalizing Birth Politics* (London: Routledge, 2018); Vania Smith-Oka, Sarah Rubin, and Lydia Dixon, "Obstetric Violence in Their Own Words: How Women in Mexico and South Africa Expect, Experience, and Respond to Violence," *Violence Against Women* 28, no. 11 (2020): 2700–2721.

13 Dána-Ain Davis, *Reproductive Injustice, Racism, Pregnancy and Premature Birth* (New York: NYU Press, 2019).

14 Camilla Pickles and Jonathan Herring, eds., *Childbirth, Vulnerability and Law: Exploring Issues of Violence and Control* (New York: Routledge, 2019).

15 Meghan Bohren et al., "The Mistreatment of Women During Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review," *PLoS Medicine* 12, no. 6 (2015).

Obstetric violence is an activist term, coined in South America, a "struggle concept."[16] But while the voices of the activist mothers, midwives, and doulas have been heard with regard to the recognition of the existence of obstetric violence, their voices tend to remain lost in academic, juridical, and policymaking discourse when it comes to their resistance to, and solutions for, obstetric violence. In struggle, critique always goes hand in hand with the fight for a better world and with a vision, often already put into practice, of how this world should be. Aiming to take seriously that obstetric violence is a struggle concept, and wanting to understand what the struggle is for as much as what it is against, we engage in an analytic dialogue with mothers, doulas, and midwives about what they believe is reproductive and birth justice, understanding their practice to be the moral expression of what they conceive of as justice.[17] This approach involves that mothers, doulas, and midwives are not only people with experiences that we can turn into knowledge which can then be used in various ways for research and policy, but that they are themselves agents of knowledge, praxis, and change, who are already planning and organizing alternatives to obstetric care. Harney and Moten make a crucial distinction between policy and planning, whereby policy captures all interventions done at a managerial level as an excercise of institutional power, such as the writing of guidelines, the issuing of reports, the setting of goals, and making of strategies, while planning contains the direct, grassroots action that people are already undertaking through mutual aid to create a different world through praxis.[18] The difference is that between writing a guideline on respectful maternity care and opening an alternative practice in which accessible, relational, personalized continuity of care is guaranteed. In a world where institutions and policy are hegemonic, the planning of care and activism tends to stay invisible. This is a problem, since solutions mostly sprout from active on-ground resistance and reimagination—indeed, from their unique moral and epistemic standpoints. The dual aim of this paper is hence to dissect, affirm, and theoretically

16 Rachelle Chadwick, "Breaking the Frame: Obstetric Violence and Epistemic Rupture," *Agenda* (*Durban, South Africa*) 35, no. 3 (2021): 104–115.

17 Margaret Urban Walker, *Moral Understandings: A Feminist Study in Ethics* (2nd ed.; Oxford: Oxford University Press, 2007). For an introduction into the Black feminist concept of Reproductive Justice, see: Loretta Ross and Rickie Solinger, *Reproductive Justice. An Introduction* (Oakland: University of California Press, 2017), and the SisterSong Women of Color Reproductive Justice Collective.

18 Stefano Harney and Fred Moten, *The Undercommons: Fugitive Planning and Black Study* (New York: Autonomedia, 2013).

further develop what activists, doulas, and autonomous midwives know about obstetric violence—taking their critique seriously as agents of knowledge, to understand better the alternative practice that they have been planning in terms of how this practice is a resistance to, and solution for, obstetric violence.

What emerges from this study, then, is that obstetric violence should not be understood as a stand-alone problem that is easily circumscribed, but as part of a bigger logic inherent to the obstetric institution that severs relationality. The intertwined expropriation of maternal subjectivity, the carcerality of the obstetric institution, characterized by captivity and punishment, and obstetric violence, leads to the isolation of the pregnant person. Since the participants do not see obstetric violence as a stand-alone problem, or even as something that you could cut out of the obstetric institution, as it is so intertwined with a more fundamental logic of separation inherent to the institution, their resistance to obstetric violence is neither characterized by reform, nor can it be understood on a level of policy. Instead, their resistance must be viewed as a form of planning of alternative forms of care that takes them outside of the obstetric institution. When we zoom in on these practices of planning, what emerges is an almost invisible but vast "undercommons"[19] of care for childbirth that is expressive of an abolitionist ethic of care: an ethic of care that does not try to reform the obstetric institution, but has a vision of its abolition—and with that, a vision of a different world altogether.

Below, we will first concisely discuss our theoretical framework and positionality, after which we will extensively elaborate on our methodology. Then we will present the results of the empirical study, consisting of two main themes representing the critique of obstetric violence on the one hand and the specific form of resistance to it on the other: (1) institutionalized separation, consisting of expropriation, carcerality, and obstetric violence, and (2) the undercommons of childbirth, consisting of fugitive planning, anarchic relationality, and obstetric abolition. Thereafter, we will discuss that the primary way of struggle against obstetric violence of the mothers, midwives, midwives in training, and doulas in this study is through a praxis of an abolitionist ethic of care which resists the isolation of mothers and midwives inherent in the obstetric institution.

19 Harney and Moten, *The Undercommons*; Stefano Harney and Fred Moten, *All Incomplete* (New York: Autonomedia, 2021).

Theoretical Framework and Positionality

Theoretical Framework: Care Ethics, Abolitionism, and Critical Midwifery Studies

Care ethics is a feminist ethics departing from the idea that we are all relationally connected through care and responsibility, and therefore vulnerable in our mutual dependency.[20] Consequently, the mothers, doulas, and midwives in this study are understood to be always already relationally embedded in a practice, and an ethics, of care. The practice of care that they engage in is taken as the direct source of the various, multiple moral and epistemic standpoints studied, standpoints that are always in the process of being developed. By taking the relationality of midwifery, including mothers, doulas, and midwives in training, as its relational moral and epistemic standpoint, this study is also situated in the emerging field of Critical Midwifery Studies (CMS), which understands midwifery to be a marginalized standpoint through which we can "study upwards" the intersections of oppression present in reproductive care.[21] CMS believes in the potential of midwifery to better neonatal and maternal health outcomes, something that is consistently proved by midwifery scholars, as well as in its potential to reduce obstetric violence and obstetric racism—but only if midwifery can incorporate critical theory such as intersectional feminism, the Black radical tradition, and decolonial theory.[22] We aim to contribute to the development of CMS by taking both care ethics[23] as well as Black abolitionist scholarship[24] as our theoretical framework to understand better what midwives and doulas know about obstetric violence and how they struggle against it.

All participants in this study have a uterus, have experienced obstetric violence, and are of diverse professional, socio-economic, sexual, gender, and

20 Joan Tronto, *Moral Boundaries. A Political Argument for an Ethic of Care* (New York: Routledge, 1993); Joan Tronto, *Caring Democracy. Markets, Equality, and Justice* (New York: NYU Press, 2013).

21 Critical Midwifery Studies (CMS) Collective Writing Group, "A Call for Critical Midwifery Studies: Confronting Systemic Injustice in Sexual, Reproductive, Maternal, and Newborn Care," Birth 49 (2022): 355–359; Chandra Mohanty, *Feminism without Borders: Decolonizing Theory, Practicing Solidarity* (Durham: Duke University Press, 2003).

22 Ibid.

23 Tronto, *Moral Boundaries*; Tronto, *Caring Democracy*; Urban Walker, *Moral Understandings*.

24 Harney and Moten, *The Undercommons*; Harney and Moten, *All Incomplete*; Marquis Bey, *Them Goon Rules. Fugitive Essays on Radical Black Feminism* (University of Arizona Press, 2019); Marquis Bey, *Anarcho-Blackness: Notes Toward a Black Anarchism* (Chico: AK Press, 2020); Marquis Bey, *Black Trans Feminism* (Durham: Duke University Press, 2022).

cultural identities and backgrounds. Some participants identify as Black, some as white, some as people of color. Some are born in the Netherlands, and others identify as having a migration background. All participants have extensive knowledge of the subject additional to their own experiences, obtained through either study, activism, or care. Following standpoint theory, their identities and experiences have familiarized them with structures of oppression and have given them insight into knowledge that would have otherwise remained unfamiliar to them.[25] Next to a common identity, a certain profession, such as midwifery, can also be considered the basis of unique knowledge. Informed by critical midwifery studies as well as care ethics, we locate the practice of midwifery as the moral and epistemic standpoint studied here, but only in so far as midwifery is understood to be a relationality including pregnant people and others supporting the laboring person. This research is hence not focused on either midwives, or mothers, or activists, but on the relational coalition between these different subjects. In other words, the standpoint that is studied is that of midwifery, but only in so far midwifery can be understood—or must wish, and fight, to be understood—as a bundle of relationality between people giving birth and people caring for people giving birth; a sociality that is irreducible to demarcated subjectivities. A sociality, if you will, that always thinks, practices, and struggles in relation, and that resists being fully individualized or professionalized.

Positionality

The main author, Rodante van der Waal (she/they), writes this paper as a white middle-class PhD candidate from Amsterdam and as an independent midwife thus participating in the standpoint being studied here. The second author, Inge van Nistelrooij (she/her), is a white middle-class senior academic and mother of three daughters. Her standpoint as a mother was enabled by the obstetric institution that provided both life-sustaining and harmful practices. The third author, Carlo Leget (he/him), is a white middle-class senior academic, father of three children, one of whom recently gave birth herself. He was closely involved in the home birth of his three children. All authors have clear ties to the subject at hand. We believe that by acknowledging the borders of our positionality and by staying faithful to our own subjectivity and the particularity of this research and our

25 Sandra Harding, *The Feminist Standpoint Theory Reader: Intellectual and Political Controversies* (New York: Routledge, 2004).

identities, we will be able to say something about widespread intersecting structures of oppression in obstetric care while staying acutely aware of the limitations of this study caused by the limitations of our identities and positions.[26]

Methods[27]

Research Design

The study is designed according to the insights of both standpoint theory which regards experiences of marginalized people as a source of knowledge that often remains unrecognized in more traditional and objectivist research methods,[28] and the insights of care ethics, which holds that theory and empirical data are always constituted in a dialectic and cannot be objectively separated.[29] To facilitate a process of study that was able to both engage with the standpoint of the participants, and further the theoretical understanding of this standpoint through the interaction of insights gained by theoretical study and insights gained by empirical study, the research was designed according to the method of responsive evaluation, in a version specifically adapted to care ethics.[30] Responsive evaluation is a democratic and dialogical method, offering room for interaction and exchange of experiences and ideas among participants and researchers. It consists of five steps: (1) creating social conditions; (2) eliciting experiences from different stakeholders; (3) consulting homogeneous focus groups; (4) consulting heterogeneous focus groups; (5) drawing up conclusions and recommendations. All five steps were followed. In line with care ethics, our theoretical framework was only developed during the phases of the empirical research, and in dialogue with the participants.

26 Mohanty, *Feminism without Borders*.

27 Some sections in this methodology are similar to the methodology presented in chapter 1 and 2, those sections are not repeated here. Please see chapter one for the data collection and the ethical considerations.

28 Harding, *The Feminist Standpoint Theory Reader*.

29 Carlo Leget, Inge van Nistelrooij, and Merel Visse, "Beyond Demarcation: Care Ethics as an Interdisciplinary Field of Inquiry," *Nursing Ethics* (2017).

30 Tineke Abma and Guy Widdershoven, "Sharing Stories: Narrative and Dialogue in Responsive Nursing Evaluation," *Evaluation & the Health Professions* 28, no. 1 (2005): 90–109; Merel Visse, Tineke Abma, and Guy Widdershoven, "Practising Political Care Ethics: Can Responsive Evaluation Foster Democratic Care?" *Ethics & Social Welfare* 9, no. 2 (2015): 164–182.

Participants and Sampling

Thirty-one participants were recruited by the first author of this paper; ten mothers, eleven midwives, five doulas and five midwives in training. Most of the birth workers involved are also mothers, many of whom have experiences of obstetric violence during their own pregnancy and childbirth. The main author contacted people through their personal network, as well as through the activist organization the de Geboortebeweging (The Birth Movement). Participants were also recruited via snowball recruitment. Sample criteria were extensive knowledge (either scholarly, activist, or embodied) of obstetric violence in addition to personal experiences with it, and engagement with either activism or alternative forms of care. This means that all participants were critical (ranging from quite to very critical) of Dutch maternity care, and that they have experience with, and ideas about, how care for birth can be better. We have hence specifically selected a group of participants that is almost certainly more critical of Dutch maternity care than an average prospective parent, in order to engage with the analytical knowledge on the nature of obstetric violence from people in the field. To be able to include a breadth of perspectives, analyses, and practices within this critical branch of people, attention was paid to establishing a diverse group of participants in terms of both identity and practices, with some engaging more in direct activism, others in reading and study, others in art, and others in alternative forms of care, but all relating to obstetric violence and the resistance to it.

Data Analysis

A new TA was conducted after the phases of data collection by the first author through Atlas.ti under supervision of the other authors. TA has five phases before the results are drawn up: (1) familiarizing yourself with the data; (2) generating initial codes; (3) searching for themes; (4) reviewing themes; and (5) defining and naming themes.[31] All phases were done and discussed, together with the codes, code tree and themes, with all authors. TA differentiates between an inductive and a theoretical approach. The theoretical approach is informed by the theoretical lens and research question of the authors, while the inductive approach establishes the research question from the bottom up through the coding process. Since care ethics recognizes that one can never separate empirical findings

31 Ibid.

from theoretical insights,[32] we chose the theoretical approach which was, in our case, further informed by care ethics as well as by abolitionist theory.[33] The theoretical framework was only developed during the different phases of data collection, and was thus informed by the dialogues with the participants. The names of the themes and subthemes attest to the theoretical framework that we developed congruently with the empirical study, as they aim to grasp most closely what the participants said, while at the same time referring to concepts that originate from the theoretical traditions described above.

For instance, although the participants did not use the rather theoretical term "expropriation" themselves, many of them did describe the experience of expropriation and understood this to be one of the causes of obstetric violence. The theoretical name of the theme is used here to further our analytical understanding of what obstetric violence is, based on an analytical engagement with the standpoint of the participants, rather than solely describing their experiences. The same counts for the subtheme "carcerality." Although the participants did not use the word carcerality, they did use the words "captivity" and "punishment," and many of them understood these terms to reenforce each other and be co-constitutive of an overall feeling of unfreedom and disciplination. In our understanding, the term carcerality captures the knowledge that the participants were communicating, combined with our theoretical study of the power structures inherent in institutions. The themes hence closely grasp the participants' standpoint, while at the same time establishing a connection to theoretical thought—this is, according to de Sousa Santos, the added value of the work of scholars in activist movements.[34] In sum, the subthemes reflect the result of the analytical dialogue with the participants through the phases of care ethical responsive evaluation in which empirical and theoretical research are used to guide and develop one another. Since this research takes place on a level of dialogical thought, analysis, and knowledge, rather than being merely descriptive, we consider the choice of the theoretical approach to TA as a further thinking along with the participants that deepens understanding, knowledge, and insights.[35]

32 Leget, Van Nistelrooij, and Visse, "Beyond Demarcation."

33 Tronto, *Moral Boundaries*; Tronto, *Caring Democracy*; Urban Walker, *Moral Understandings*; Harney and Moten, *The Undercommons*; Harney and Moten, *All Incomplete*; Bey, *Them Goon Rules*; Bey, *Anarcho-Blackness*; Bey, *Black Trans Feminism*.

34 De Sousa Santos, *The End of the Cognitive Empire*.

35 Urban Walker, *Moral Understandings*.

Results

Two main themes and various subthemes were established. The first is "institutionalized separation" with the subthemes of "expropriation," "carcerality," and "obstetric violence." The second theme is "undercommoning childbirth" with the subthemes of "fugitive planning," "anarchic relationality," and "obstetric abolition."

Institutionalized Separation

The mothers describe an overall sense of isolation within the obstetric system, as a result of a severance of two relationships: that between the mother and her child, and that between the mother and her community of care. The mothers construe how a felt separation between mother and child takes place when care workers take over the responsibility for the baby, thereby negating maternal responsibility and knowledge that is essential to their mother-child relationship. Consequently, this violation of trust, in a combination with feeling objectified, violated, captive, and expropriated, is described as a severance of the relationality between the mother and her community of care, resulting in the experience of isolation. The theme institutionalized separation hence consists of three subthemes: (1) "expropriation," where the responsibility for the baby and the autonomy of the maternal body are expropriated; (2) "carcerality," consisting of a feeling of isolation and captivity of both the mothers and birth workers, combined with the threat of punishment; and (3) "obstetric violence," consisting of continuous and overlapping experiences of violence. "Expropriation" is a term borrowed from Federici,[36] and "carcerality" is a term borrowed from Bey.[37]

Expropriation

Most mothers in this study understand themselves to have intuitive or bodily knowledge on how to birth, on how to be in a relationship of care and responsibility with their child when pregnant, and understand themselves as embedded in a community of care and responsibility. Mothers felt actively expropriated by the obstetric system of their capacity to birth:

36 Silvia Federici, *Caliban and the Witch: Women, the Body, and Primitive Accumulation* (New York: Autonomedia, 2004).

37 Bey, *Anarcho-Blackness*; Bey, *Black Trans Feminism*.

A lot of people in the hospital told me, "It's my job to keep the baby safe." But I didn't see that as their job. I thought their job was to help me birth. It's their job to keep me safe, it's my job to keep the baby safe. [...] *But that was not very—actually, that was never mentioned. This felt really lonely. I felt suddenly I didn't speak the language anymore. In books, in writing, I found people who shared these opinions but they weren't with me; they were not having coffee with me, were not here to be my midwife and were also not my partner. I know other people felt the way I felt but I didn't find them.* (*Mother 1*)

In the quote above, the hospital staff takes responsibility for the baby rather than that they take care of the mother and let the mother take responsibility for her child, causing the mother to experience isolation, and loss of autonomy with regard to herself and her child. While mothers expected to gain in care and relationality when entering the obstetric system, they instead felt more and more devoid of what they understood to be care the further they progressed into the obstetric institution, as if the institution was actively taking something away from them:

Everything went fine until the staff in the hospital realized that I was already pushing, [...] *I was laboring, and my husband was with me, and we had a really good ... we had rhythm, and a little ritual, we were equal, and it was good. But then, at some point somebody heard all the sounds coming and recognized this is a woman who is bearing down, and at that moment everybody rushed into the room. A lot of team, a big team rushed into the room, they got me to move onto another bed, and pushed me into the delivery room, and from that moment on it was about push, push, push, and I felt very bad.* [...] *I became like a procedure, it wasn't about me.* [...] *Yeah, I think from that moment on I didn't feel anymore it was, it wasn't my experience, it wasn't about me, it was about the baby coming out* [...], *it wasn't anymore mine* [...], *it was delegated to all these others.* (*Mother 3*)

Rather than going further into the relationship and rhythm of care that this mother had already established with her husband, which felt good, in which she knew what to do, and in which they could experience the birth together, the staff took over, appropriating her laboring body, and, quite literally, expropriating both parents from their autonomy, experience, relationality, knowledge of, and responsibility and care for birthing their child. Consequently, the mother was isolated from both the relationship to her child and her community of care, in this case her husband.

Mothers experience expropriation on multiple levels: expropriation of their body which no longer feels as their own; expropriation of their

experiences, in which they either do not matter or have no control over them; existential expropriation in which they are not given the freedom to experience birth as something more than a clinical and biological experience; and expropriation of their relationship with their child and the community of care in which they were embedded. Some participants regard these layers of expropriation as the core of obstetric violence:

The core of obstetric violence in my view lies in handing over every aspect of your functioning to a professional. We do not seem to understand how disempowering that really is. (*Midwife 10*)

Carcerality

Carcerality is chosen as the name for this subtheme to capture an intertwined and mutually constitutive experience of both captivity, described by both mothers and birth workers, and a fear of punishment, again described by both mothers and birth workers. Together, the experience of captivity and the fear of punishment amount to what can be called a carceral tendency within the obstetric system. In the same movement in which expropriation (discussed in subtheme 'expropriation') takes place, participants describe an appropriation of the mother's body:

I was on my knees giving birth in the bathroom and she came in and she said, "Get on the bed! I must examine you." And I said, almost begging, I asked her, "Can't I stay here?" And she says, "No. I really have to examine you." She looked at me and she spoke to me as if I were a difficult child who wouldn't listen and said, "Come on, I really have to feel the dilation." And then I had to go to the birth clinic, we raced there, and within half an hour [...] *my child was born. And afterwards I thought that I might as well have just stayed in that bathroom and given birth to my child in a way that felt good to me, but she wanted to examine me and then she really wanted to hand me over to the hospital, because there was also another delivery going on and she was really persuading me* [...] *that I was an inconvenience. I was being difficult. And it wasn't really my birth anymore. And I thought afterwards: what if it had been my birth? I would have loved to stay in that bathroom and just have my kid there.* (*Midwife in training 2*)

In the quote above, a midwife in training describes how, when giving birth herself, she had an unnecessary and unconsented vaginal examination and was afterwards brought to the hospital without consent. In the Netherlands this is an even more clear violation of choice, bodily autonomy, and freedom

of movement, than perhaps in other places , since homebirth is an integral part of Dutch maternity care. She describes how her body and birth no longer belonged to her, and how the way in which she was birthing her child, which went well, felt good, and was safe, was interrupted by the midwife who tookk charge of her body and her labor. She was brought to the hospital against her will, and she tells how she and her birth were captured by the obstetric system in the same movement as she was expropriated of responsibility, autonomy, and self-determination. She describes how the midwife related to her as "being difficult," reflective of an expectation of punishment, like with difficult children.

For mothers, midwives, midwives in training, and doulas, the institution feels like a system in which they are captured through disciplining, governance, protocols, and punishment:

It's a form of captivity to work in this system. How to empower or make space for women when you have no space or power yourself? (*Midwife in training 4*)

[*The care*] *had a very controlling aspect, they assumed that they had to act like a detective to find out what had already gone wrong with the pregnancy or would go wrong with the pregnancy. Yes, that was the terrible thing about it.* (*Mother 2*)

This mother had a healthy pregnancy, but wanted to be cared for in a different way, which was met with punishment in the form of suspicion, controlling behavior, and shroud waving. Participants also point to a threat of punishment that disciplines pregnant people as well as care workers, before they do anything out of the ordinary:

If I comply, then I cannot be punished. [*They*] *are saying: you are either with us, and if you're not, then you're on your own. And then comes the blaming and the shaming.* (*Mother 9*)

When I look back to when I would always stick with the protocols and all the time refer to the obstetrician, well that was not because I thought that it was the best thing for mother and child. [...] *It was because ... because I don't know how it ends either. And if it doesn't end well, then I'm done for. I'm done for..* (*Midwife 7*)

Care workers fear legal repercussions as well as social ones. They express that this fear disciplines them to be complicit in the institution, which contributes

to the overall theme of "institutionalized separation," as it separates them from the mother, binding them more strongly to the institution than to the people they care for. Even though being a doula and a midwife in primary care are still independent professions in the Netherlands, both describe being appropriated by the obstetric system to function as part of the logistics of the system, alongside the expropriation of their professional subjectivity. Similarly to the mothers, they note that obstetric care circumscribes and confines them and punishes them when they are seen as difficult. For midwives and doulas this mostly leads to a sense of forced complicity to the carcerality of the institution. For instance, when people's bodies are "handled" without consent, while the midwives and doulas do not dare to truly intervene:

I think it was a Moroccan woman [...]. *And at one point, she had to pee. But she wasn't allowed to get off EFM. And then they wanted to give her a catheter. But she didn't want one. And then I said: she doesn't have to get one, she can just go to the toilet. But no, she really wasn't allowed to get off the bed. And then she was put on top of the bed on a birthing stool in the middle of the room to pee, which she sat on with her bare buttocks. I felt that it was not okay for her, with those two strange men also present, two male interns,* [...] *it was very naked for her.* (*Midwife 7*)

Scenes like the one above describe that laboring people can experience a captivity within obstetrics that feels like punishment. This captivity simultaneously severs the relationality of the mother with her community of care, and takes away her authority and responsibility over herself and her child. At the same time, it perpetuates instances of violence and punishment on all levels of care, even when the care workers, like in the quote above, did not seem to have the intention of punishing or violating the birthing mother. This logic of captivity and punishment is what we have termed carcerality. The participants understand the carcerality of the institution to be above all else a consequence of the prioritization of the unborn child. We could understand this prioritization as a first principle that dominates the rest of the care:

The ultimate consequence of saving the child above all else, is that they will drag the mother to the hospital in a military manner if necessary. (*Mother 6*)

Obstetric Violence

Most participants view violence within obstetric care as institutionalized violence rather than as violence coming from one specific person. They

furthermore understand violence to be intertwined with the expropriation of subjectivity of mothers, midwives, and doulas, as well as with a logic of captivity and punishment that we have termed "carcerality," described above. This means that most of the participants do not regard obstetric violence as a stand-alone problem that is easily circumscribed, but as part of a bigger problem, namely a logic inherent in the obstetric institution that primarily undoes relationships. Ultimately, obstetric violence is thus only one of the subthemes that co-constitute the experience of isolation that is central to obstetric violence due to the severance of relationality, and is seen more as a necessary part of, rather than an incongruence within, the obstetric institution.

The most frequently listed occurrences of violence in obstetrics in this study are: (1) obstetric racism;[38] (2) epistemic injustice, mainly playing the dead baby card;[39] (3) physical violence, consisting of interventions without consent;[40] (4) penetrative violence, that is, violence linked to, or reminiscent of, rape or sexual assault; and (5) unconsented and/or unwarranted, and/or unwanted vaginal examinations. In the quote from a midwife in training below, all five of these forms of violence are present in a situation in which a vaginal examination is being done. This quote demonstrates how different forms of obstetric violence overlap with each other, and how violence is part of the expropriation and carcerality described in the subthemes above:

She was so scared, and I said to the midwife, "I know it's evening, but can't we get an interpreter to translate?" [...] *But the midwife said, "You know, just do it." And then I said, "But she doesn't understand it." You know, I'm not going to just put my fingers in someone, while someone doesn't understand, I think just really that that is a form of rape. That's real, you know. And I just don't want to do that.* [...] *I notice that when people are foreign and do not speak Dutch, they also use the opportunity to just do it, to let the student practice more.* [...] *People are side-lined. My sister-in-law told me about her birth that "someone else came in again, didn't even say anything and just stuck their fingers in me."* [..] *I am familiar with sexual violence. So, for me it's extra difficult if I see midwives do that, if they go in with their fingers while someone screams: "No, stop! What are you doing? Stop!" Yes, for me, that is even more difficult, to ... Yes.* (*Midwife in training 3*)

38 This topic is more extensively studied in chapters 2, 3 and 8.

39 See chapter 1 for a further empirical exploration of this topic, and chapters 4 and 5 for a theoretical one.

40 See chapter 1 for a more extensive elaboration on these last three instances.

In the quote above, it becomes clear how tricky it is to differentiate between different forms of obstetric violence, and to differentiate obstetric violence from other structures of oppression within the obstetric system. Multiple instances of violence are intertwined and point to a problem of widespread cultural and institutional violence characterized by expropriation and carcerality. First and foremost, obstetric racism is present in this quote. There is no interpreter, the laboring person does not understand what is going on, and the midwife in training says that people who do not speak Dutch are used to practice on more, which is a classic form of medical racism and medical apartheid. Second, we see the presence of epistemic injustice. The mother does not understand what is going on and her lack of understanding is used to the benefit of the institution. Third, there is physical violence in the form of a medical intervention without consent. Fourth, there is penetrative violence; a vaginal exam about to happen with neither consent nor understanding, and the midwife in training refers to other instances of penetrative violence. Here, it also becomes clear how mother and midwife cannot fully be separated as different standpoints. While we do not know if the unconsented vaginal examination was reminiscent of rape to the laboring person, it was to the midwife in training. The obstetric violence here thus also concerns her, as it was triggering of past trauma. And fifth, it is a case of an unwarranted and unwanted vaginal examination. Clearly it was unconsented, but was also unwarranted since the only indication for the extra exam by the student was so that the student could practice.

The above quote also shows how obstetric violence intertwines with the expropriation of the mother's knowledge and autonomy, and how the violence is part of the carcerality of the system, as it amounts to the captivity of the mother's body by taking charge of it for practice, and the experience of punishment which is not only present in the other mothers screaming "no," but also in the threat of punishment felt by the student midwife if she were not to comply. It becomes visible in this quote how the subthemes of expropriation, carcerality, and even violence all also count for the midwife in training who is held captive in the push to complicity with something what she experiences as, and has in the past experienced as, sexual violence. It thereby shows as well how not only mothers, but also midwives and midwives in training are expropriated, made complicit in the obstetric institution through its carcerality of punishment and capture, and pressured to participate in its violence—all contributing to the overall theme of institutionalized separation that constitutes maternal isolation.

The Undercommons of Childbirth

Rather than fighting the institution, the midwives, mothers, and doulas in this study mostly opted to "flee" from it, planning alternative practices themselves. They reappropriated care outside of the obstetric institution, taking their care, birth, and pregnancy into their own hands. Considering all the practices that they have enabled or that they participate in, a grand underground landscape of care for childbirth becomes visible that exists either fully outside of the institution or holds space within the institution. This landscape, which relies on relations, collaborations, unofficial networks, and mutual aid, could be characterized as an "undercommons." If the obstetric institution is the national commons of reproductive care, the invisible networks and resources of care that do exist outside of the obstetric institution, can be understood as an invisible "underground" of care. This undercommons is organized in various ways; through doula communities, through a big group of alternative midwives sharing knowledge and asking each other for help, or, for instance, through the activist movement De Geboortebeweging (The Birth Movement) that many of the participants are affiliated with. De Geboortebeweging has a phone you can call 24/7, a very active Facebook page where mothers and birth workers can ask for help and that functions as a resource of knowledge on birth, and a network of many midwives and doulas that provide alternative and respectful care. This undercommons also extends to within the obstetric institution through coalitions built with obstetricians and gynecologists, through which the public resources of the obstetric institution can be used outside of its protocols. The "undercommoning" is done by mothers and midwives through fugitive planning, the reconstruction of relationality in an anarchic way, and a vision of abolition. In the elaboration of the theme below, the undercommons is hence understood as constituted by three subthemes: (1) "fugitive planning"; (2) "anarchic relationality"; and (3) "obstetric abolition." "Undercommons" and "fugitive planning" are terms borrowed from Harney and Moten.[41]

Fugitive Planning

Many, almost all, mothers were determined to take matters into their own hands after the birth of their first child in which they had experienced obstetric violence. Refusing the further expropriation of their relationship with their child as well as with their community of care, mothers

41 Harney and Moten, *The Undercommons*.

planned their second birth fugitively, searching for the relationality that was denied to them during their first birth, and found independent alternative midwives outside of the obstetric institution. Their "flight" made their birth an "underground action" and they wanted to protect it as such:

It is an opting out, the building of a refuge to flee away from, the making possible of a place from where you can go elsewhere. [...] *I described it myself, to a friend of mine who was also pregnant, we always said to each other: we must stay under the radar. We shouldn't be in the picture. This is an underground action. Once they see you, you can't get away, so you must stay under the radar.* [...] *Stay away from the hospital, that's what we did.* (*Mother 4*)

The midwives whom the mothers found were either working mostly outside of the institution already, or they started to plan fugitively along with the mothers:

So, they [*the mothers*] *realize that the world is much more beautiful and bigger when they look outside* [*the institution*]. *And at some point, I made the fundamental decision: if someone wants it, I'll go with it.* [...] *And if it doesn't feel safe, I'm going to look if I could do it with someone who has more experience.* [...] *In principle, anything is possible.* [...] *It means that all protocols and guidelines will be placed in a completely different light. And when I made that decision, I stopped working in regular care.* (*Midwife 3*)

Mothers either first went back to their old midwifery practice or hospital with new demands but were refused care, or they refused the care offered by the institution themselves and started looking for alternative care when they were pregnant:

And the second time, I was on to them [...]. *I absolutely did not want to start in the hospital for the second time. With a VBAC* [*vaginal birth after cesarean*], *it's very difficult, but I said, I won't do it, forget it. I just straight out refuse that. I made a whole scene and then found a construction with a doctor and a midwife* [*outside of the hospital*] *who would allow me to birth at home.* (*Mother 6*)

Some people even got pregnant again only after they had built a relationship with an alternative midwife who would accompany their birth outside of the institution. In contradiction to free-birthers (people who give birth

without any medical assistance),[42] all the mothers in this study did want care; it was the reappropriation of a community of care that mattered most to them. Their fugitive planning was not only a planning towards autonomy or merely freedom from oppression, but a search for care that can only be found in community. They describe it as a resistance to the "institutionalized separation" (of mother and child, and of mother and her community of care) discussed in theme one. Both mothers and midwives plan alternative forms of care together where they can be in safe relationship with each other and in which birth workers are not forced to be complicit in expropriation, carcerality, or violence. They do this either fully outside the institution or in collaboration with birth workers within the obstetric institution. As such, mothers organized the most complex medical care cases responsibly and, in their opinion, more safely, than they could have if they had followed the protocols of the obstetric institution. They pushed midwives further, made new connections, and got involved in birth activism. As such, their fugitive planning contributes to the existence and growth of an undercommons of childbirth care. The existence of this undercommons gives hope to most participants, especially to midwives in training, keeping the possibility open for them to also plan fugitively towards this:

Knowing that there are other midwives and a growing group of birth workers who practice the way that I want, and that they will also welcome me, that they reach out for me, that they are there for me, that helps me a lot. If they hadn't been there, you would have a future of only obstetrics that you really don't agree with. In that case, I would have to go in a completely different direction on my own. I would probably have stopped then. Yes, I think so. (*Midwife in training 5*)

The planning of mothers, midwives, and doulas thus also makes a future undercommons of birth possible for a next generation of midwives, functioning as a point on the horizon. As such, it also reestablishes a relationality between birth workers themselves, characterized by mutual aid rather than enmity and captivity, and between birth workers and the people they will care for. Students now have the prospect of a form of relationality that they believe in, rather than seeing no other option than becoming complicit in a violent form of care.

42 Lianne Holten and Esteriek de Miranda, "Women's Motivations for Having Unassisted Childbirth or High-Risk Homebirth: An Exploration of the Literature on 'Birthing outside the System,'" *Midwifery* 38 (2016): 55–62.

Anarchic Relationality

But what makes the relationality of care in the undercommons so different than the severed relationality within the institution? Instead of a relationality that is limited to, and inhibited by, carcerality and expropriation, and the hierarchy and authority that come with it, the relationality in the undercommons of midwifery care is understood by the participants as fundamentally non-hierarchical in terms of professional authority but also in terms of principles. There is no longer a first principle, such as saving the life of the child at all costs, that justifies the carcerality or dogmas of the rest of the system. We could hence qualify this relationality as "anarchic," in the literal meaning of the word as "an-arche," that is, without first principle. There is nothing, except that which develops in the relationship itself, that equals an order, a hierarchy, or a rule. This anarchic quality of the relationship changes the definition of care from something that is established in a certain way in protocols, to needs which can only arise out of the relationship itself:

If something does not require attention, it does not need to receive attention. Then, all attention is with mother and baby and I'm out of the picture. (*Midwife 3*)

Anarchic relationality does not mean that the care is not organized or that it is chaotic, rather the opposite; it is organized in a relational and personalized way that resists every general form of categorization and every general first principle. The relationship is formed on the basis of a mutual willingness to go along with the opacity between midwife and/or doula and the pregnant person and their wishes, rather than demanding transparency and obedience as a prerequisite for a relationship of care, or sacrificing the relationship of care to the first principle of the institution:

The institution of the hospital is so disciplinary. [...] *This was completely different with my own midwife. She simply came to sit at the table with me and took my medical history on the couch with me. Yes, really, I just thought: this is brilliant.* [...] *I really liked it because we remained in my process, she came to visit me, and I could also show her a bit of who I was and how we were. She saw my kids, she just kind of joined in. I loved it.* (*Mother 4*)

In the quote above, the mother describes that where the obstetric system issues a call to order, severing the relationality and care that were already going on, this midwife does exactly the opposite: she joins the movement and rhythm of already existing care, and blends into it, instead of disrupting it. This testifies to a fundamentally different understanding of what care

is, and of what kind of relationality is needed in care. From the perspective of the midwife, this is described as follows:

We were more in dialogue, I left more to the woman, more to herself, I waited more, did less and less. That was the most important: I started doing less and less. I ended my education very assertively, like "I'll do those deliveries"—that was a very normal saying back then. Yes, I was trained to be very assertive, to coach pushing very much from the first moment. And slowly, I unlearned that, I began to see how little you must do. That midwifery is mostly not-doing. (*Midwife 2*)

Both the midwives, mothers, and doulas refuse the institutionalization and protocolization of birth, letting birth run its own course within a newly reconstructed relationality of care in which the mother reappropriates her relationship with her child by birthing herself and with a community of care that does not captivate her, but lets her be. It is this relationality, in which there is no prior principle nor ultimate hierarchy, authority, or goal, that is the primary substance that the undercommons of birth are made of. The independent midwives and doulas in this study see it as their most important job to guard and constitute this relationality; they make sure the emotional safety and freedom it provides keeps on existing:

There are fragile moments in which you can cross someone's borders, I feel that in every fiber of my being. I don't know if I'm important as a person, but it is important that there is always someone with her who is aware of that. (*Midwife 11*)

Midwives do have to be careful, however, that they make sure that the relationality of midwifery indeed stays anarchic, and that there is not a new first principle or dogma that takes over. Some participants flagged that the resistance to the obstetric institution of certain midwives and doulas tends to be reactionary and dogmatic, highlighting that this can again become a form of care in which certain values and principles—such as the prioritization of the natural above the technological—of the care worker decide how care should be, rather than care staying truly open and thus truly liberating. Also, it was noted by some mothers that some midwives and doulas have the desire to care so differently and resist every form of authority, hierarchy, and disciplining, that they are regarded by the people who seek their care as "dogmatically soft," towards the mothers, leaving everything up to the mothers themselves, which made the mothers uneasy. Both these

critiques were not regarded as a reason to decline care by these midwives, however. The participants point out that the difference with the institution remains that where problems with care are almost impossible to address or change within the obstetric system, in the personal relational forms of care outside of the institutions, one can more easily address and discuss potential problems, due to the individualized and small-scale character of the care offered. But there is an obvious risk here, namely that alternative forms of care develop their own dogmas, rather than dare to stay with the anarchic character of relational care that would be the true alternative.

Obstetric Abolition

The last subtheme is "obstetric abolition." Midwives and mothers lost faith in the possibility to reform the obstetric institution, which is why they became part of an undercommons of care. Most argued for radically new systems of care rather than for reforming the institution that we have. They could only imagine radical change either outside, or instead of, the obstetric institution—a call for dismantling rather than reform that can be called abolitionist:

I wish there were no nationalized birth care, [...] *I wish there were no controlling powers in birth,* [...] *that we do things radically different.* (*Midwife 1*)

Most participants would not give birth themselves in the institution in the way it exists now, if they were to give birth (again). When asked to reimagine birth care in a reimagination exercise in the heterogenous focus groups, most participants reimagined maternity care outside of the institution as we know it today:

Everything just kind of goes on as normal. You know you're surrounded by your family. The world goes on, while you create this little bubble for birth. It's definitely centered around the home, away from institutions. There are these other people present who the person giving birth chooses. If there are other children in the home and in the family, then they're around. Birth is something not to be scared of and not to hide away inside a special building. [...] *It's like everyday life with a quiet, intimate moment at the center.* (*Doula 5*)

[*I see*] *a little hut on a hill. Or a little house on a hill. It doesn't matter. For me, it stands for freedom. For living outside of systems. And to be able to be born, and die, outside of systems.* [..] *And then for birth to be something joyful, in which you experience this kind of freedom and autonomy. For there to be less*

fear and more knowledge of birth itself or of the setting. [...] *And to be helped by someone that you know, has faith, who is confident and relaxed.* (*Midwife in training 1*)

According to many participants, only fundamental change could create a different, life-affirmative system of care. An example of fundamentally differently organized care would be for instance if care was not defined by obstetrics, but by the relationality of midwifery:

The moment the whole system would be midwifery, [...] *then there is, for instance, an obstetrician who comes to a home birth, because that is very important for a woman. Then obstetricians would simply work outside of the institution as a colleague of mine once experienced; a woman could give birth on the birthing stool, with her own midwife and an obstetrician in the corner.* (*Midwife 11*)

Understanding the obstetric institution as a system that reproduces inequality, as almost all participants do, a radical change of the way we care for birth is something that could have great consequences according to most participants. Their vision for what another type of care for birth means goes beyond the physical event of birth, and is directly related to questions of world-making. This can be regarded as an abolitionist vision, in which the abolition of something is always related to the abolitionist creation of better worlds:

What you can gain is that you don't facilitate inequality before someone is even born. That the start with which you are born as a person is more equal. And if you prevent women from being traumatized by childbirth, in whatever way, you indirectly ensure that an entire generation grows up differently and probably happier or healthier for that reason. And if an entire generation grows up better, then that in turn has a lot of effects for the rest of the world. [...] *I think that's how you make the world a little better every time.* (*Midwife 9*)

The Undercommons of Childbirth and Its Abolitionist Ethic of Care

Both the expropriation that mothers, midwives, doulas, and midwives in training experience, as well as the carcerality that the participants bring to the fore, are intertwined with the obstetric violence that all participants have experience of. Together, they contribute to the institutionalized

dissolution of a double relationality that is constitutive of reproductive justice: (1) the relationship between pregnant person and their child; and (2) the relationship between the pregnant person and their community of care. According to the participants, obstetric violence should not be understood as a stand-alone problem that is easily circumscribed, but as part of a logic inherent in the obstetric institution that undoes relationality, leading to the isolation of the laboring person, through (1) the expropriation of maternal subjectivity, (2) the carcerality of the obstetric institution, characterized by captivity and punishment, and (3) obstetric violence.

Carcerality is understood by Marquis Bey as a characteristic of a system that is:

> penchant to proliferate capture and expropriation along racist and sexist axes [...] via assumed ownership over racialized and/or non-masculinely-gendered subjects, circumscription [...], regulation of movement and inhabitation of private space, and extraction of surplus goods and resources (be it labour, sex, sexual labour, time, etc.).[43]

Bey develops further what has been at the heart of institutional critique since Foucault, who has famously shown how most modern institutions are modeled after penitentiary institutions and thus have a carceral structure and tendency.[44] The description of the obstetric care system as carceral is not new, but stands in a tradition of Ann Oakley's *The Captured Womb: A History of the Medical Care of Pregnant Women*,[45] Adrienne Rich's *Of Woman Born: Motherhood as Experience and Institution*,[46] and Michelle Goodwin's *Policing the Womb: Invisible Women and the Criminilization of Motherhood*,[47] and is in line with what Anna Horn has recently coined "obstetric carcerality" in her piece "Birthing while Black": "Handcuffed by a cannula, strapped to a cardiotocograph that monitors my baby's heartbeat, I writhe with pain. The hospital bed physically and mentally shackles me. The aching pierces beyond the body like intense waves crashing through

43 Bey, *Anarcho-Blackness*.

44 Michel Foucault, *Discipline and Punish: The Birth of the Prison*, trans. Alan Sheridan (London: Penguin Classics, 2020 [1975]).

45 Ann Oakley, *The Captured Womb: A History of the Medical Care of Pregnant Women* (London: Blackwell, 1984).

46 Adrienne Rich, *Of Woman Born: Motherhood as Experience and Institution* (New York: W.W. Norton & Company, 1986 [1976]).

47 Michelle Goodwin, *Policing the Womb. Invisible Women and the Criminalization of Motherhood* (New York: Cambridge University Press, 2020).

me. This was the prison in which I feared birthing my son."[48] According to our participants, the obstetric system indeed makes mothers and midwives feel captured, and control and disciplining are effectuated through a fear of punishment. This carcerality, in combination with expropriation and violence, isolates the pregnant person both from their maternal relationality, of which responsibility for the child is one of the defining elements, as well as from their relationship with a community of care, constituting the double separation that we have termed "institutionalized separation."

If we understand obstetric violence to be part of a broader problem of the dissolution of relationality, then, according to the participants, the project must be to heal and reappropriate these relationships. And if it is the case that the obstetric institution is defined by the institutionalized dissolution of relationality, then the participants rightfully question the possibility of reappropriating relationality within the institution itself. Instead, most adopt what Marquis Bey calls a "fugitive" approach.[49] Fugitivity is a concept developed in the Black radical tradition and is based on the practice of the maroons in which formerly enslaved people escaped the institution of slavery and started other communities fully outside the institution. Many Black scholars have expanded their understanding of fugitivity to other current forms of activism, care, and the building of abolitionist worlds, such as Bey's fugitivity when it comes to gender and the gender binary in *Black Trans Feminism*, and Moten and Harney's conceptualization of fugitive planning as the opposite of "policy" when it comes to the institution of the university and the practice of study. Fugitive planning, according to Moten and Harney, is every practice contributing to the liberation of study which has become captivated and controlled by the institution that is the university. Together, these alternative practices constitute the undercommons of study, where studying, freely and collectively in sociality, is still possible. Similarly, developing a critique of the institutional policy of obstetrics, our participants attempted to liberate the practice of birth from obstetrics by planning to labor elsewhere—planning other types of care tapping into, or further developing, the undercommons of childbirth defined by an anarchic relationality. This undercommons of childbirth refuses the "call to order" of the institution and rebuilds care by strengthening the relationality that already exists in homes and communities.[50]

48 Anna Horn, "Birthing While black," *Red Pepper*, accessed July 10, 2023, https://www.redpepper.org.uk/birthing-while-black-pregnancy-bodies-nhs-childbirth-maternity-medical-racism-carcerality/.

49 Bey, *Anarcho-Blackness*; Bey, *Black Trans Feminism*.

50 Harney and Moten, *All Incomplete*.

The activist reaction of mothers, midwives, and doulas to the situation they are in is hence not an attempted reform of the obstetric institution. Instead, they tend to take direct responsibility through caring *otherwise*, expressing their moral convictions through an alternative praxis of care, defined by what we have termed "anarchic relationality." As such, the undercommons of childbirth can be understood as expressive of an ethics of care, functioning as Walker's collaborative-expressive ethical model in which moral convictions are expressed through experiments, practices, experience, and collaboration.[51] This undercommons is reflexive of the four phases of care that care ethicist Joan Tronto distinguishes, practiced by both midwives and mothers. First, they are attentive to their own and each other's needs. Second, they take responsibility for them. Third, they take care of each other. And fourth, they are fully guided by the responsiveness and feedback of the one they care for, rather than being directed by protocols (underscoring the anarchic character of relationality and care). Tronto's four phases of care are fully organized within this relational undercommons of care, outside of the obstetric institution in a way that affirms and reappropriates the relational communality and responsibility of all involved.[52] Interestingly, as such, it also constitutes Tronto's fifth phase of care, namely "caring with," that carries the responsibility of making sure that all the four phases of the care cycle above are able to take place. According to Tronto, the organizational responsibility of this fifth phase of care constitutes a "caring democracy."[53] In the case of obstetric violence, however, safe care is no longer guaranteed by the national commons (such as national public healthcare institutions) of the caring democracy. Instead, the mothers, midwives, and doulas in this study make sure themselves that this fifth phase is still taken care of, thereby establishing a caring democracy underground, or, a "caring undercommons." The undercommons of childbirth can thus be understood as an otherworld in which responsibility for the four phases of care is assumed, but not by the nationalized "commons" of a state, but by the mutual aid and fugitive planning of mothers, midwives, and doulas themselves. It is this fifth phase, then, which makes these loose alternative practices truly into an undercommons, that is, a new commons, an otherworld of care with abolitionist potential, since they take over the responsibility of the caring democracy. As such, they become the body that replaces the solidarity and trust that connects people to the national

51 Urban Walker, *Moral Understandings*.

52 Tronto, *Moral Boundaries*.

53 Tronto, *Caring Democracy*.

community of the caring democracy, through the establishment of an underground communal substitute responsible for, and expressive of, the moral good when it comes to the realization of respectful maternity care and birth justice.

These five phases of care in the undercommons are hence expressive of a specifically abolitionist ethic of care, dissenting from the old commons that the caring democracy provided in the form of the obstetric institution. The undercommoning of the obstetric institution is hence not only a fruitful ground to reimagine reproductive care and justice anew, but is itself already a form of dismantling of the obstetric institution. The thick relationality of the undercommons works, as Harney and Moten write, like a "kink" in the cable of the institution, as these networks of care resist, in our case, the access to pregnant people and their institutionalized separation, creating "inaccessible relational refuges of life."[54] These refuges outside the institution are what Foucault did not thematize in his conceptualization of institutions and their discursive influence on the world: the networks of care, relationality, epistemology, and praxis that have always existed and have kept on existing outside of the institutions and discursive structures of the state, discursively producing otherworlds in addition to the hegemonic one, outside of the carcerality of institutional governance. Foucault was able to ruthlessly critique the power that institutions have in shaping our world, but as a post-structuralist rather than decolonial thinker, he did not theorize that there was, after all, an outside to the hegemonic discursivity of modernity in the way that the undercommons shapes otherworlds of care, subjectivity, and community, slowly undoing the hegemonic one. Abolition has as its objective to dismantle this world and its institutions through alternative practices of care outside of, and sometimes parasitically through, hegemonic institutions. The undercommons of childbirth can be understood as one such practice of abolitionist care, as it, indeed, replaces current failures of democratic societies with the horizon of another world.[55]

The undercommons of reproductive care must, however, not be misunderstood—especially not by those who participate in it—as a move to pre-modern, pre-obstetric times. Midwifery in white middle-class circles too often risks getting lost in a reactionary ideology that is characterized by being anti-modern, as well as anti-technological, antigender, anti-trans,

54 Harney and Moten, *All Incomplete*, 121; Ruth Wilson Gilmore, *Change Everything: Racial Capitalism and the Case for Abolition* (Chicago: Haymarket Books, forthcoming 2024).

55 Denise Ferreira da Silva, "Toward a Black Feminist Poethics," *The Black Scholar* 44, no. 2 (2014): 81–97.

anti-abortion, anti-medical, anti-LGBTQ+, and anti-interventionist. According to our study, the abolitionist ethic of care in the undercommons expresses something quite different, and must continue to do so, exactly because of its anarchic character. Since there can be no first principle that functions as a precept, there can be no question of being for or against medicine or technology, or of any other first principles that structure the relationality of abolitionist care with new dogmas. Instead, the abolitionist care of the undercommons relies on a relationship of openness, trust, the affirmation of opacity rather than the demand of transparency, and on personal histories, personal preferences, and solidarity.[56] The undercommons is not anti- or premodern, but is, exactly as the words says, "undercommon modernity"; it parasites on it, taking what it needs and wants, strengthening the relational community of care that exists, though only slightly, outside of it in search of abolitionist futures. The abolitionist care of the undercommons is hence by no means a call for the destruction of technology, medical knowledge, or life-saving obstetric care; it is in fact the opposite. Abolition is a call for presence, not absence, as Ruth Wilson Gilmore says; a call for everything we need in a life-affirming world. In the case of technology and medical intervention, it is a call to dare to think of technology and medicine outside of the obstetric institution, to ask how we can affirm the autonomous anarchic independent undercommons of reproductive care and let our networks flourish with all the technology, medicine, gynecologists, obstetricians, nurses, midwives, doulas, painkillers, and interventions we need. The challenge lies in asking how we will have appropriate anesthesia and C-sections without being captured in obstetric carcerality, isolated through expropriation, and dehumanized through violence. The only question regarding technology and medicine that is truly fit for the undercommons is how medical technology could amount to a blossoming of a relationality so thick that we can never be forced to give birth, or to give birth in a particular way, again.

Conclusion

In this study, we offer an analysis of obstetric violence through a study of the standpoint of the actors involved, such as midwives in training, practicing midwives, doulas, and mothers. We engage with their understanding of obstetric violence and racism, and with the question how they resist. By

56 Rodante van der Waal, "Specter(s) of Care: A Symposium on Relationality, Midwifery, and Reproductive Justice to-Come," *Frontiers: A Journal of Women's Studies* 44, no. 2 (2023): 98–123.

placing the standpoint of the participants in dialogue with critical theory, especially with care ethics and abolitionist thought, two main themes are established: (1) "institutionalized separation" with the subthemes of "expropriation," "carcerality," and "obstetric violence," and (2) "undercommoning childbirth" with the subthemes of "fugitive planning," "anarchic relationality," and "obstetric abolition." Institutionalized separation is understood to be the severing of multiple relationships of the pregnant person, i.e., a severance of relationality between mother and child, and between mother and a partner, a community of care, and/or midwives and other birth workers, and a consequent experience of isolation. "Obstetric violence" is conceptualized as the logic of institutionalized separation rather than as a stand-alone problem. This particular analysis of the problem of obstetric violence determines the participants' choice of strategy to combat obstetric violence. The second main theme describes this specific strategy of the participants to resist and has been coined "undercommoning childbirth." Undercommoning childbirth is understood as the formation of a network of knowledge, mutual aid, and radical care. The aim of this strategy is to reconstitute or heal the relationality that was broken through "institutionalized separation" and to resolve the experience of isolation. For, as the participants know, but as is less often recognized in academic research and public policy documents on obstetric violence: if a severance of relationality and an expropriation of (relational) autonomy causes obstetric violence, it must be a healing of relationality and a refusal of severing the relationalities that already exist that will abolish the existence of obstetric violence. Our participants therefore turn to "fugitive planning" rather than policy in their struggle against obstetric violence. And we believe that their fugitive planning, which is constitutive of the undercommons of childbirth, can, in its relation to the obstetric institution (but also beyond it), be understood as expressive of an abolitionist ethic of care.

8 Obstetric Violence: An Intersectional Refraction through Abolition Feminism

Rodante van der Waal, Kaveri Mayra, Anna Horn, and Rachelle Chadwick[1]

Abstract

In this chapter, 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. We locate the abolitionist futures of maternity care in Black, indigenous, and independent doula and midwifery practices.

Keywords

Reproductive violence, gynecological violence, obstetric institution, midwifery, childbirth

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Introduction

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

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.[2] It ranges from failing to obtain 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.[3] It is considered to be both gender- and race-based violence[4] as well as colonial violence,[5] specifically affecting Black and Indigenous communities.[6] Evidence of obstetric violence has been

2 Meghan A. Bohren et al., "The Mistreatment of Women During Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review," *PLoS Medicine* 12, no. 6 (2015): e1001847, discussion e1001847; Rachelle Chadwick, *Bodies That Birth: Vitalizing Birth Politics* (London: Routledge, 2018); Sara Cohen Shabot, "We Birth With Others: Towards a Beauvoirian Understanding of Obstetric Violence," *European Journal of Women's Studies* 28, no. 2 (2020): 1–16; Kaveri Mayra, Zoë Matthews, and Jane Sandall, "'Surrogate Decision-Making' in India for Women Competent to Consent and Choose During Childbirth," *Agenda* (*Durban, South Africa*) 35, no. 3 (2021): 92–103; Stella Villarmea, Ibone Olza, and Adela Recio, "On Obstetrical Controversies: Refocalization as Conceptual Innovation," in *Normativity and Praxis: Remarks on Controversies*, ed. Ángeles J. Perona (Milan: Mimesis International, 2015), 157–188.

3 Nazdeek, *Hidden Traumas: Uncovering Experiences of Obstetric Violence* (New Delhi: Nazdeek, 2020).

4 Sara Cohen Shabot, "Making Loud Bodies 'Feminine': A Feminist-Phenomenological Analysis of Obstetric Violence," *Human Studies* 39, no. 2 (2016): 231–47; Dána-Ain Davis, "Obstetric Racism: The Racial Politics of Pregnancy, Labor, and Birthing," *Medical Anthropology* 38, no. 7 (2019a): 560–573.

5 Rachelle Chadwick "Breaking the Frame: Obstetric Violence and Epistemic Rupture," *Agenda* (*Durban, South Africa*) 35, no. 3 (2021): 104–115; Rosalynn A. Vega, *No Alternative: Childbirth, Citizenship and Indigenous Culture in Mexico* (Austin: University of Texas Press, 2018); Lydia Zacher Dixon, "Obstetrics in a Time of Violence: Mexican Midwives Critique Routine Hospital Practices," *Medical Anthropology Quarterly* 29, no.4 (2015): 437–454.

6 Arachu Castro, Virginia Savage, and Hannah Kaufman, "Assessing Equitable Care for Indigenous and Afrodescendant Women in Latin America," *Revista Panamericana de Salud Pública* 38, no. 2 (2015): 96–109; Davis, "Obstetric Racism"; Vega, *No Alternative*.

recorded in 34 countries, as stated in a systematic 2015 review.[7] 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.[8] 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 to be a misnomer since mistreatment by healthcare workers should not be considered intentional.[9] It is often argued that the term risks alienating healthcare workers by indicating intentionality, prompting defensive reactions instead of the enhancement of obstetric care. "Obstetric violence" should, however, first and foremost be regarded, and judged, as a feminist activist key word that addresses a structural problem in reproductive healthcare from the viewpoint of its victims. As an activist key word, it is most commonly used in Latin America and the Caribbean.[10] 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.[11] It has already propelled impressive changes, such as the inclusion of obstetric violence in the Venezuelan law regarding violence against women in 2007.[12] 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.[13] Nonetheless, a theoretical defense of the term against

7 Bohren et al., "The Mistreatment of Women."

8 White Ribbon Alliance, "Respectful Maternity Care: The Universal Rights of Childbearing Women," (2019), accessed April 8, 2022, https://cdn1.sph.harvard.edu/wp-content/uploads/sites/2413/2014/05/Final_RMC_Charter.pdf.

9 Maura Lappeman and Leslie Swartz, "How Gentle Must Violence against Women Be in Order to Not Be Violent? Rethinking the Word 'Violence' in Obstetric Settings," *Violence Against Women* 27, no. 8 (2021): 987–1000.

10 Virginia Savage and Arachu Castro, "Measuring Mistreatment of Women During Childbirth: A Review of Terminology and Methodological Approaches," *Reproductive Health* 14, no. 1 (2017): 138.

11 Castro, Savage, and Kaufman, "Assessing Equitable Care."

12 Ibid.

13 Chadwick, "Breaking the Frame."

aformentioned objections constitutive of an intersectional feminist conceptualization of the term remains a work in progress.[14] With this chapter 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.[15] It understands institutionalized violence as inherent in an institution, developed through its intertwinement with oppressive 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.[16] 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.[17] Strongly connected to intersectional thought, its current foremothers are Black feminists Angela Davis, Mariame Kaba, Ruth Wilson Gilmore, and Dorothy Roberts.

In this chapter, we use an abolitionist framework to refract the concept of obstetric violence to be more explicitly understood as institutionalized, racializing violence inherent in 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.[18] 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

14 See for instance: Chadwick, "Breaking the Frame"; Davis, "Obstetric Racism"; Kaveri Mayra, Rodante van der Waal, and Rachelle Chadwick, "'Bodies that Birth' and the Violence It Bears: In Conversation with Rachelle Chadwick," *Agenda* (*Durban, South Africa*) 35, no. 3 (2021): 130–135; Villarmea, Olza, and Recio, "On Obstetrical Controversies."

15 Stephano Harney and Fred Moten, *The Undercommons: Fugitive Planning and Black Study* (New York: Autonomedia, 2013).

16 Mariame Kaba, *We Do This 'Til We Free Us: Abolitionist Organizing and Transforming Justice* (Chicago: Haymarket Books, 2021).

17 Angela Y. Davis, Gina Dent, Erica R. Meiners, and Beth E. Richie, *Abolition. Feminism. Now* (Chicago: Haymarket Books, 2022).

18 Ruth Wilson Gilmore, *Golden Gulag: Prisons, Surplus, Crisis, and Opposition in Globalizing California* (Berkeley: University of California Press, 2007), 28.

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. In doing so, we follow both Angela Davis's abolitionist historiography, in which she focuses on anti-Black racism to highlight the connection of chattel slavery and the carceral state,[19] 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.[20]

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 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 possibility 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.[21] 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

19 Angela Y. Davis, *Are Prisons Obsolete?* (New York: Seven Stories Press, 2003).

20 Patricia Hill Collins, "On Violence, Intersectionality and Transversal Politics," *Ethnic and Racial Studies* 40, no. 9 (2017): 1460–1473; Kimberlé Crenshaw, "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics," *University of Chicago Legal Forum*, Article 8 (1989); Kimberlé Crenshaw, "Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color," *Stanford Law Review* 43, no. 6 (1991): 1241–1299.

21 Davis, "Obstetric Racism."

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.[22] 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 chapter 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.[23] Autoethnographic writing makes it possible to

22 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' abolitionist historiography of the prison industrial complex: Angela Y. Davis, *Freedom is a Constant Struggle: Ferguson, Palestine, and the Foundations of a Movement* (Chicago: Haymarket Books, 2016).

23 Hélène Cixous, *The Hélène Cixous Reader*, ed. Susan Sellers (New York: Routledge, 1994); Elizabeth Dauphinee, "Writing as Hope: Reflections on the Politics of Exile," *Security Dialogue* 44, no. 4 (2013a): 347–61; Elizabeth Dauphinee, *The Politics of Exile* (London: Routledge, 2013b); Dána-Ain Davis and Christa Craven, *Feminist Ethonography. Thinking through Methodologies, Challenges, and Possibilities* (1st ed.; New York: Rowman & Littlefield, 2016); Audre Lorde, *Sister Outsider: Essays and Speeches* (Berkeley: Crossing Press, 1984); Sameena Mulla, *The Violence of Care: Rape Victims, Forensic Nurses, and Sexual Assault Intervention* (New York: NYU Press, 2014).

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.[24] It involves taking seriously our positionality within this field, which brings to the fore that our experiences are both irreducible and that there is a shocking continuance of severe violence within the obstetric institution globally.[25] 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.[26] 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 key word 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 does 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 with nursing from a government college that is affiliated with the largest tertiary level hospital in West Bengal, India, which predominantly serves people from lower income backgrounds.

I was selected for one of the only 15 seats available to millions of young women from the eastern part of the country to study nursing and midwifery. Fees were 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.

24 Dauphinee, "Writing as Hope"; Davis and Craven, *Feminist Ethnography*.

25 Davis and Craven, *Feminist Ethnography*.

26 Cixous, *The Hélène Cixous Reader*; bell hooks, "Paulo Freire," in *Teaching to Transgress: Education as the Practice of Freedom* (New York: Routledge, 1994).

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.[27] 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 would 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."[28] Having experienced sexual violence numerous times, I wanted to steer clear of a circumstance in which I could not protect myself.[29]

Around the same time as 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.

27 Rodante van der Waal et al., "Obstetric Violence within Students' Rite of Passage: The Relation of the Obstetric Subject and Its Racialised (M)other," *Agenda* (*Durban, South Africa*) 35, no. 3 (2021): 36–53.

28 Jenny Brown, *Birth Strike: The Hidden Fight Over Women's Work* (Oakland, CA: PM Press, 2019)

29 Kaveri Mayra, "Docsplanation. A Malady of the Healthcare Profession," *Economic and Political Weekly* 55, no. 10 (2020); Kaveri Mayra, "A Starched Cotton Fluorescent-Yellow Saree, Khopa, Belly Button and Safety Pins: Decoding the 'Dignified Indian Nurse-Midwife,'" *The Practicing Midwife Journal* 23 (2020).

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,[30] 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 modern use of the term originated.[31] It has gained a place in the law in Venezuela (2007), Argentina (2009), Bolivia (2013), Panama (2013), and Mexico (2014).[32] Several observatories, such as those in Argentina, Chile, and Italy, archive obstetric violence in their countries and raise awareness.[33] 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.[34] 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 26 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.[35]

Multiple attempts have been made to define obstetric violence.[36] In Venezuelan criminal law it is one of 19 punishable acts of violence against women, and is defined as the appropriation of the reproductive processes

30 James Blundell, "Lectures on the Theory and Practice of Midwifery: Delivered at Guy's Hospital by Dr James Blundell. Lecture 28: After-Management of Foodings, and on Transfusion," *Lancet* 8, no. 1 (1827): 673–681.

31 Chadwick, *Bodies that Birth*; Patrizia Quattrocchi, "Obstetric Violence Observatory: Contributions of Argentina to the International Debate," *Medical Anthropology: Cross-Cultural Studies in Health and Illness* 38, no. 8 (2019): 762–776.

32 Roberto Castro and Sonia M. Frías, "Obstetric Violence in Mexico: Results From a 2016 National Household Survey," *Violence Against Women* 26, no. 6–7 (2020): 555–72.

33 Quattrocchi, "Obstetric Violence Observatory."

34 Ana Ignacio, "Brazil's Debate Over 'Obstetric Violence' Shines Light on Abuse During Childbirth," *Huffpost Brazil*, August 9, 2019, https://www.huffpost.com/entry/obstetric-violence-brazil-childbirth_n_5d4c4c29e4b09e72974304c2.

35 Dubravka Šimonović, "A Human Rights-Based Approach to Mistreatment and Violence Against Women in Reproductive Health Services with a Focus on Childbirth and Obstetric Violence. Note by the Secretary-General," *Report of the Special Rapporteur on Violence Against Women* (New York: United Nations, 2019).

36 Savage and Castro, "Measuring Mistreatment."

of the body by healthcare providers.[37] It calls out obstetric violence 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.[38] expanded this definition by adding women's marginalization in the larger political economy, as did Rachelle Chadwick[39] by referring to the fact that the issue is shaped by racialized, medicalized, and classed norms. It has been theorized as structural violence,[40] normalized violence,[41] birth abuse,[42] and symbolic violence[43]—all ways to explain the structural dimension of obstetric violence connected to hierarchy, power, status, and control. Sara Cohen Shabot[44] defined it as gender-based violence that functions to reproduce feminized gender identities through shame, gaslighting, and epistemic injustice. Dána-Ain Davis[45] 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:[46]

> 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

37 Milli Hill, *Give Birth Like a Feminist* (London: HQ Publisher, 2019); Rogelio Pérez D'Gregorio, "Obstetric Violence: A New Legal Term Introduced in Venezuela," *International Journal of Gynaecology and Obstetrics: The Official Organ of the International Federation of Gynaecology and Obstetrics* 111, no. 3 (2010): 201–202.

38 Michelle Sadler et al., "Moving Beyond Disrespect and Abuse: Addressing the Structural Dimensions of Obstetric Violence," *Reproductive Health Matters* 24, no. 47 (2016): 47–55.

39 Chadwick, *Bodies that Birth*.

40 Andrea Solnes Miltenburg et al., "Disrespect and Abuse in Maternity Care: Individual Consequences of Structural Violence," *Reproductive Health Matters* 26, no. 53 (2018): 88–106.

41 Chadwick, *Bodies that Birth*.

42 Hill, *Give Birth Like a Feminist*.

43 Karen Morgan and Suruchi Thapar-Björkert, "'I'd Rather You'd Lay Me on the Floor and Start Kicking Me': Understanding Symbolic Violence in Everyday Life," *Women's Studies International Forum* 29, no. 5 (2006): 441–452.

44 Cohen Shabot, "Making Loud Bodies"; Cohen Shabot, "We Birth with Others."

45 Davis, "Obstetric Racism."

46 Davis, "Obstetric Racism"; Dána-Ain Davis, Cheyenne Varner and LaConté J. Dill, "A Birth Story: How Cross-Disciplinary Collaboration Illuminates the Burdens of Racism During Birth," *Anthropology News*, August 27, 2021, https://www.anthropology-news.org/articles/a-birth-story/.

> 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."[47]

In Latin America, obstetric violence has been proven to specifically affect Black, Indigenous, rural, and lower-class communities. Vega[48] 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.[49] 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.[50]

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.[51] The expectations that some women should be able to bear more pain based on their race, class, and other social constructs, coined as "obstetric hardiness" by Davis,[52] 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

47 Davis, Varner, and Dill, "A Birth Story."

48 Rosalynn A. Vega, *No Alternative: Childbirth, Citizenship and Indigenous Culture in Mexico* (Austin: University of Texas Press, 2018).

49 Vega, *No Alternative*; Castro, Savage, and Kaufman, "Assessing Equitable Care."

50 Kaveri Mayra, Zoë Matthews, and Sabu S. Padmadas, "Why Do Some Care Providers Disrespect and Abuse Women during Childbirth in India?" *Women Birth* 35, no. 1 (2021): e49–e59.

51 Dána-Ain Davis, *Reproductive Injustice: Racism, Pregnancy and Premature birth* (New York: NYU Press, 2019); Deirdre Cooper Owens, *Medical Bondage: Race, Gender, and the Origins of American Gynecology* (Athens: University of Georgia Press, 2018).

52 Davis, *Reproductive Injustice*.

performed obstetric hardiness to avoid obstetric violence when I was being born in the mid-1980s at a government military hospital in western India.

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's) 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.[53] 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.[54] More acceptable terminologies include "mistreatment"[55] and "disrespect and abuse,"[56] which Gita Sen, Bhavya Reddy, and Aditi Iyer[57] divide into "disrespect" for lesser forms of violence and "abuse" for the more extreme instances of violence.

Obstetric violence is the most contested and feared terminology,[58] 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 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.[59] Meghan A. Bohren et al. responded to this critique, stating that the intentionality that the term obstetric violence implies makes it difficult to engage with healthcare workers and policymakers.[60] Two recent examples of the controversy surrounding the

53 See also Sylvie Lévesque and Audrey Ferron-Parayre, "To Use or Not to Use the Term 'Obstetric Violence': Commentary on the Article by Swartz and Lappeman," *Violence Against Women* 27, no. 8 (2021): 1009–1018.

54 Ignacio, "Brazil's Debate."

55 Diana Bowser and Kathleen Hill, *Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth: Report of a Landscape Analysis* (Washington DC: Harvard School of Public Health and University Research, 2010); Bohren et al., "The Mistreatment of Women."

56 Lynn P. Freedman et al., "Defining Disrespect and Abuse of Women in Childbirth: A Research, Policy and Rights Agenda," *Bulletin of the World Health Organization* 92, no. 12 (2014): 915–917.

57 Gita Sen, Bhavya Reddy, and Aditi Iyer, "Beyond Measurement: The Drivers of Disrespect and Abuse in Obstetric Care," *Reproductive Health Matters* 26, no. 53 (2018): 6–18.

58 Sadler et al., "Moving Beyond Disrespect."

59 Melania M. Amorim, Maria Helena da Silva Bastos, and Leila Katz, "Mistreatment During Childbirth," *Lancet* 396, no. 10254 (2020): 816.

60 Meghan A. Bohren et al. "Mistreatment During Childbirth—Authors' Reply," *Lancet* 396, no. 10254 (2020): 817–818.

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.[61]

In a response to reported obstetric violence from an online community survey in Italy,[62] 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."[63] 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."[64] 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.[65] Michael Rost et al. condoned these responses, citing the harsh language devoid of any empathy and the supercilious denial of the issue.[66]

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[67] argued that the lack of intent on the part of the healthcare providers makes the term "violence" debatable; they were concerned that its use, and Chadwick's conceptualization of "gentle violence,"[68] 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.[69]

61 Lappeman and Swartz, "How Gentle Must"; Claudia Ravaldi et al., "Abuse and Disrespect in Childbirth Assistance in Italy: A Community-Based Survey," *European Journal of Obstetrics, Gynecology, and Reproductive Biology* 224 (2018): 208–209.

62 Ravaldi et al., "Abuse and Disrespect."

63 Scambia et al., "'Obstetric Violence': Between Misunderstanding and Mystification," *European Journal of Obstetrics, Gynecology, and Reproductive Biology* 228 (2018): 133.

64 Ibid.

65 "Prävalenz zur Gewalt in der Geburtshilfe weiterhin unklar," *Deutsches Ärzteblatt*, accessed May 30, 2021, https://www.aerzteblatt.de/nachrichten/107793/Praevalenz-zur-Gewalt-in-der-Geburtshilfe-weiterhin-unklar.

66 Michael Rost, Louisa Arnold, and Eva De Clerq, "'Boiling up the Problem of Violence' in Childbirth? An Ethical Viewpoint on Medical Professional Responses to Women's Reports of Mistreatment in Childbirth," *Ethik in der Medizin* 32, no. 2 (2020): 189–193.

67 Lappeman and Swartz, "How Violent Must"; Leslie Swartz and Maura Lappeman, "Making Care Better in the Context of Violence: The Limits of Blame," *Violence Against Women* 27, no. 8 (2021): 1028–1034.

68 Chadwick, *Bodies that Birth*.

69 Camilla Burnett, "Commentary on the Article "How Gentle Must Violence Against Women Be in Order to Not Be Violent? Rethinking the Word 'Violence' in Obstetric Settings," Reframed Within a Critical Discourse Orientation," *Violence Against Women* 27, no. 8 (2021): 1001–1008.

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.[70] The value and potential of the concept should not be measured against intentionality, since this approach is negligent of structural, epistemic, and institutionalized forms of violence and distracts from understanding obstetric violence as intersectional.[71] 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, we should start in matters of violence and injustice with the materiality of the violence of those who suffer it.[72] 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.[73] To do so, it starts from the intersectional perspective of the one who is suffering, subsequently dismantling the intersections of structural violence inherent to the institution.[74]

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 have been 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

70 Angela Y. Davis, *Freedom Is a Constant Struggle*; Lévesque and Ferron-Parayre, "To Use or Not to Use."

71 Cynthia L. Salter et al., "Naming Silence and Inadequate Obstetric Care as Obstetric Violence is a Necessary Step for Change," *Violence Against Women* 27, no. 8 (2021): 1019–1027.

72 Kaba, *We Do This*.

73 Ibid.

74 Crenshaw, "Mapping the Margins"; Collins, "On Violence"; Davis, *Are Prisons Obsolete?*; Kaba, *We Do This*.

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 29-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 key word 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 through 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, she reminded herself every morning 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, De Geboortebeweging (The Birth Movement), 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 50 out of the 70

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, sometimes 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.[75] Obstetric violence was the concept I needed to understand obstetrics as an institution that effectively produced birth as violence, which included 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.[76] 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 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 shows how the witch hunts in premodern Europe were essential in establishing state control over reproduction, which was necessary for the constitution of modern biopolitical institutions.[77] 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

75 Susan Crowther, *Joy at Birth: An Interpretive, Hermeneutic, Phenomenological Inquiry* (London: Routledge, 2019).

76 Davis, *Are Prisons Obsolete?*; Gilmore, *Golden Gulag*; Avery F. Gordon, *Ghostly Matters: Haunting and the Sociological Imagination* (Minneapolis: University of Minnesota Press, 1997).

77 Silvia Federici, *Caliban and the Witch: Women, the Body, and Primitive Accumulation* (New York: Autonomedia, 2004).

miscarriage, or their children had died from starvation.[78] 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.[79] 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.[80] A direct relation of responsibility of the patriarchal authorities for potential offspring was established, undermining the mother as a responsible self-determining subject, thereby undoing the primary relationship between the 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 they had to participate in witch trials, publicly examining women's bodies to ascertain whether they had been pregnant or not.[81] Midwifery was removed from its autonomous domain within the community and appropriated into disciplining and controlling state structures, breaking a relationship of equity and trust between mothers and midwives. The control of reproduction by secular powers in Europe through the severing of the relationships between mother and child and mother and midwife was the early modern foundation of biopolitics, which proved to be essential for the modern development of the obstetric institution within colonial and racial capitalism.[82]

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.[83] 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

78 Ibid., 88.
79 Ibid., 12, 22.
80 Ibid., 89.
81 Ibid.
82 Ibid.; See chapter 5 for a theoretical elaboration on this topic.
83 Owens, *Medical Bondage*.

stock" for slave labor.[84] 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.[85] 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"[86] that constituted the modern obstetric institution, right at the heart of racial capitalism.

Remembering Ruth Wilson Gilmore's definition of racism as "the state-sanctioned and/or legal production and exploitation of group-differentiated vulnerability to premature death,"[87] 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.[88] 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.[89] 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 dissolution 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 increasing state control over reproduction through the witch hunts, expropriating women's power over their own body through charges of infanticide,[90]

84 Ibid.; Granny midwives were an alternative practice of maternity care in the US, 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.

85 Owens, *Medical Bondage*.

86 Denise Ferreira da Silva, *Toward a Global Idea of Race* (Minneapolis: University of Minnesota Press, 2007).

87 Gilmore, *Golden Gulag*, 28.

88 Davis, *Reproductive Injustice*.

89 Khiara M. Bridges, *Reproducing Race: An Ethnography of Pregnancy as a Site of Racialization* (Berkeley: University of California Press, 2011); Gilmore, *Golden Gulag*.

90 Federici, *Caliban and the Witch*.

and 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."[91] These logics of separation are still inherent in the institutionalized violence of obstetrics.[92] The multiple court-ordered hospital births and cesarean sections over the last decades make continuous state control over childbearing bodies explicit.[93] The still presumed "dangerous irrationality" of midwives and pregnant people echoes the trope of witchcraft. Premature Black birth and Black maternal and neonatal mortality is a consequence of the origin of obstetrics in racial capitalism. The relationship 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.[94] And the demonization of midwives is not a thing of the past, as proven by the 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.

91 Lisa Guenther, "Fecundity and Natal Alienation: Rethinking Kinship with Emmanuel Levinas and Orlando Patterson," *Levinas Studies* 7, no. 1 (2012): 1–19; Hortense Spillers, "Mama's Baby, Papa's Maybe: An American Grammar Book," *Diacritics* 17, no. 2 (1987): 64–81.

92 Rodante van der Waal and Inge van Nistelrooij, "Reimagining Relationality for Reproductive Care: Understanding Obstetric Violence as 'Separation,'" *Nursing Ethics* 29, no. 5 (2021): 1186–1197.

93 Clare Dyer, "Judge Criticizes NHS Trust for Delaying Legal Request to Carry Out Elective Caesarean on Woman With Severe Learning Disabilities," *BMJ* (*Clinical Research Ed.*) (2020): 371; Elizabeth Prochaska, "Another Court-Ordered Cesarean Case," last modified January 30, 2014, https://www.birthrights.org.uk/2014/01/30/another-court-ordered-cesarean-case/.

94 Kirsten Small et al., "Midwives Must, Obstetricians May: An Ethnographic Exploration of How Policy Documents Organise Intrapartum Fetal Monitoring Practice," *Women and Birth: Journal of the Australian College of Midwives* 35, no. 2 (2021): e188–e197.

In any other situation, it would be a criminal offense to insert fingers into someone's vagina without explicit and continuous consent.[95] In her discussion of the prison industrial complex, Davis 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.[96]

According to Davis, this infamous example of unjust treatment "exposes an everyday routine [...] that verges on sexual assault."[97] 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.[98]

Obstetric Racism

Black bodies are under surveillance and under threat by institutions of power, historically and at present, all around the world. From slaveholders

95 Caroline Pickles and Jonathan Herring, ed., *Women's Birthing Bodies and the Law: Unauthorised Intimate Examinations, Power and Vulnerability* (London: Hart, 2020).

96 Davis, *Are Prisons Obsolete?*, 63.

97 Ibid.

98 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. See: Brigitte Amiri, "Reproductive Abuse is Rampant in the Immigration Detention System," last modified September 23, 2020, https://www.aclu.org/news/immigrants-rights/reproductive-abuse-is-rampant-in-the-immigration-detention-system/; Carolyn Sufrin, *Jailcare: Finding the Safety Net for Women Behind Bars* (Oakland: University of California Press, 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. See: Diane Taylor, "Damning Report Published Into Death of Baby Born to Teenager in Prison Cell: Inquiry Into How 18-Year-Old Gave Birth on Her Own in HMP Bronzefield in Ashford Finds Many Failings," *The Guardian*, September 22, 2021, https://www. theguardian.com/society/2021/sep/22/damning-report-published-into-death-of-baby-born-to-teenager-in-prison-cell.

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 such as Black feminism and intersectional feminism.[99] 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.[100]

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

99 Crenshaw, "Demarginalizing the Intersection"; Crenshaw, "Mapping the Margins."
100 Obstetric racism is defined by Davis, Varner, and Dill, "A Birth Story", as standing at the intersection of obstetric violence and medical racism.

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, if 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.[101] Second, this act of obstetric racism shows how the fundamental logic inherent to the system continuously reproduces itself. The two junior doctors learn from the behavior modeled by the senior doctor how to dismiss a patient's concerns, how to enact racist views in a medical diagnosis (since race is not biological,

101 Davis, *Reproductive Injustice*; Leith Mullings, "Resistance and Resilience: The Sojourner Syndrome and the Social Context of Reproduction in Central Harlem," *Transforming Anthropology* 13, no. 2 (2005): 79–91.

being "half Black," as the doctor declared, does not necessarily decrease the baby's chances of developing keloids), and 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 women's "superhuman strength" or "hardiness" and their vulnerable disposition continue in the discourse around Black women's experiences and bodies.[102] Medical and public health articles often describe Black women in different contexts across the globe as medically high-risk and/or socially vulnerable.[103] 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.[104]

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.[105] 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,[106] many on-the-ground narratives from Black women express concern about receiving less infant feeding support because Black women are deemed

102 Bridges, *Reproducing Race*; Davis, *Reproductive Injustice*.

103 Sarah J. Holdt Somer, Rachel G. Sinkey, and Allison S. Bryant, "Epidemiology of Racial/Ethnic Disparities in Severe Maternal Morbidity and Mortality." *Seminars in Perinatology* 41, no. 5 (2017): 258–265; Marian Knight et al., "A National Population-Based Cohort Study to Investigate Inequalities in Maternal Mortality in the United Kingdom, 2009–17," *Paediatric and Perinatal Epidemiology* 34, no. 4 (2020): 392–398; Alaerte Leandro Martins, "Mortalidade materna de mulheres negras no Brasil," *Cadernos de Saude Publica* 22, no. 11 (2006): 2473–279; Renata Palópoli Pícoli, Luiza Helena de Oliveira Cazola, and Everton Ferreria Lemos, "Maternal Mortality According to Race/Skin Color in Mato Grosso do Sul, Brazil, from 2010 to 2015," *Revista Brasileira de Saúde Materno Infantil* 17, no. 4 (2017): 729–737.

104 Bridges, *Reproducing Race*.

105 Davis, *Reproductive Injustice*.

106 Fiona McAndew et al., *Infant Feeding Survey 2010* (Leeds: Health and Social Care Information Centre NHS, 2010).

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.[107]

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[108] and a measure of strides toward health equity.[109] 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.[110] Black women face the highest odds of maternal death in the UK, being four times more likely to die than white women.[111] Meanwhile, the national government released a report, following an investigation, concluding that there is no evidence of systemic racism in the UK.[112] The report received much criticism for its objection to macro-level racism in the UK.[113] 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.[114] Epidemiological data from Brazil also show that the risk of maternal death for Black and Indigenous women is nearly fourfold compared to white women.[115] Hence, we may conclude that transnational

107 Chadwick, *Bodies that Birth*.

108 Lale Say et al., "Maternal Near Miss—Towards a Standard Tool for Monitoring Quality of Maternal Health Care," *Best Practice & Research. Clinical Obstetrics & Gynaecology* 23, no. 3 (2009): 287–296.

109 Michael R. Kramer et al., "Changing the Conversation: Applying a Health Equity Framework to Maternal Mortality Reviews," *American Journal of Obstetrics and Gynecology* 221, no. 6 (2019): 609.e1–9.

110 Marian Knight et al., *Saving Lives, Improving Mothers' Care: Lessons Learned to Inform Maternity Care from the UK and Ireland. Confidential Enquiries into Maternal Deaths and Morbidity 2016–18, MBRRACE-UK Report* (Oxford: National Perinatal Epidemiology Unit, University of Oxford, 2020), https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2020/MBRRACE-UK_Maternal_Report_Dec_2020_v10_ONLINE_VERSION_1404.pdf.

111 Ibid.; Many recently funded initiatives and research studies have been 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-hmaternity-services/.

112 Tony Sewel, ed., *Commission on Race and Ethnic Disparities: The Report* (London: Commission on Race and Ethnic Disparities, 2021).

113 Gareth Iacobucci, "What Did the Commission on Race and Ethnic Disparities Say on Health?" *BMJ* (*Clinical Research Ed.*) (2021): 373.

114 Holdt Somer, Sinkey, and Bryant, "Epidemiology."

115 Martins, "Mortalidade materna"; Pícoli, de Oliveira Cazola, and Lemos, "Maternal Mortality."

anti-Black obstetric racism is *the* epidemic crisis of the obstetric institution, with detrimental consequences.[116]

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 establishes the importance of understanding racism as an independent contributor to poor health outcomes and experiences for Black women and their babies.[117] Building on Davis's[118] 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 first and foremost be understood as reproduced by this intersection in which multiple systems of oppression are glued together and reproduced within the obstetric institution.[119] If it is not 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.[120] 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

116 See chapter 2 for data of, and a study on, obstetric racism in the Netherlands.

117 Davis, *Obstetric Racism*.

118 Ibid.

119 Collins, "On Violence."

120 "Sarah Everard: How a Woman's Death Sparked a Nation's Soul-Searching," BBC, accessed April 10, 2022, https://www.bbc.com/news/uk-56384600.

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's) 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 in which 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 now stand up for people in a situation similar to the first birth I saw. But many situations are more ambiguous, gray, invisible, and complex. 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 saving lives as its task. 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.[121] This group-differentiated inequality 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 in Latin America, Australia, Canada, the United 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 such as Latin America and India highlight how a spectrum of social categories such as class, caste, rurality, indigeneity, and skin color is intersectionally

121 Gilmore, *Golden Gulag*, 28.

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 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.[122] 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 such as the mandatory wearing of bodycams.[123] 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 in 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. Birth workers have very little possibility to resist because they are overworked, burned out, and traumatized as laborers in an unhealthy neoliberal capitalist institution.

To reform an institution is to remold it out of what was good about the original idea.[124] 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."[125] We are stuck in a paradigm in which we think that the problems of obstetric violence and obstetric racism have to do with individual intentionality and could therefore be fixed without having

122 Davis, *Freedom is a Constant Struggle*; Kaba, *We Do This*; Silva, *Toward a Global Idea*.

123 Davis, *Freedom is a Constant Struggle*; Kaba, *We Do This*.

124 Kaba, *We Do This*.

125 Davis, *Are Prisons Obsolete?*, 26.

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.[126] We think of doula and midwifery work as possible valuable reforms of 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 argue 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, such 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 also 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. 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. Instead of reforming a system that cannot be fundamentally changed, we propose that we see and

126 Andrea Nove et al., "Potential Impact of Midwives in Preventing and Reducing Maternal and Neonatal Mortality and Stillbirths: A Lives Saved Tool Modelling Study," *Lancet: Global Health* 9, no. 1 (2021): e24–321.

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.

Centering obstetric racism in activism and theorizing obstetric violence leads us towards 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 whether 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 Ruth Wilson Gilmore 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."[127] The presence of obstetric abolition, then, is the praxis of Black, Indigenous, and other independent midwives and doulas globally. They are already our abolitionists.

127 "In the Wake: A Salon in Honor of Christina Sharpe," BCRW Videos, filmed February 2017 at Barnard College, New York, video, 1:34:40, https://vimeo.com/203012536.

Abolishing 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[128] 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.[129]

– Following feminist abolitionism, the obstetric institution can be regarded as both a postslavery and a neoliberal capitalist institution.[130] 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 prosecution of individuals. Not only does individual persecution increase fear among birth workers, and hence increase obstetric violence, we cannot let the fight against obstetric violence become another form of white carceral feminism either.

– We need to think about the ideological dimension of institutions.[131] 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

128 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.

129 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's method of peneaelogy regarding the penal system. See: Whitney Richards-Calathes, "The Story of Aya: Peneaelogy, Black Women's Kinship, and the Carceral State," *Feminist Anthropology* 2, no. 1 (2021): 50–64.

130 Davis, *Are Prisons Obsolete?*

131 Ibid.

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 such as 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."[132]
– 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.[133] 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 due to the perception that it places 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 prosecution. 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

132 Critical Resistance, "What Is PIC? What Is Abolition?," accessed May 5, 2021, http://criticalresistance.org/about/not-so-common-language/.

133 Zacher Dixon, "Obstetrics in a Time"; Lydia Zacher Dixon, Mounia El Kotni, and Veronica Miranda, "A Tale of Three Midwives: Inconsistent Policies and the Marginalization of Midwifery in Mexico," *Journal of Latin American and Caribbean Anthropology* 24, no. 2 (2019): 351–369.

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 with regard 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. 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.

9 Undercommoning Anthrogenesis: Abolitionist Care for Reproductive Justice

Rodante van der Waal[1]

Abstract

In this chapter, I differentiate between two strategies at play in the contemporary Marxist reimagination of reproduction: 1) a *communist* approach whose focus is primarily on fundamentally restructuring the commons of reproductive care on a grand societal scale; and 2) an "undercommoning" approach that aims to fugitively abolish public institutions through small-scale mutual aid and radical care practices which are already constituting otherworlds of reproductive justice through transnational coalitions. Highlighting abortion and birth networks in the Netherlands, the second strategy is proposed as the more promising one for the anthrogenesis of human beings *otherwise*.

Keywords

Abolition, abortion, birth, midwifery, anarchafeminism, fugitivity.

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Waal, van der, R., *Birth Justice. From Obstetric Violence to Abolitionist Care*. Amsterdam: Amsterdam University Press 2025
DOI: 10.5117/9789048562398_CH09

Liberating Anthrogenesis

> *Rather than romanticizing care or ignoring its demons, radical care is built on praxis. As the traditionally undervalued labor of caring becomes recognized as a key element of individual and community resilience, radical care provides a roadmap for an otherwise.*
> —Hi'ilei Julia Kawehipuaakahaopulani Hobart & Tamara Kneese[2]

When a friend of mine became pregnant, we tried to organize the right type of maternity care for her. After a violent experience birthing her first child, she did not want to give birth in a German hospital again, even though she had a high-risk pregnancy. Together with the independent midwifery practice where I work in Amsterdam, my friend's independent midwife in Germany, and an obstetrician at the local hospital in Amsterdam, we made a care plan. A couple of weeks before her due date, she came to stay in Amsterdam with her first child, her partner, and her dogs, and arranged for a homebirth in a small apartment in the west side of the city. She had a good labor with the help of an independent midwife from our practice and an obstetrician from the hospital. Afterwards, she stayed in Amsterdam for another couple of weeks, taken care of by our practice and her friends and family, before she went back home to Germany. Although far from an ideal situation, this is an example of both radical care—a response to direct needs situated within a crisis of institutionalized care—and of what I call in this paper the "undercommoning of anthrogenesis." The "undercommons" is defined as loose networks of mutual aid and sociality that exist both outside and within public institutions.[3] In this case, a form of transnational radical care was made possible by the already existing undercommons of independent midwives and open-minded obstetricians that run through our public healthcare system.

Following the leak of the US Supreme Court's draft anticipating the overturning of Roe v. Wade at the end of May 2022, the feminist Marxist author and reproduction studies scholar Sophie Lewis published an article entitled "Free Anthrogenesis: Antiwork Abortion."[4] In her piece, she defines anthrogenesis as "the production of human beings" and calls for a radical

2 Hi'ilei Julia Kawehipuaakahaopulani Hobart and Tamara Kneese, "Radical Care, Survival Strategies for Uncertain Times," *Social Text 38* (2020): 13.

3 Stefano Harney and Fred Moten, *The Undercommons: Fugitive Planning and Black Study* (New York: Autonomedia 2013).

4 Sophie Lewis, "Free Anthrogenesis: Antiwork Abortion," *Salvage Zone*, accessed November 14, 2022, https://salvage.zone/free-anthrogenesis-antiwork-abortion/.

reimagining of gestational politics and praxis.[5] This reimagination could take place in the context of the current battle for abortion, Lewis argues, but only if this battle is able to go beyond the liberal focus on rights, privacy, and choice, which form the primary conceptual and discursive basis of most of the contemporary fights for reproductive freedom. If we really aim to reimagine reproduction through conceiving of what anthrogenesis might mean, i.e., the new and production *otherwise* of human beings, rather than the attempted reproduction of the same, we must do anthrogenesis radically differently. The same eugenic, necropolitical, and colonial institutions that are characterized by strong power relations that have developed throughout modernity cannot be reformed drastically enough within neoliberal capitalism to facilitate a production of human life *otherwise*, one which would have to be, for starters, characterized by reproductive justice.[6] In Lewis's work, the potential for the reimagination of anthrogenesis lies in a communist political framework—what she calls "gestational communism" or "communist amniotechnics"—inspired by Shulamith Firestone, and akin to contemporary thinkers such as xenofeminist Helen Hester, urging us to organize for reproductive justice as part of an anti-capitalist perspective.[7]

Reproductive care has been in a dire situation long before the overturning of Roe v. Wade due to neoliberal mismanagement, capitalist profit-making policies, and the accumulation of wealth and power of the "medical industrial complex" that defines what Barbara Rothman terms the present-day "biomedical empire."[8] Its effects not only come to the fore in abortion access, but care during pregnancy and postpartum has long been under severe threat too. From high maternal and neonatal mortality and morbidity rates for Black people and people of color, to severe forms of obstetric violence and obstetric racism during childbirth, to a lack of choice in childbirth options or forms of care: institutions that are supposed to care

5 Lewis, "Free Anthrogenesis." This is akin to what Rachelle Chadwick aims to do with the term "gestationality" that she has recently developed. See: Rachelle Chadwick, "Visceral Acts: Gestationality as Feminist Configuration," *Signs* 48, no. 1 (2022): 229–255.

6 I derive this definition of institutions from Ruth Wilson Gilmore, who defines institutions as "hierarchical relationships (structures) that persist across time." See: Ruth Wilson Gilmore, *Golden Gulag: Prisons, Surplus, Crisis, and Opposition in Globalizing California* (Berkeley: University of California Press, 2007), 28.

7 Sophie Lewis, *Full Surrogacy Now: Feminism against Family* (New York: Verso, 2019): 21, 167; Shulamith Firestone, *The Dialectic of Sex: The Case for a Feminist Revolution* (New York: Verso 2015 [1970]); Helen Hester, *Xenofeminism* (Cambridge: Polity Press 2018).

8 Beatrice Adler-Bolton and Artie Vierkant, *Health Communism* (New York: Verso, 2022); Barbara Rothman, *The Biological Empire: Lessons Learned from the Covid-19 Pandemic* (Redwood City: Stanford University Press, 2021).

for pregnant people have been failing them for decades.[9] And this does not only happen within the privatized care system of the Unites States, but in the National Health Service of the United Kingdom, too, Black mothers die four times more often than white mothers, the leading causes of maternal death postpartum being suicide and mental health problems. And recently, a cesarean section without consent was again allowed by a judge—all pointing to a tragic lack of care, bodily autonomy, and self-determination.[10] In the Netherlands, students report obstetric racism in their training, such as the "traditional" form of medical apartheid where students "practice" more on people of color.[11] Additionally, 54% of parents indicate that they have experienced forms of obstetric violence, and 42% and 47% gave no consent for an episiotomy (a cut in the vaginal wall and pelvic floor) or for medication during labor respectively.[12] We therefore have dire problems

9 Obstetric violence happens through the whole spectrum of reproductive care, i.e., during pre-conception care, abortion care, miscarriage, pregnancy, birth, and the postpartum period. Also, it happens within ART pregnancies, such as during IVF, IUI, and surrogacy. See: Molly Altman et al., "Information and Power: Women of Color's Experiences Interacting with Health Care Providers in Pregnancy and Birth," *Social Science & Medicine* 238 (2019); Khiara M. Bridges, *Reproducing Race. An Ethnography of Pregnancy as a Site of Racialization* (Berkeley: University of California, 2011); Dána-Ain Davis, *Reproductive Injustice. Racism, Pregnancy, and Premature Birth* (New York: New York University Press, 2019). Dána-Ain Davis, "Obstetric Racism: The Racial Politics of Pregnancy, Labor, and Birthing," *Medical Anthropology* 38 (2019); Brad Greenwood et al., "Physician-Patient Racial Concordance and Disparities in Birthing Mortality for Newborn," *Proceedings of the National Academy of Sciences* 117, no. 5 (2020).

10 Marian Knight et al., *Saving Lives, Improving Mothers' Care: Lessons Learned to Inform Maternity Care from the UK and Ireland. Confidential Enquiries into Maternal Deaths and Morbidity 2018–20, MBRRACE-UK Report* (Oxford: National Perinatal Epidemiology Unit, University of Oxford, 2022), https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2022/MBRRACE-UK_Maternal_MAIN_Report_2022_UPDATE.pdf; "Girl, 16, Can Undergo Caesarean Section, Judge Rules, judge rules," BBC News, November 21, 2022, https://www.bbc.com/news/uk-england-manchester-63699594.amp. Obstetric violence happens within the obstetric institution globally. For more information, see the 2019 UN report: Dubravka Šimonović, "A Human Rights-Based Approach to Mistreatment and Violence Against Women in Reproductive Health Services with a Focus on Childbirth and Obstetric Violence. Note by the Secretary-General," *Report of the Special Rapporteur on Violence Against Women* (New York: United Nations, 2019).

11 See chapter 2 and 3 for evidence and an elaboration on this topic. Practicing on people of colour has been differentiated by Harriet Washington as one of the main forms in which medical apartheid manifests. See: Harriet A. Washington, *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present* (New York: Harlem Moon, 2008).

12 Marit van der Pijl et al., "Disrespect and Abuse during Labour and Birth amongst 12,239 Women in the Netherlands: A National Survey," *Reproductive Health* 19, no. 160 (2022): 1-16; Marit S.G. van der Pijl et al., "Consent and Refusal of Procedures during Labour and Birth: A Survey among 11 418 Women in the Netherlands," *BMJ Quality & Safety* (2023).

within the obstetric institution that can be traced back to the development of racial capitalism and, subsequently, neoliberalism in the afterlife of slavery.[13]

Communism, as an anti-capitalist revolutionary movement, is certainly a useful framework to "save health from capitalism."[14] But keeping in mind that the fundamental problems of the obstetric institution—obstetric violence and obstetric racism—are intimately tied to racial capitalism, which developed partly *through* the modern institutionalization of sexual reproductive care, we may wonder if communism is the right political strategy to save anthrogenesis from reproductive and institutional violence, since communism traditionally relies on a modernist vision of society, involving grand-scale institutionalization as well.[15] Would a gestational communism be able to create life-affirming institutions that can truly care for anthrogenesis differently? As a typically modern tradition, rooted in a well-known history of institutional violence, we must question what "communism" exactly means if we are to strive for a gestational communism.

At the same time, another strategy is emerging in the radical reimagination of anthrogenesis on the left: rather than an attempt to take over the commons and seize power over reproductive health institutions, this strategy is a flight to an "undercommons" of radical care and mutual aid. More and more people are contributing to, and starting to rely on, transnational and autonomous abortion networks and midwifery practices. These networks are not only serving as emergency care in times of crisis, but they are teaching us how to organize reproductive health care that is no longer characterized by crisis. They have organized an "underground" of autonomous maternity and abortion practices of reproductive justice and bodily self-determination. Autonomous, Black, queer, and indigenous abortion and midwifery practices are epistemically developing the answers to obstetric violence, obstetric racism, and the Black maternal mortality crisis, and are delivering better outcomes than the obstetric institution.[16]

13 For the history of obstetrics, see: Deirdre Cooper Owens, *Medical Bondage. Race, Gender, and the Origins of American Gynecology* (Athens: The University of Georgia Press, 2017).

14 This is the primary project of the recent thorough book *Health Communism* by Adler-Bolton and Vierkant.

15 Barbara Rothman, *A Bun in the Oven: How the Food and Birth Movement Resist Industrialization* (New York: NYU Press, 2016).

16 Alicia Suarez, "Black Midwifery in the United States: Past, Present and Future," *Sociology Compass* 14 (2020); Jennie Joseph and Stephan Brown, *The JJ Way: Community-Based Maternity Center. Final Evaluation Report* (Orlando: Visionay Vanguard Group, 2017); Jennifer Almanza et al., "The Impact of Culturally-Centered Care on Peripartum Experiences of Autonomy and Respect in Community Birth Centers: A Comparative Study," *Maternal Child Health Journal* 26, no. 4 (2021): 895–904; Leseliey Welch et al., "We Are Not Asking Permission to Save Our

Hi'ilei Julia Kawehipuaakahaopulani Hobart and Tamara Kneese define radical care as "a set of vital but underappreciated strategies for enduring precarious worlds."[17] Dean Spade makes a plea for the revaluation of these strategies, and hence the importance of mutual aid, as:

> a form of political participation in which people take responsibility for caring for one another and changing political conditions, not just through symbolic acts or putting pressure on their representatives in government but by actually building new social relations that are more survivable.[18]

According to Marquis Bey, the building of these new social relations amounts to the constitution of "otherworlds" within this one.[19] Drawing on the Black radical tradition, Bey uses the concept of "fugitivity" to describe this form of radical politics in which one flees structural oppression and exclusion, towards, and through the constitution of, otherworlds of radical care. Fred Moten and Stefano Harney have termed such otherworlds "the undercommons"—inspired, just as Bey's concept, by maroon communities.[20] The "undercommons" is a play on the concept of the "commons," in which everything that one needs is provided through a mutually shared source, but where those networks of care remain fluid, non-institutionalized, non-individualized, and invisible to the outside world.

It seems that there is a crucial differentiation to be made between Hester's and Lewis's modern communist reimagination of sexual reproduction on the one hand, which still relies on a traditional Marxist conception of the commons, and the explicitly anti-institutional planning of the undercommons that has grown out of the intellectual history of the Black radical tradition, and that can be either fugitive, decolonial, or anarchist, represented by activists and philosophers such as Cedric Robinson, Marquis Bey, Françoise Vergès, Harsha Walia, Dean Spade, Alexis Pauline Gumbs, Chiara Bottici, Stefano Harney, and Fred Moten. In this chapter, I aim to

Own Lives: Black-Led Birth Centers to Address Health Inequities," *The Journal of Perinatal & Neonatal Nursing* 36 (2022); Keisha Goode and Arielle Bernardin, "Birthing #blackboyjoy: Black Midwives Caring for Black Mothers of Black Boys During Pregnancy and Childbirth," *Maternal Child Health Journal* 26 (2022); Ruha Benjamin, *Viral Justice: How We Grow the World We Want* (Princeton: Princeton University Press, 2022), chapter 5.

17 Hobart and Kneese, "Radical Care," 2.

18 Dean Spade, "Solidairty not Charity. Mutual Aid for Mobilization and Survival," *Social Text* 38 (2020): 136.

19 Marquis Bey, *Black Trans Feminism* (Durham: Duke University Press, 2022).

20 Harney and Moten, *The Undercommons*; Bey, *Black Trans Feminism*.

lay bare these diverging strategies towards reproductive justice that often remain somehow implicit in current debates: a difference between attempting to reappropriate and restructure the public institutionalized commons or to build and expand an undercommons of autonomous networks; a difference between an institutional or an anti-institutional perspective; a difference between centering grand-scale reimagination or reimagining through practices of local mutual aid and radical care.[21] I will locate the possibility of the radical reimagination of anthrogenesis that Lewis argues for in the already existing fugitive undercommons of anthrogenesis, rather than in modernist utopic visions of a new commons: in the undercommons of feminist networks of care; in the work of independent, Black, queer, and indigenous midwives, doulas, and abortionists operating outside of the obstetric institution; in fugitive mothers' flight, and in the many abortion funds and global networks that give pregnant people the care they need whether the state is with them or not.

"We Aim to Be Communist about Communism":[22] Institutions, Modernity, and the (Under)commons

The institution makes it impossible for us to see how much goes on in the outside of it.
Stefano Harney and Fred Moten[23]

The 2022 documentary *The Janes*, which is already celebrated amongst reproductive justice activists, gives an insight into an impressive mutual aid network in the years before the legalization of abortion in the United States.[24] The Janes consisted of a group of women who provided abortions in weekly changing living rooms, picking pregnant people up with a car at a set time after they had dialed the number under the widely distributed advertisement: "Pregnant? Call Jane." Not only did they safely provide much-needed affordable abortion care, but their aim was also to reappropriate, and further develop, knowledge about how to control one's own reproductive

21 Hester, *Xenofeminism*, 148. This tension is not only present in current debates and practices that engage with reproductive justice, but also within abolitionism itself. There is a side that is more focused on replacing the institutions that we have with, as Ruth Wilson Gilmore says, life-affirming ones, and another side that takes a more anti-institutional approach, such as that articulated by Fred Moten and Stefano Harney.

22 Harney and Moten, *The Undercommons*, 82.

23 Ibid., 114.

24 Tia Lessin and Emma Pildis, *The Janes* (documentary HBO Max, 2022).

body, and consequently, reclaim it. In so doing, they brought to life a feminist form of care that people in the documentary describe as "transformative" and "the best healthcare experience they ever had"—many joining the Janes after their abortion. As one member points out, their activism was not only directed against the repressive laws of the state, but also against the authority and patriarchy of the medical industrial complex. Upon the legalization of abortion, however, the Janes believed that their work was no longer necessary, and they quit, once again leaving the knowledge and practice surrounding abortion in the hands of medical institutions. Helen Hester consequently doubts the political impact of such self-help movements that have proven, according to her, that they are not radical, grand-scale, and political enough.[25] But it could be that both the demands of Hester's grand-scale communism, as well as the quitting of the Janes upon the legalization of abortion, mistakenly rely on the same modern ideological structure that limits the vision and strategy we generally have for reproductive justice; namely, the modern (state) institution.

As a midwife and scholar of reproductive violence, I feel confident to assume that even in countries where abortion is legal nowadays, the Janes would have still provided more respectful care than many abortion clinics are able to facilitate. This is not merely due to the taboo that surrounds abortion but also to the problematic that underpins institutions characterized by capitalist, colonial, misogynist, industrial and carceral logics that have appropriated the reproductive body throughout modernity.[26] Against the backdrop of the work of Michel Foucault and Sylvia Wynter, the concepts of "modernity" and "institution" must be understood in an inextricable relation to each other: the *institution* as we know it today has developed through, and made a vital contribution to, the development of *modernity*, understood as the globalization of the world through racial capitalism, following Cedric Robinson's critique of Marx and Engels.[27] The eugenic biopolitical control of people, which is fundamental to modernity and the development of racial capitalism, could only be achieved through the industrial institutions that have developed throughout modernity in all sectors of life, tightening the

25 Hester, *Xenofeminism*.

26 Sylvia Wynter would call the underlying logic of the modern institution 'plantational' rather than 'industrial.' See: Katherine McKittrick, ed., *Sylvia Wynter: On Being Human as Praxis* (Durham: Duke University Press, 2015).

27 Robinson adds, crucially, to Marx and Engels that colonialism and the plantation were central to the development of capitalism and hence to modernity. See: Cedric J. Robinson, *Black Marxism: The Making of the Black Radical Tradition* (Chapel Hill: University of North Carolina Press, 2021).

grip on land, wealth, resources, and people. Institutions molded the subjects of modernity into a specific form of the human, which Wynter terms "Man2," and dehumanized those subjected to the oppression upon which modernity could thrive.[28] The institution must hence not only be seen as the disciplinary and industrial factories of modernity that produce the modern subject, as with Foucault, but also as the place where the reproduction of people and capital is necro- and biopolitically controlled according to a racializing scheme, which is why philosophers such as Sylvia Wynter, Achille Mbembe, and Katherine McKittrick characterize the institutions of modernity as working according to a necropolitical plantational, rather than a merely industrial or carceral logic.[29]

Fred Moten and Stefano Harney take this characterization a step further again, defining the whole of modernity as a "plantocracy" of "democratic despotism."[30] Modernity, developed through the colonies, the plantations, and industrialization, came to a stage where almost everything is accumulated according to the racializing scheme of the plantation, facilitating the white planter who aims "to control and concentrate all the land, all the water, all the air, all the food, animals, and plants"[31] via the modern institutional logistics of policy and financialization. But this phase of plantocracy that modernity is in, is particularly dangerous precisely because the grip on the world is exercised through seemingly democratic and neutral institutions that function mostly through racializing policy measures, carceral logistics, and unjust management, and hence through a violence that is slower, more indirect or invisible than the violence that marked the primitive accumulation of colonialism and slavery which characterized the beginning of modernity. These "logistics" and "policies," are, however, reproducing the necropolitical regulation of racialized life and capital, no longer in plantations, but through other institutions that can be understood as their afterlife.

The obstetric institution is no exception here. Deeply rooted in the history of slavery, eugenics, and the control of sexual and social reproduction by

28 Sylvia Wynter and Katherine McKittrick, "Unparalleled Catastrophe for Our Species? Or, to Give Humanness a Different Future: Conversations," in *Sylvia Wynter, on Being Human as Praxis*, ed. Katherine McKittrick (London: Duke University Press, 2015), 42.

29 Sylvia Wynter, "Unsettling the Coloniality of Being/Power/Truth/Freedom: Towards the Human, after Man, Its Overrepresentation–An Argument," CR: *The New Centennial Review* 3, no. 3 (2003): 257–337; Katherine McKittrick, "Axis, Bold as Love," in *Sylvia Wynter: On Being Human as Praxis*, ed. Katherine McKittrick (Durham: Duke University Press, 2015), 145; Katherine McKittrick, "On Plantations, Prisons and a Black sense of Space," *Social & Cultural Geography* 12, no. 8 (2011): 947–963.

30 Stefano Harney and Fred Moten, *All Incomplete* (New York: Autonomedia, 2021), 119.

31 Ibid., 121.

the state, obstetric violence and obstetric racism became a fundamental part of its institutional practice.[32] As a consequence, obstetric protocols and policies are ridden with racism, making pregnant people feel isolated and captivated within the reproductive system, lacking a communal sociality of care.[33] Abolition critiques the notion that modern institutions appear to be part of the natural order of things rather than relatively recent inventions, and questions if they should not better be dismantled or reformed so fundamentally that we cannot really call it the same institution anymore.[34] When it comes to the obstetric institution, we have the same sense of inevitability and permanence as with regard to modern institutions such as prisons, the police, and the school. Analyzing the persistence of violence in these institutions, abolitionists argue for their abolition, as a way of, ultimately, abolishing racial capitalist modernity, rather than wasting our energy on minor reforms. But even abolitionists differ in opinion on what needs to happen after the abolition of those modern institutions. Some, such as Marquis Bey, Alexis Pauline Gumbs, Stefano Harney, and Fred Moten, argue for a radical anti-institutional approach, while others, such as Sophie Lewis and Mariame Kaba believe that we can replace "death-making" institutions with "life-affirming" ones.[35] If institutions are inextricably bound up with modernity, however, and if modernity is inextricably tied to racial capitalism, how can we feel confident that we, as abolitionists, are able to create institutions that are not characterized by gender-based racializing violence?

32 The obstetric institution, like many modern institutions, directly emerged from US slavery: After the closing of the abolition of the transatlantic slave trade, many collaborations between plantation owners and doctors started to increase the reproductive health and thus "breeding" capacities of enslaved people, resulting in many international scientific articles and medical inventions, such as the speculum, that gave rise to obstetrics and gynecology as independent specialties. See: Owens, *Medical Bondage*; Davis, "Obstetric Racism"; Davis, *Reproductive Injustice*; Annie Menzel, "The Midwife's Bag, or, the Objects of Black Infant Mortality Prevention," *Signs* 46, no. 2 (2021): 283–309.

33 Anna Horn has coined the concept "obstetric carcerality" to address this. See: Anna Horn, "Birthing While Black," *Red Pepper*, accessed July 10, 2023, https://www.redpepper.org.uk/birthing-while-black-pregnancy-bodies-nhs-childbirth-maternity-medical-racism-carcerality/.

34 In the case of the obstetric institution, approximately a century and a half, only gaining more power over birthing bodies since the post-war period. Since the beginning of the existence of the obstetric practice and research, its violence has been critiqued by both mothers, midwives, as well as male scientists – one of the latter mentioned the term "obstetric violence" for the first time in the *Lancet* in the 1827. See: James Blundell, "Lectures on the Theory and Practice of Midwifery: Delivered at Guy's Hospital by Dr James Blundell. Lecture 28: After-Management of Floodings, and on Transfusion," *Lancet* 8, no. 1 (1827): 673–681.

35 Mariame Kaba, *We Do This 'Til We Free Us: Abolitionist Organizing and Transforming Justice* (Chicago: Haymarket Books, 2021).

Gestational Communism

Feminists such as Lewis and Hester encourage us to open "our collective imaginations," asking us to go further than mere abortion access and "spend a little time speculating about what—besides the right to make private gestational choices, or the right to healthcare—gestators might demand. What freedoms might gestators together articulate, and seize?"[36] And they urge us to, consequently, "cultivate the exercise of positive freedom."[37] In pressing the radical reimagination of anthrogenesis, they invoke the thought of Shulamith Firestone, who laid the foundation for a radical utopic reimagination of reproduction through what Lewis calls "communist amniotechnics," arguing for ectogenesis as a way in which people with a uterus can be liberated from oppression, but only if it goes hand in hand with a *revolutionary* reconfiguration of the institutions in which ectogenesis is supposed to take place.[38] While both Firestone's, Lewis's, and xenofeminist proposals involve abolitionist questions—"What lives, households, social relations, worlds must we unproduce in order to produce the ones that we desire?"[39]—and hence describe themselves as abolitionists (Lewis of the family, Firestone of sex, and Hester's xenofemenism of gender), an unproblematized and often implicit reliance on (state) institutions persists in their work, which is tied to their communist framework. The crucial question is how exactly to understand "communism" in the Firestonian feminist scholarship of both Lewis and Hester, and how to understand communism in relation to the reproductive violence of the modern institution.

As we know, communism was both a world-changing liberation movement that was able to challenge various forms of oppression, and the ideological legitimation of disciplinary and genocidal regimes in the twentieth century,

36 Lewis, "Free Anthrogenesis."

37 Laboria Cuboniks, *The Xenofeminist Manifesto. A Politics for Alienation* (New York: Verso, 2018), 33.

38 In her thorough discussion of reproductive technology in The Dialectic of Sex, Sarah Franklin points out multiple times that ectogenesis should be placed in a double context: First, Firestone took pains to argue that there can be no technological fix within a patriarchal capitalist society. And second, the proposal of ectogenesis should be placed in Firestone's broader understanding of reproductive technology as essential to, and presenting our greatest chance for, reproductive control and autonomy. Not unproblematically, however, and like to reproductive justice activists such as Marie Stopes and Margaret Sanger, Firestone understood biotechnology not only as detrimental to the liberation of women, but also to the taking control, and improvement, of the human race, and hence as a form of neo-Malthusian eugenics. See: Sarah Franklin, "Revisiting Reprotech," in *Further Adventures of the Dialectic of Sex: Critical Essays on Shulamith Firestone*, ed. Mandy Merck and Stella Stanford (New York: Palgrave MacMillan, 2010); Lewis, *Full Surrogacy Now*, 167.

39 Lewis, "Free Anthrogenesis."

specifically due to the dogmatic institutionalization of its politics. Because of the latter, it remains important to scrutinize our pleas for communism, grand-scale institutions, and universalism, and to engage with the problem that has been central for critical theory: the dangerous and violent discrepancies seemingly inherent in the communist tradition between theory and praxis, between the party and the people, between authoritarian partisanship and an anarchic plurality of ways to be free. Certainly, a wide range of theoretical traditions, from the Frankfurt School to French post-Marxism, to multiple waves of feminist, queer, and decolonial theory have attempted to come to terms with the complicated legacies of communism. Also, it remains important to stress that Marxism must be understood as an open-ended horizon rather than be discredited due to its historical employments.[40] But while communism as the liberation from capitalist oppression is still a promising approach for thinking about transformative politics, the thoroughly debated and difficult question within and outside of the extremely diverse communist tradition remains *how*. If we go back to Marx and Engels, communism meant to abolish class, private property, and wage labor through the appropriation of the means of production by the working classes.[41] Communism can then broadly be understood as the reappropriation and restructuring of the commons into public institutions which are to be governed by the proletariat. In that sense, it is a modernist project relying on grand-scale centralized industrialization and institutionalization, and hence on a certain type of universalism dictated by a privileged subject, the proletariat, and on a utopianism, as all this happens only *after* the revolution.

Firestone takes up a similar understanding of communism but expands it in a revolutionary feminist manner. Understanding that more naturalized institutions such as the family and childhood, are also oppressive, she aims for their abolition in addition to the abolition of class.[42] And she even goes one step further: not only must these kinds of oppressive social constructions be abolished, she juxtaposes Marx and Engels's historical materialism with a biological materialism, arguing that we are not only oppressed by capitalism, but by the biology of sexual reproduction as well. Firestone recognizes

40 See for instance: Lydia Sargent, ed., *Women and Revolution: A Discussion of the Unhappy Marriage of Marxism and Feminism* (Montréal: Black Rose Press, 1981); Robinson, *Black Marxism*; Jacques Bidet and Stathis Kouvelakis, *Critical Companion to Contemporary Marxism* (Leiden/Boston: Brill, 2008).

41 Karl Marx and Friedrich Engels, *De Duitse ideologie*, trans. Henk Hoeks and Hugues C. Boekraad (Amsterdam: VanTilt, 2018 [1846, 1932]).

42 Firestone, *The Dialectic of Sex*; Engels did already touch upon this. See: Friedrich Engels, *The Origin of the Family, Private Property and the State*, trans. Alick West (New York: Verso, 2021 [1884]).

that the biological reality of childbearing and rearing has a fundamental influence on the structuring of society: it determines whose bodies are free without dependents, who is able to accumulate wealth, whose bodies are considered surplus, whose bodies are made vulnerable by biological processes, etc.[43] If we are really to be free, Firestone argues, not only must class or the family be abolished, but so must the root of sexual inequality, that is, sexual difference itself, and the burden of pregnancy that comes with it. Thus, only when "sex" is abolished and replaced by ectogenesis, will gestators be able to govern anthrogenesis in a truly liberatory way.[44] Whatever one thinks of ectogenesis or biofuturism, her focus on gestators as the proletariat of biological materialism, and hence her understanding of them as a revolutionary subject, is a crucial, and still quite unrecognized, contribution to feminist theory that urges us to take up the challenge to not only reappropriate the means of production, but the means of reproduction as well, understood not only as reproductive care work, but essentially as the physical labor of gestation.[45]

43 It is important to recognize that this is a different contribution to Marxist feminism than for instance Social Reproduction Theory (SRT). Within SRT, the primary source of oppression remains capital, class, and the doctrine of waged and unwaged labor. SRT recognized that not only wage laborers are suppressed in this regime, but that waged labor relies on the whole domain of unwaged social reproduction. Firestone addresses the oppression inherent to biology itself. This is why Firestone's revolutionary agenda not so much addressed the unwaged labor of reproduction, but the abolition of the biological process of pregnancy itself. It is this agenda that is taken up very fiercely by xenofeminism, which goes by the slogan: "If nature is unjust, change nature." Rather than doing this in a problematic radical feminist essentialist way (for instance that of Mary Daly or Janice Raymond, who situates the source of oppression not in the process of pregnancy but rather in testosterone, sex chromosomes, and the literal penis, which they understand as the sources of patriarchy), however, Firestone less problematically recognized that the biological process of sexual reproduction matters for our oppression, lived experience, vulnerabilities, distribution of responsibilities, and so on. See: Laboria Cuboniks, *The Xenofeminist Manifesto*.

44 Firestone, *The Dialectic of Sex*.

45 Silvia Federici sketches the history of the expropriation of the means of reproduction, or the reproductive commons, brilliantly in Silvia Federici, *Caliban and the Witch: Women, the Body, and Primitive Accumulation* (New York: Autonomedia, 2004). She shows how women's control over the means of reproduction was violently appropriated in the witch-hunts. Women's bodies and labor were consequently primitively accumulated and made into a commons of reproduction *themselves*, consisting of unwaged reproductive labour such as housework and pregnancy through the naturalization of their work. For Federici, the revolutionary project was consequently also a communist one, although in a less technological and biological sense than in Firestone's project. Federici aims to reappropriate the reproductive commons through the making visible and revaluation of unwaged reproductive labor, ultimately aiming for an autonomous reproductive commoning instead of exploitation. This is only possible within a grand-scale revolution, however, exactly because capitalism relies so heavily on reproductive labor as a free commons. The moment it becomes valued or waged, capitalism would fall, which

Undoubtably, this why Lewis and Hester revived Firestone so passionately half a century later.[46] Lewis's gestational communism is indebted to Firestone's feminist communism as she also centers the lowest class of sexual reproductive subjects in her work: surrogates, mothers, and abortion-seeking pregnant people, convincingly arguing for utopic communist reproductive futures that are envisioned and governed by gestators themselves. Lewis has a couple of propositions on how to do this. First, surrogates must be in charge of surrogacy, a classic communist argument that puts the worker in charge of the factory, and hence in charge of the means of (re)production.[47] Second, and similarly, gestators must be in charge of sexual reproductive healthcare, hence her plea for free and on-demand abortions to be provided by the communist state, also a classic communist argument that puts the proletarian subject in charge of the public commons.[48] Third, surrogacy must become the norm rather than the exception that sustains the rule of the nuclear family, i.e., that the understanding of children as property, as "ours" or as "our blood," should be abolished (since surrogacy is only an abnormality if we understand children within a property relation).[49] Fourth, the family—also alternative and marginalized families or kinship structures—must be abolished to free children from their oppressive childhood and mothers from the privatized unwaged care in the household.[50] And fifth, we should embrace communist amniotechnics as a current-day reconfiguration of Firestone's abolition of sex in the form of ectogenesis, to not only abolish sex but free gender from its binary, and our bodies from the possible dangers of gestation for those who want to engage in gestation.[51] Together, this entails a gestational communist revolution through which gestators are liberated as revolutionary subjects and from which a general revolution will necessarily follow.

We cannot yet fully see, however, what comes beyond the horizon of this revolution, making it a form of *utopic* communism: rather than sketching what

is exactly the revolutionary point of the Wages for Housework movement. As such, Federici's revaluation of reproductive labour is a feminist strategy for a communist revolution, in line with SRT. See: Federici, *Caliban and the Witch*; Silvia Federici, *Revolution at Point Zero: Housework, Reproduction, and Feminist Struggle* (Oakland: PM Press, 2020).

46 Franklin argues that Donna Haraway is the true heir of Firestone, as she developed a situated ethics of "reevolution" devoted to biology and the technological means of changing it. In this paper I engage with the more communist heritage of Firestone, though, which is why I focus on Lewis and Hester rather than Haraway. See: Franklin, "Revisiting Reprotech," 50.

47 Lewis, *Full Surrogacy Now.*

48 Lewis, "Free Anthrogenesis."

49 Lewis, *Full Surrogacy Now.*

50 Sophie Lewis, *Abolish the Family: A Manifesto for Care and Liberation* (New York: Verso, 2022).

51 Lewis, *Full Surrogacy Now.*

comes instead of the family, or how communist ectogenesis will be governed, Lewis's plea is for an "abundant nothing" that we cannot yet understand within patriarchal capitalism.[52] We must therefore be ready, just as with communist revolutions, to sacrifice who we are and what we love for a better, more equal, and more rich "red love" for everyone.[53] Given that we know, following Foucault and Wynter, that institutions are the site where anthrogenesis takes place, and where subjectivity is formed, where the human is made into Man, theorists such as Shulamith Firestone, Sophie Lewis, and Helen Hester argue for a liberation of anthrogenesis through the seizing of power over the current reproductive commons and a reconstitution of new ones through fundamental reforms. A new configuration of the human can then only appear *after* the constitution of these new commons, thus locating the transformative potential in the revolutionary restructuring of the commons—which is why Lewis insists that we must be ready to give up the current configuration of ourselves.[54] This, indeed, paints a quite classic communist picture regarding both strategy and vision, albeit fully inspired by both Firestone's biological materialism as well as social reproduction theory more broadly. Lewis's horizon of gestational communism can hence be understood as a feminist *and* sexual reproductive take on a communist revolution that deeply knows and understands that "all politics is reproductive politics."[55]

Just as the point of Wages for Housework was to destroy capitalism by asking for wages since capitalism would never be able to afford these wages, rather than to make a plea for a kind of basic income within the structure of capitalism, Lewis's plea for the abolition of the family is a strategy to destroy capitalism because capitalism will, similarly, not be able to function without the free care and human beings provided for by the family.[56] The focus on feminist issues is hence a strategy to attempt communist revolution via the means of reproduction, rather than the means of production. That does mean, however, that the liberation of anthrogenesis remains in the future, since it depends on a grand-scale revolution—one that, as Lewis admits, will probably not happen during her lifetime.[57] Helen Hester's Firestonian xenofeminist critique of second-wave mutual aid networks on account of them being too small-scale and not political enough testifies to her own

52 Ibid.; Lewis, *Abolish the Family*, 88.

53 Ibid., referencing Aleksandra Kollontai, 50–54.

54 Ibid.

55 Laura Briggs, *How All Politics Became Reproductive Politics: From Welfare Reform to Foreclosure to Trump* (Berkely: University of California Press, 2017).

56 Federici, *Revolution at Point Zero*.

57 Lewis, *Abolish the Family*.

ultimate dismissal of radical care networks, as she closes the end of her book: "ensuring the provision of safer, cheaper, fully accessible gender-disruptive and reproductive healthcare should be our priority. I am grateful to have second-wave self-help to appropriate and learn from, but ultimately we need to construct alternative models for xeno-reproduction."[58] Rather than siding with the autonomous care workers who do illegal, risky, and invisible radical care and mutual aid work, and who thus know the crisis of care and the needs of sexually reproductive people intimately, Hester does not think they will be able to construct alternative models of care and radically reimagine anthrogenesis. While helpful and inventive, she argues, they will not suffice because they will never be up to scale to achieve reproductive justice. Hester hence reiterates the ultimate siding with grand-scale communist approaches over the anarchist sympathy that *The Xenofeminist Manifesto* also displays: "can we stitch together the embryonic promises held before us by pharmaceutical 3D printing ('reactionware'), grassroots telemedical abortion clinics, gender hacktivist and DIY-HRT forums, and so on, to assemble a platform for free and open-source medicine?"[59] While recognizing the inspiration provided by radical care communities, these are reasserted as small "promises"—*embryonically* small ones even, hence neglecting the major impact these practices of care actually have on peoples' lives, being far less merely a promise than our utopic communist future is. Lewis always adamantly makes sure to affirm and uplift local radical care networks and would hence never dismiss mutual aid in the way that xenofeminism does, but in her argument as a whole, these networks do not function as the essential thing to affirm when it comes to a communist revolution.

Another consequence of the utopic take on the liberation of anthrogenesis is that we do not know what a family-free world would look like, and that we have no lived experience to actually form alternative forms of care in a responsible way based on community-building and trial and error. Lewis, similarly to xenofeminism, uses radical care merely as glimpses of what another world *could* be like[60]—glimpses which are still captured in social relations determined by capital—describing them as having "perhaps proto-communist potential."[61] As a consequence, she argues explicitly against the revolutionary queering of Black motherhood by Gumbs, and against the use of family designations such as "mother" or "brother" in ballroom families,

58 Hester, *Xenofeminism*, 150.

59 Laboria Cuboniks, *The Xenofeminist Manifesto*, 81.

60 Harney and Moten, *The Undercommons*.

61 Lewis, *Full Surrogacy Now*, 148.

alternative kinship models, and revolutionary movements.[62] Hence, rather than using the kinship-like local radical care relations already built in a transformative manner to then radicalize these otherworlds further, Lewis scrutinizes them for still being too ideological. Consequently, within her general argument they implicitly become configured, in a more traditional communist way, as a vehicle to cultivate revolutionary consciousness, after which the "real" revolution, in which we do away with all networks of care that resemble the family in favor of a loving and "abundant nothing," must still take place.[63] As such, mutual aid networks such as the Janes and their contemporary counterparts are merely constructed as a vehicle to reimagine a grand-scale platform of open-source medicine, risking the possibility that grassroot care is negated in favor of large-scale universalism, and, as a consequence, the artificial modern dichotomy between the local and the global, the particular and the universal, is reaffirmed, and the question of the replacement of the family stays dangerously unclear in light of the history of communism.[64] At the end of *Abolish the Family*, for instance, Lewis flags that it is difficult to come up with an alternative for the family that does not involve "state-owned children" and "mass, state-run daycare," but refutes this problem by stating that we can devise answers to this "by tomorrow."[65]

While Lewis thoroughly takes up the feminist critique and reconstruction of communism, we should also engage with the extensive and diverse critiques of critical theory considering what communism has come to mean in the twentieth century. The problems attached to communism, such as its utopic element that hinges on the outcomes of the revolution and the modernist understanding of grand-scale centralized institutions, also adhere to Lewis's feminist configuration. Even without explicitly arguing for large-scale (state) institutions, these approaches tend to reproduce the need for modernist institutions by not addressing the problem of the theoretical and historical limitations of institutions as the ultimate horizon of radical politics.

The Undercommons of Anthrogenesis

The supposed contradiction between the local and the global has been rebutted many times by both intersectional and decolonial feminists, such as Françoise Vergès and Chandra Mohanty, who argue that for both critical

62 Lewis, *Abolish the Family*.
63 Ibid., 88.
64 Laboria Cuboniks, *The Xenofeminist Manifesto*, 13, 29, 43.
65 Lewis, *Abolish the Family*, citing Lou Cornum, 86–87.

analysis and revolutionary action one can only conceptualize a multi-dimensional feminism of "totality" (Vergès) or "universality" (Mohanty) within the specific expression, and mutual reconstitution, of global structures within the local.[66] From local networks, they argue, we must build coalitions, rather than start out from large-scale feminist enterprises or ideologies, hence insisting on the intersectionality of the particular. Upscaling, then, is not naïvely put aside, but practiced otherwise through coalitional networks of plurality and difference. In other words, universalism as such is not rejected by intersectional and decolonial feminists, but they understand that the universal could only ever be (partially) reached through a zooming in on, rather than negation of, the local and the specific: it is through the particular that the global structures of oppression are understood and resisted. The problem of doing it the other way around, by relying either implicitly, with Lewis and Silvia Federici, or explicitly, with Hester, on grand-scale modernist models, is, even aside from the problem of institutional violence, that they also tend to be unable to account for the unique configuration of both oppression and fugitive paths towards liberation within local reproductive landscapes.

We must recognize here that liberating anthrogenesis only starts, rather than ends, with access to medicine and healthcare. It fully depends on the local and direct configuration and organization of care whether that care will be violent, exclusionary, discriminatory, or not. If we are to free anthrogenesis, the relationality of care in which it is fundamentally embedded must be (re-)constituted. Small-scale radical care networks do exactly that by directly responding to people's needs and organizing their care accordingly. They are consequently able to heal the relationality that is severed by state policy and institutions, and build communities on the basis of this recovered and reconfigured relationality that is essential for non-violent abortion, pregnancy, birth, and parenthood. Using care to directly respond to people's needs is understood as "radical care" because it is used as the primary "material" through which new social relations are built. Therefore, care has been regarded by care ethicists as one of the most crucial means for the reshaping of society.[67]

Small-scale radical care networks, such as the Janes, Black doulas, and indigenous Birthing on Country midwifery practices, are in fact doing precisely

66 Françoise Vergès, *Decolonial Feminism* (London: Pluto Press, 2019); Chandra Mohanty, *Feminism without Borders: Decolonizing Theory, Practicing Solidarity* (Durham: Duke University Press, 2003).

67 Joan Tronto, *Moral Boundaries: A Political Argument for an Ethic of Care* (New York: Routledge, 1993); Joan Tronto, *Caring Democracy. Markets, Equality, and Justice* (New York: NYU Press, 2013).

what follows from Firestone's analysis, but in a different way: they start within the specific intersectional configuration of the way anthrogenesis has been expropriated from them, and take it back locally by reconstituting different non-oppressive social relations. Although that might not directly instigate a communist revolution, it is nonetheless a powerful political approach, since within their specific political understanding of their context and practice, they manage to liberate anthrogenesis directly. They are for instance able to guarantee reproductive justice when public institutions are unable or unwilling to do so, and they epistemically develop a unique medical and social standpoint when it comes to knowledge about caring for anthrogenesis in an emotionally and physically safe way. As gestators, they, indeed, articulate their freedoms and seize them, by reconfiguring anthogenesis anew in a plurality of ways. The question is whether grand-scale institutions or utopic visions would also be able to rebuild and repurpose social relations concerning sexual reproduction in the same generative way.

Where Firestone and Lewis explicitly follow a Western, modernist, Marxist tradition, abolition as a revolutionary approach arises from what Cedric Robinson has coined the Black radical tradition. While closely related to Marxism, Robinson counterposes the Black radical tradition, or "Black Marxism," in multiple decisive ways. It is exactly these differences that we can also recognize in the comparison between gestational communism and the undercommons of anthrogenesis. Severely critiquing Marx and Engels for having misunderstood the English (or European) proletariat as the *universal* class of capitalism, and hence as the universal subject of revolution, Robinson shows extensively how capitalism has been racialized from the start, creating various classes of marginalized people all over the world, thereby undermining the focus on the factory, the proletariat, and the universal revolution. Assuming that the European proletariat is the subject of revolution is, as Robinson points out, an imperialist mistake that universalizes a local and specific English situation and does not take the full global reality of capitalism into account, whose development fully relied on the colonies and the plantations.[68]

Consequently, Robinson shows how Black and indigenous struggles against racial capitalism have looked rather different than the European proletarian movement.[69] A genealogy of Black struggle led Robinson to

68 Robinson, *Black Marxism*, 27.

69 "Marxism's internationalism was not global; its materialism was exposed as an insufficient explanator of cultural and social forces; and its economic determinism too often politically compromised freedom struggles beyond or outside of the metropole. For Black radicals, historically

maroon communities as the early locus of revolution, rather than the proletariat, as he reveals an explicitly different type of struggle, namely that of fugitivity: the tactic of fleeing from oppressive institutions to build new social relations.[70] Rather than aiming to seize institutions (such as factories), they opted for full disavowal of the institution of slavery and the plantation to create a fundamentally different community somewhere else.[71] According to Robinson, this type of struggle does not follow from class consciousness gaining insight into the objective trajectory of historical materialism, like in traditional Marxism, but sprouts from a consciousness formed by African cultures that were not engaged in the European project of universal modernity, but posed a contradiction to modern society.[72] Later, Robinson points out, Black struggle developed from marronage into abolition, since enslaved peoples became more fully engulfed by modern society and maroon communities became more difficult to sustain.[73] Rather than aiming to overtake society and its institutions, the Black Marxist approach can hence be understood as a dismantling of modern society through fugitivity, as the flight away from the institution and the building of other relations, *and*, simultaneously, abolition, as the abolition of institutions that reproduce the modern world, starting with the abolition of slavery.

This results in a praxis of struggle that has less of a prefigurative program and more of a local social praxis of liberation. As such, Black Marxism has a different conception of temporality than European Marxism. Robin Kelley points out that, rather than being a teleological understanding of history and revolution, liberation is only a promise within the temporal presence of struggle itself.[74] Struggle, in other words, consists of time which is generative by virtue of the doing and the promise of liberation, rather than

and immediately linked to social bases predominantly made up of peasants and farmers in the West Indies, or sharecroppers and peons in North America, or forced laborers on colonial plantations in Africa, Marxism appeared distracted from the cruelest and most characteristic manifestations of the world economy. This exposed the inadequacies of Marxism as an apprehension of the modern world, but equally troubling was Marxism's neglect and miscomprehension of the nature and genesis of liberation struggles which already had occurred and surely had yet to appear among these peoples." See: Robinson, *Black Marxism*, 29.

70 Ibid., 349

71 David Graeber describes a similar way of doing revolution, in his differentiation between anarchism and communism. Anarchism, according to Graeber has always consisted of the flight from certain societies to establish a more egalitarian society somewhere else, while communism has been focussed on overthrowing society by seizing power over its institutions. See: David Graeber, *Fragments of an Anarchist Anthropology* (Chicago: Prickly Paradigm Press, 2004).

72 Robinson, *Black Marxism*, 314, 348–349, 356.

73 Ibid., 350.

74 Robin D. G. Kelley, "Foreword," in Robinson, *Black Marxism*.

a teleological prefigurative conception of history. As Bey asserts: "There is no 'end' because to know the end is to think one knows the totality of the landscape, a line of thinking that cannot account for that which falls outside the dictates of legibility. […] Fugitive planning plans for what it cannot plan for by refusing to plan for it."[75] There is hence no objective "force of law, of the line that connects, divides, and directs" as Denise Ferreira da Silva writes, but only "jus generativity, which can be read as the quality and capacity to give—not in the context of an economy (as in the managing of scarcity) but as generosity (as in the abundance of the rain forest)."[76]

What Kelley terms the "blues time" of Black Marxism is a generative constantly changing praxis that is already at play as liberation in the present, rather than being a strategic vision. Or as Silva writes: "Un-prehensible, undercommons sociality, or black study, might just take us along, without plot or plan, as/in earthly existence, that is, guided but by the jus generativity that prevails under existence's unbounded generosity."[77] Moten and Harney, Silva, and Bey hence explicitly understand the undercommons as *the* radical challenge to modernity and its institutions, since they are the "jus generativity" which dismantles institutions and which institutions can never provide nor capture due to their universal claim, their disciplinary character, their discursive formation of subjects, and their regulation of access. This also points to the fundamental difference between the institutions and their fugitive maroon communities: the latter, where you can simply get what you need without rules, captivity, circumscription, violation, or the demand of transparency, are not an institution.

Most police and prison abolitionists aim to abolish institutions through the building of alternative communities. These alternative communities should not be understood as traditional communities but as autonomous forms of social life, characterized by generative time, via radical care, mutual aid, and transformative justice. Fugitive abolitionist approaches often start with alternative kinship-like relationships (such as othermothers, ballroom families, etc.) and radicalize them further, in contrast to how Lewis and Hester relate to radical care practices.[78] They hence attempt to unsettle and replace the prison industrial complex with *something* (rather than, in Lewis's care,

75 Marquis Bey, *Anarcho-Blackness: Notes Toward a Black Anarchism* (Chico: AK Press, 2020), 28–29.

76 Silva, *All Incomplete*, preface, 11.

77 Ibid., 7.

78 Bey, *Black Trans Feminism*; Harney and Moten, *The Undercommons*; Alexis Pauline Gumbs, China Martins, and Mai'a Williams, *Revolutionary Mothering: Love on the Front Lines* (Los Angeles: PM Press, 2016).

nothing) that gives—which is why Ruth Wilson Gilmore insists that "abolition is presence, not absence."[79] The difference with a communist utopia is that in the undercommons, speculative futures are the "thing that we preserve by inhabiting," and, while unfathomable from the outside—"policy can't see it, policy can't read it"—, they do not rely on a utopic "nothing," but are in fact "intelligible if you got a plan."[80] For Moten and Harney, the undercommon networks of radical care and mutual aid are a "ceaseless experiment with the futurial *presence*," where life *otherwise* is already taking place:[81]

> In the undercommons of the social reproductive realm [...] the plan is to invent the means in a common experiment launched from any kitchen, any back porch, any basement, any hall, any park bench, any impoverished party, every night. This ongoing experiment with the informal, carried out by and on the means of social reproduction, as the to-come of the forms of life, is what we mean by planning; planning in the undercommons is not an activity, not fishing or dancing or teaching or loving, but the ceaseless experiment with the futurial presence of the forms of life that make such activities possible.[82]

Abolitionists would hence argue that there are people who are already raising children well, who are already attending births respectfully and without violence, who know how to provide both physically and emotionally safe abortions—who are already constituting another version of the human within their networks, because anthrogenesis, within these otherworlds, is already liberating—all of this is already happening now, and not after a revolution. Within the feminist experiments that are carried out by (other) mothers, midwives, doulas, activists, and abortionists, they are already figuring out, in the generative time of "futurial presence," how to care for each other without being violent.[83] By affirming radical care and mutual aid and putting it at the center of our efforts to liberate anthrogenesis, we would be able to see that the place where reproductive justice exists is in fact already

79 Ruth Wilson Gilmore, "Making Abolition Geography in California's Central Valley," *The Funambulist* December 20, 2018, https://thefunambulist.net/magazine/21-space-activism/interview-making-abolition-geography-california-central-valley-ruth-wilson-gilmore.

80 Harney and Moten, *All Incomplete*.

81 Harney and Moten, *The Undercommons*, 75, my emphasis.

82 Ibid.

83 Dána-Ain Davis has a thorough analysis of doula work and mutual aid and radical care that goes beyond birth work, presented during the *Reproductive Justice Network Lecture Series 2022* and the *Humanizing Birth Summer School 2022*.

among us, despite the constant threat of prosecution, loss of autonomy, and disciplinary restrictions. Utopia, in other words, does not need to be imagined, it just needs space to breath, to grow, and to multiply. What makes fugitive abolition unique within the current resurgence of radical activism on the left is that rather than aiming to *take over* the means of production, it attempts to abolish the institutionalized commons *through* the building of these alternative social relations that subvert institutionalized practices, aiming to deem the institution unnecessary and dismantle it in the process. Abolitionist thinkers hence argue that rather than reorganizing the public commons, it is about fleeing to the already existing undercommons of anthrogenesis as a way "to be communist about communism," meaning to be "unreconstructed about reconstruction" and "absolute about abolition," i.e., to stick with the undercommons resisting the persistence of the modern institution.[84]

Moten and Harney's undercommons thus aims to combine precisely the two aspects that are unique to the Black radical tradition, namely the concepts of abolition and fugitivity. They attempt to expand the concept of marronage from meaning purely the otherworld that is constituted outside of the institution from the flight from slavery, to a holding onto an outside, being complicit in it, *while* living in the world and its institutions that we have today.[85] Since these institutions are still characterized by the past of slavery, and continue to bio- and necropolitically reproduce racial capitalism, Moten and Harney argue that it is possible to draw an analogy between the fugitive planning of the maroons and the fugitive planning that happens in current modern institutions, like the university. Fugitive planning in the university builds, or rather taps into, another world; the undercommons,

84 Harney and Moten, *The Undercommons*, 82.

85 "[U]nderstanding this regime as a plantocracy thriving in the individuating violence of democratic despotism does not lead to the thought that there is no outside to the world. [...] It leads to finding some land to share and with which to share. Because in the face of this despotism we need somewhere to really care, which is the collective destruction of the interpersonal, and with and through it the delusion of the individual, in open practices of welcome and visitation. That cannot be done in conflict with the plantocracy, where the interpersonal, or freedom, or non-fascist living, becomes our faulty weapon. It is a battle that can only be won in the militant, self-defensive, self-annihilative retreat of the new attackers. And given the nature of the rule under plantocracy, retreat means finding land that is fugitive from the rule over land, water, air, etcetera, and then setting that land up anautonomously enough to start the treatment. That land may be a squatted garage in the city or an abandoned mill in the countryside. That treatment may entail forming a band, hosting a barbeque, a dance and a drink. It may be a farm and a daycare, an experimental writing collective, or a mechanics shop. Any form of detoxification from the interpersonal. There will be no allies, no citations, no counter-portraiture. Every aggression will be massive. And when we win, blackness will rain in sun showers while the time disappears." See: Harney and Moten, *All Incomplete*, 121.

where "study" is liberated from its captivity in the university. By liberating study through fugitivity, i.e., by practicing it beyond the university, it "undoes" the university that relies on study as its core practice, and is hence a project of abolition. Rather than going back to the fugitive communities of the maroons that exist fully outside of the institutions of the plantocracy, in the undercommons fugitivity takes on a more fluid form. Precisely because it is not a total exodus, it can simultaneously amount to the abolition of the institution by being complicit in a fugitive outside:

> we are in the institution, complicit with others who are not there in the institution, conspiring with them while inside, tangled up in the institution with the thought or the sound or the feel of the outside, which is in us, which we share in this sharing with, this ongoing folding with, this unaccomplishable com + pli. That kind of complicity can be deepened even as we deepen our place in, as we dig down through, the institution. We can provoke here not a strategy of within and against, but a way of living that is within and against strategy, not as a position, relation, or politics, but as a contradiction, an embrace of the general antagonism that institutions feed off but deny in the name of strategy, vision, and purpose. Our complicity refuses the purposive as its own reward and the more it grows the more the underlying entanglement of the institution overwhelms its strategy. We will have been violent to, or malignant in, the institution, cutting it together apart into nothingness.[86]

There is hence a specifically abolitionist, or, as Joy James would have it, militant call,[87] as the undercommons aims to dismantle the institution fully through a shared complicity. The undercommons hence consists of an active refusal of the policy of the institution, a form of "squatting"—an active (or activist) transgression. The undercommons is part of Western modernity, but only as its outside and its abolitionist resistance. As Moten and Harney put it: "the undercommons is not a collection of individuals-in-relation, which is precisely how the commons has traditionally been theorized. Instead, it is the sociality of sharedness and incompletion that the commons where not able to regulate, capture, differentiate, reproduce."[88] As such, it is not

86 Harney and Moten, *All Incomplete*, 125.

87 In *Revolutionary Love*, Joy James lays out the four stages of revolutionary love of the captive maternal; 1) conflicted caretaker, 2) movement builders, 3) marroon communities, 4) militant war resisters. Here, too, care, fugitivity and abolition are hence connected. See: Joy James, *In Pursuit of Revolutionary Love: Precarity, Power, Communities* (London: Divided Publishing, 2023), 16.

88 Harney and Moten, *All Incomplete*, 122.

necessarily tied to the university per se, but can be understood as a specific struggle tied to any institution or oppressive structure of modernity, as its specific resistance, as that which is left after institutionalization, typically in the form of sociality, refusal, mutual aid, resistance, and unwatchability:

> The undercommons is not, except incidentally, about the university; and the undercommons is crucially about a sociality not based on the individual. Nor, again, would we describe it as derivative of the individual—the undercommons is not about the dividual, or the pre-individual, or the supra-individual. The undercommons is an attachment, a sharedness, a diffunity, a partedness.[89]

This sharedness can be found in any institution or structure of Western modernity as its sociality that has escaped, *contra* Foucault, the subjectification processes that our modern institutions are biopolitically responsible for. The undercommons establishes "a worldliness that will not go away and, while remaining here, will not heed the world's rules."[90] It is, in other words, the power and the struggle of an *otherworld*.[91]

Ultimately, the question is whether radical care and mutual aid networks will prove transformative in their formation of new social relations and hence be able to achieve reproductive justice. Or whether they are a revolutionary utopia that will be able to transform the public commons and consequently forge new relations that can facilitate care characterized by reproductive justice. Are radical care networks, such as the Janes and abolitionist doula and midwifery practices more likely to constitute new social relations that will liberate anthrogenesis, or is it utopic grand-scale reimaginations that

89 Harney and Moten, *All Incomplete*, 124. Harney and Moten also point to the health sector on this page.

90 Marquis Bey, *Them Goon Rules: Fugitive Essays on Radical Black Feminism* (Tucson: University of Arizona Press, 2019), 18.

91 For Silva, for instance, the project would be to abolish the world as we know it, in favor of a world as Plenum. She hence works towards the end of this world, which is, according to her, characterized by separability, determinacy and sequentiality. These three characistics are classic epistemic structures of modern institutions, such as those of slavery an colonialism, but also the characteristics of education and even of critique. As there would be no institution or commons in the traditional understanding without reliance of separability, determinacy, and sequentiality, the approach to a different world must be anti-institutional and involve a practice of "difference without seperation" which echoes the shared life without individuation and hence without relationships, of the undercommons. See: Denise Ferreira da Silva, "On Difference without Separability," in *32nd Bienal de Sao Paulo. Incerteza Viva*, ed. Jochen Volz et al. (Sao Paulo: Bienal Sao Paulo, 2016), 57–65.

must preferably do so? It is a question of where the transformative potential of change lies in the case of doing anthrogenesis *otherwise*. But I think that it might be possible to further Firestonian communist thought not only as a communist amniotechnics, but, in the undercommons, as a fugitive anarcha-abolitionist one, meaning to repurpose Firestonian gestational communism towards a Firestonian anarcha-abolitionist *undercommoning* of anthrogenesis. This would enable us to see that the mistake of the Janes was not their lack of scale or politics, nor their lack of capacity to seize and liberate anthrogenesis as gestators, nor their lack of utopic reimagination—their praxis *already was* political speculative generative reimagination. The only mistake that they made was that they quit, due to an ultimate reliance on the institution, misunderstanding themselves as doing the work of the state in times of crisis, like a band aid, rather than the fugitive work of the constitution of another world through abolitionist care.

Fugitive Abolitionist Care

> *Can you see us, feel us, hear us, catch us? Nah. Over here, and under here, where we be at* [...] *is all up in the cut, refusing to succumb, struggling, loving, living.* [...] *The emergence of our fugitive impulses will not be known by the proverbial "they"; our moves of fugitivity will go under, over, across, and beyond the radar.*
>
> -Marquis Bey[92]

What if abolition, as poet Alexis Pauline Gumbs asks, "isn't a shattering thing, not a wrecking thing, not a crashing ball event? What if abolition is something that sprouts out of the wet places in our eyes, the broken places in our skin, the waiting places in our palms, the tremble holding in my mouth when I turn to you?"[93] Marquis Bey defines abolition as:

> the political strategy of eradicating rather than reforming systems, discourses, and institutions that structure life and liveability. These systems (e.g., prisons, the gender binary, etc.) have at their foundation an ongoing violence that masquerades as banal or, worse, natural and good. Abolition, then, promotes a dismantling of these systems in search of life and liveability by other means not predicated on violence.[94]

92 Bey, *Them Goon Rules*, 155–156.
93 Alexis Pauline Gumbs, quoted in: Bey, *Black Trans Feminism*, 211.
94 Marquis Bey, *Anarcho-Blackness*, 91–92.

Bey then asks us as well: what if abolition is already happening in the mundane "minutiae of our living."[95]

Below, I will discuss two examples of what I understand to be the undercommoning of anthrogenesis in Amsterdam, the Netherlands, in the "mundane minutiae of my living," drawing your attention to some of the activists, mothers, and midwives there who are constantly shaping, fugitively planning, and making sure that we can abort and give birth otherwise. In choosing to draw my examples from Amsterdam, I am not claiming exclusivity or universality for this particular location, on the contrary; the choice to focus on the local, non-institutionalized networks is grounded in a standpoint epistemology that starts from the bottom up, from the relational and plural perspective of the autonomous, and marginalized, feminist subject position that is midwifery.[96] I choose this position because it is what I know, and my situated knowledge is therefore richer, and, according to both standpoint epistemologyand decolonial feminism, theory is best drawn from the specificity of socially situated perspectives.[97] The two examples discussed are informed both by prior empirical research and by my own experiences.[98] The first is a feminist network of birth activists, De Geboortebeweging (The Birth Movement), to which I am loosely connected, as an example of undercommons of knowledge and care and the fugitive planning of pregnant people; and the second is the Abortion Network Amsterdam that I am part of, and which is an example of transnational anarchic coalition building.

Rather than primarily fighting the institution, the mothers in my research who had experienced obstetric violence with their first birth organized themselves to make the care they needed possible outside of the obstetric institution, just like my friend from Germany did, understanding their pregnancy and birth as, in their own words, "an underground action that must remain hidden from the hospital."[99] Fleeing from the institution and

95 Bey, *Black Trans Feminism*, 211.

96 Kathi Weeks, *Constituting Feminist Subjects* (New York: Verso, 2018); Critical Midwifery Studies (CMS) Collective Writing Group, "A Call for Critical Midwifery Studies: Confronting Systemic Injustice in Sexual, Reproductive, Maternal, and Newborn Care," *Birth* 49 (2022): 355–359.

97 Vergès, *Decolonial Feminism*; Mohanty, *Feminism without Borders.*

98 My empirical research consisted of 31 individual semi-structured interviews, followed by six homogenous focus groups and six heterogenous focus groups. Data were analyzed using Thematic Analysis. Rodante van der Waal, Inge van Nistelrooij, and Carlo Leget, "The Undercommons of Childbirth and Their Abolitionist Ethic of Care: A Study into Obstetric Violence amongst Mothers, Midwives (in Training) and Doulas," *Violence Against Women* 0(0): 1–27.

99 Van der Waal et al., "The Undercommons of Childbirth and Their Abolitionist Ethic of Care."

finding their way to the undercommons started in their case, too, with a "refusal of what has been refused to you," which is, according to Jack Halberstam, a refusal "to ask for recognition" and instead wanting to "take apart, dismantle, tear down the structure that, right now, limits our ability to find each other, to see beyond it and to access the places that we know lie outside its walls."[100] Fugitivity is hence a "game changing refusal" of the choices offered, and a speculative reimagination of care.[101] Determined to take matters into their own hands, the mothers in my study planned their care with independent doulas, midwives, and open-minded obstetricians, and either immediately started looking for alternative care when pregnant, or after first going back to their old midwifery practice or hospital with new demands, only to be refused care altogether.[102] As one mother describes it: "it is an opting out, the building of a hill to fly away from, the making possible of a place from where you can go elsewhere."[103]

Marquis Bey understands fugitivity as a refusal of carcerality and captivity, "the living outside of time and civilization because it [fugitivity] yearns for something not legible in current frameworks."[104] Like many modern institutions, the obstetric institution is characterized by a carceral logic.[105] Carcerality is defined by Bey as a system that has a "penchant to proliferate capture and expropriation along racist and sexist axes […] via assumed ownership over racialized and/or non-masculinely-gendered subjects" resulting in a "circumscription of who is permitted to appear in public, regulation of movement and inhabitation of private space, and extraction of surplus goods and resources (be it labour, sex, sexual labour, time, etc.)," thus constituting a relationality that is dependent on "various mechanisms of confinement, punishment, capture, or circumscription."[106] Similarly, the carcerality of the obstetric institution manifests itself as the separation of people, circumscribing and confining them, punishing them by negating the care they need, humiliating them, and categorizing them (either based on medical knowledge or on prejudices)—all contributing to the isolation of pregnant people.[107] But also midwives, doctors, and abortionists fear carceral repercussions for providing care outside the law or protocols,

100 Jack Halberstam, in: Harney and Moten, *The Undercommons*, 6.
101 Ibid.
102 Van der Waal et al., "The Undercommons of Childbirth and Their Abolitionist Ethic of Care."
103 Ibid.
104 Bey, *Black Trans Feminism*, 216.
105 Van der Waal et al., "The Undercommons of Childbirth and Their Abolitionist Ethic of Care."
106 Bey, *Anarcho-Blackness*, 94.
107 Van der Waal et al., "The Undercommons of Childbirth and Their Abolitionist Ethic of Care."

forcing them to be complicit in the institution, constricting the plurality of possible ways of anthrogenesis.[108] Fugitivity is hence that which gives pregnant people and midwives a way out: "It is life that ain't got time for the purportedly validating gaze of white cisnormative patriarchy, choosing instead to imagine itself through itself, its own (non) rubrics, and creating something else."[109] In Keguro Macharia's definition, fugitivity is "seeing around corners, stockpiling in crevices, knowing the 'unrules,' being unruly, because the rules are never enough, and not even close."[110] And against common medical opinion that one of the negative consequences of obstetric violence is that mothers refuse to comply with hospital policy the next time around, mothers in my research organized the complex medical care cases responsibly and more safely than they could have under the protocols of the obstetric institution.[111]

In the Netherlands, there are multiple loose networks of alternative midwives. There is a collaboration of independent caseload midwives (Samenwerkende vroedvrouwen), and there is De Geboortebeweging (The Birth Movement), a loose organization of mothers, midwives, and doulas that emerged from increasing dissatisfaction with obstetric care.[112] Concerned with the lack of autonomy of pregnant people, obstetric violence, and the disciplinary nature of the obstetric institution regulated by logistics and protocols, De Geboortebeweging started small with a couple of midwives, doulas, and mothers, and expanded over the years. They do actions, but also have a phone service attended by midwives that is available around-the-clock, and a large nationwide network of midwives, midwifery practices, hospitals, and obstetricians who are willing to go outside of regular care to facilitate what the pregnant person in question needs. As such, the network organizes radical care on the peripheries of institutionalized obstetrics. This undercommons of birth exists both outside and within the obstetric institution—"the institution cannot necessarily be excluded from the undercommons it tries so hard to exclude."[113] However hard it tries to keep midwives out of its doors or pregnant people with the wrong birth plans outside of its labor wards, the

108 Ibid.

109 Bey, *Black Trans Feminism*, 212. See also: Akwuho Emejulu, *Fugitive Feminism* (London: Silver Press, 2022); Stephen Dillon, *Fugitive Life: The Queer Politics of the Prison State* (London: Duke University Press, 2018).

110 Keguro Macharia, quoted in: Bey, *Them Goon Rules*.

111 Van der Waal et al., "The Undercommons of Childbirth and Their Abolitionist Ethic of Care."

112 Caseload midwifery is one-on-one independent midwifery care, rather than team-based midwifery care. See: https://www.geboortebeweging.nl.

113 Harney and Moten, *The Undercommons*.

obstetric institution as a commons of healthcare is a resource that will and can be used to undercommon the care that we need. The Facebook pages of De Geboortebeweging and Samenwerkende vroedvrouwen contain knowledge and facilitate ongoing discussions and questions for help. Within these networks, junior midwives are also assisted by senior alternative midwives in setting up alternative care practices supporting them with both the practicalities and intellectual and emotional support in complex cases. As such, it is a vast undercommons of knowledge which helps not only mothers, but also midwives and midwives in training to find knowledge on pregnancy and birth they would not otherwise reach. In this way, it makes it possible to strengthen their autonomous vision and practice that is often challenged in the places where they work and learn—contributing to an undercommoning not only of knowledge, but also of experience and professional subjectivity.

The Abortion Network Amsterdam (ANA) is another example of an undercommons of anthrogenesis. One that is again local, but not restricted to the borders of nation states, nor itself circumscribed by the borders of its own organization.[114] ANA provides help in arranging abortions for pregnant people, mostly from Poland where abortion is highly restricted, but also from other European countries where abortion is more restricted and difficult to access than one might think; the Netherlands is the only country in continental Europe where you can get on-demand abortions until 22 weeks of pregnancy. ANA is part of the coalitional Abortion Without Borders (AWB) network that contains multiple other European organizations in different countries—the undercommons can hence achieve transnational scales. After the 2020 ruling in Poland that made abortions nearly completely illegal, AWB helped 32,000 people in one year, either in Poland or abroad.[115] As a transnational coalition, AWB is able to fund all abortions needed if people cannot pay themselves. To give you an idea: in the Netherlands, an abortion between 18 and 22 weeks costs approximately 1,300 euros, excluding travel and accommodation costs. ANA started out as an anarcha-feminist. "Anarchic" means the absence of a first principle, a unique factor, or a decisive origin, and hence the absence of the equation of a first principle with command and hierarchy.[116] Chiara Bottici sees the vitality of anarchafeminist organizations in their capacity to display order without an orderer and "to transcend state boundaries and methodological nationalism."[117] It is a way to exist in the world "where our

114 See: https://abortionnetwork.amsterdam.

115 See: https://abortion.eu/#about.

116 Chiara Bottici, *Anarchafeminism* (London: Bloomsbury Academic, 2022), 58.

117 Ibid., 15.

existence is predicated on how we aid each other mutually" and "concede to a non-coerced ethic of opacity."[118] The undercommons of anthrogenesis relies on a strictly non-hierarchical organization similar to what Alexis Pauline Gumbs would call a "school," after a school of dolphins, that has no established hierarchical order but where sometimes some swim in the front, then at the back, then at the visible surface, and then in the deep.[119] This does not mean that the undercommons is chaotic, but that it is organized as a sociality that resists every form of categorization but is willing to go along with the opacity of both the organization and the pregnant person and their wishes. AWB does not ask people why they need what they need, nor does it judge them, but it just does its best to help them.[120] The anarchic character of the undercommons hence facilitates opacity and as such the radicalization of reproductive autonomy within networks of solidarity and mutual aid. The undercommons resists (or must resist) any tendency towards institutionalization.[121] Stefano Harney, for instance, critiques the move of autonomists to build an autonomists institution:

> I think you don't need to build an autonomist institution. You need to elaborate the principle of autonomy so you become even less of yourself; or you overflow yourself more than what you're doing right now. You just need to do more of the shit that you're doing right now and that will produce the scale. […] I'm interested in the way that a deepening of autonomy […] is a deepening of scale.[122]

The fugitivity of both ANA and of the alternative midwifery networks is ultimately possibly most fiercely dedicated to an extension, protection, and

118 Ibid.

119 Additionally, Gumbs takes five lessons from these dolphin pods, that are very reminiscent of the undercommons of anthrogenesis; 1) roll deep, 2) better together – just like Bey, Harney, and Moten she aims for a dangerously radical inclusivity – 3) we can be seen on our own terms, 4) do your depth work, 5) be ready to transform. See: Alexis Pauline Gumbs, *Undrowned: Black Feminist Lessons from Marine Mammals* (Chico: AK Press, 2020).

120 Of course, this does not mean that there can be no violence in collectives, communities, and forms of mutual aid. It is not a protection against violence per se, but it is a subversion of the structural and systemic violence we already know too well. Scale and anarchic sociality might not be everything, but is of fundamental importance, because it resists policy, management, and supervision, and makes the violence that does manifest itself addressable, which it is not in Kafkaesque institutions that never seem to be able or willing to change their policies.

121 For a book-lengthy defense of a variety of forms of reproductive autonomy with ART, abortion, pregnancy etc., see: Emily Jackson, *Regulating Reproduction: Law, Technology, and Autonomy* (Oxford: Hart Publishing, 2001).

122 Harney and Moten, *The Undercommons*, 146.

hence indeed "deepening" of reproductive autonomy. So much so that this becomes a reimagination and reconstitution of anthrogenesis itself, and hence of the production of humans *otherwise*, since we have to go much further out of the box, transgress many more moral and logistic boundaries, than we ever could have imagined. Autonomy is not "deepened" as transparency, but rather as a radical acceptance of what Édouard Glissant would call, the "right to opacity." It is this opacity of anthrogenesis that is taken in the undercommons as the basis for relational sociality, knowing that we do not have to understand the other to take risks with the other. Opacity is an anti-enclosure, anti-captivity, and anti-regulation kind of sociality.[123] Opacity as the deepening of autonomy affirms the unwatchability of birth. It means resisting the urge to feel where the head of the baby is, trusting the one laboring that they will know what to do—birth being one of these things that will only be able to unfold in liberaty if it is not being watched—but also giving up control over abortion pills, imagining a world in which they are available in the supermarket or on the street corner: known amongst reproductive justice activist as the "boring future of abortion."[124]

Fugitive planning is hence not only doing the same thing—the "real," or as Moten and Harney say the "actual," thing—elsewhere.[125] It is not to merely have a non-violated birth or the abortion that you would otherwise not have been able to have. Rather, as Bey argues, fugitivity "more *substantially, fertilizes the conditions of possibility for otherwise and unsung and unknown emergence.*"[126] By fleeing to the undercommons, one also flees the disciplining of gender and racialization that is at the crux of anti-abortion policies and the disciplining of childbirth, keeping the leaking, roaring bodies in labor in the confinement of quiet and docile femininity.[127] The undercommons of anthrogenesis, then, is an anarchic femininity, as Bey would put

123 For a theoretical elaboration on Glissant's poetics of relationality and concept of opacity, see chapter 10.

124 As Bey has it, the undercommons is the "subversive place where the revolution radicalizes revolution, a place inhabited by folks who came together illegally and unexpectedly because they operated according to other ways of relating. We still, always, do abolition today and tomorrow as subversive intellectuals, feminist killjoys, Black radicals, 'nasty women,' activistic accomplices, muhfuckin' goons." There is hence a specific epistemic furthering of revolutionary thought that is idiosyncratic to the undercommons because of its different sociality, its refusal to follow rules, and the plurality of its members. See: Bey, *Them Goon Rules*, 105. See Asia Bordowa's "The Boring Furture of Abortion" here: https://www.makeinroads.org/get-involved/fellowships/past/Asia

125 Bey, *Anarcho-Blackness*, 26.

126 Ibid., original emphasis.

127 Sara Cohen Shabot, "Making Loud Bodies 'Feminine': A Feminist-Phenomenological Analysis of Obstetric Violence," *Human Studies* 39, no. 2 (2016): 231–247.

it.[128] Moving and screaming when one wants, doing abortion with pills and friends at home, is transgressing the deep act of gendering that takes place at the vulnerable event that is our ability to gestate. Fugitivity, and especially, I would add, when concerning anthrogenesis, is, as Bey has it, a form of gender radicality, of gender abolition, exactly because we provide a relational space to let ourselves become, experiment, and break away from the cisnormative patriarchy that the law and the institution inscribe upon us during these specifically fluid events. Small-scale grassroots mutual aid networks that fugitively undercommon anthrogenesis via radical care are abolitionist in the sense that their care "looks like self-defence" but is, in fact, "radically transformative."[129]

If we truly want to do anthrogenesis *otherwise*, the undercommons gives us a chance to let a sociality that consists of non-subjectivist social relations enter us, and through this surrogacy that we are shared by, resist the capture, demarcation, individualization, confinement, gendering, and isolation that come with pregnancy. Contrary to the public commons which is characterized by the interpersonal relationship—that is a relationship between two separate individuals that can be described as "as a set of resources and relations that we, as otherwise exploited and expropriated people, build or protect, manage or exploit,"—the undercommons is the life that is already shared:

> The undercommons is the refusal of the interpersonal, [...] is to live incomplete in the service of a shared incompletion, which acknowledges and insists upon the inoperative condition of the individual and the nation [...] something underneath the individuation that the commons bears, and hides, and tries to regulate. It is what is given in the impossibility of the one and the exhaustion of the very idea of the one.[130]

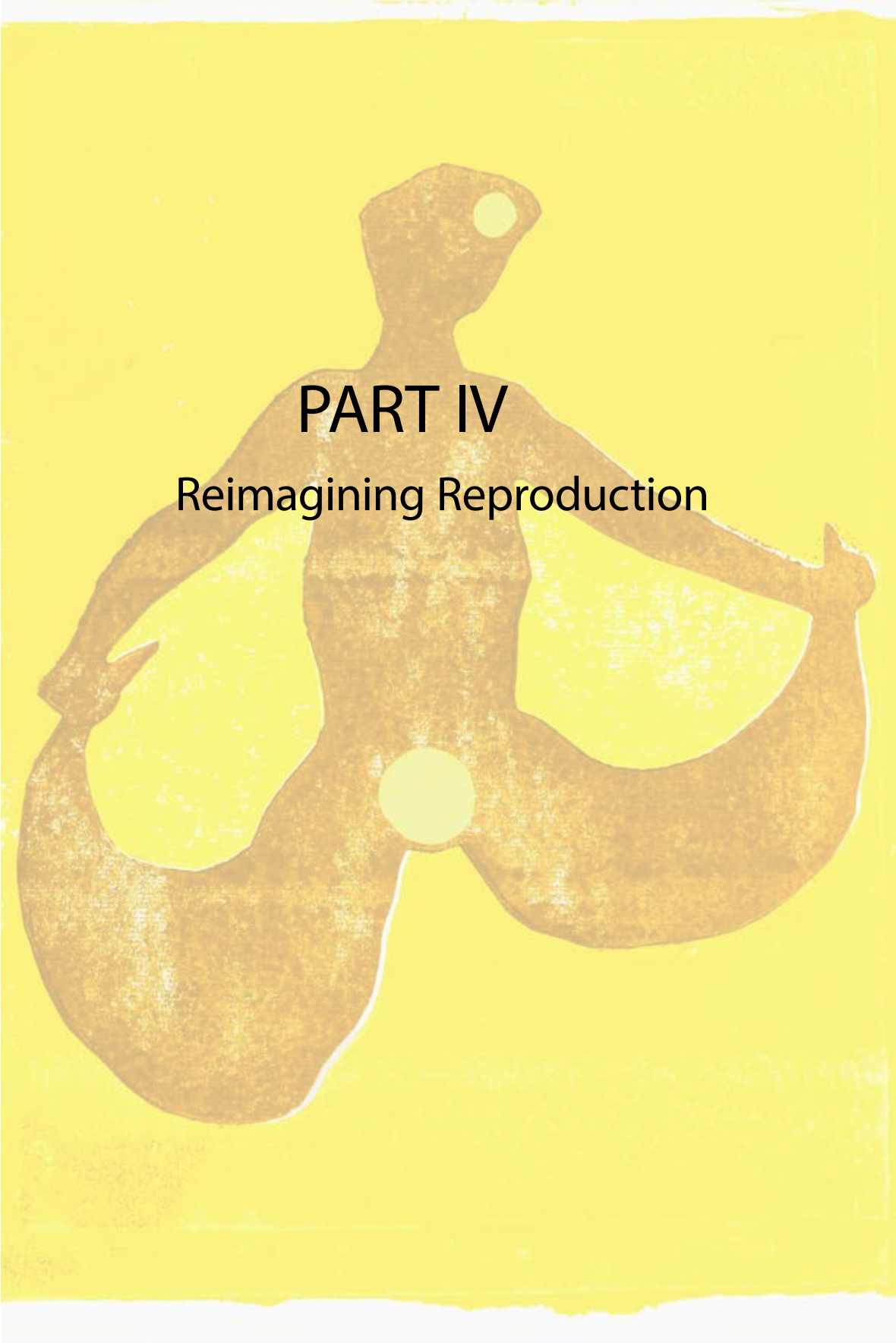
Pregnancy, as such, is already the undercommons of Man, and is already the undercommoning of the subject, since pregnancy, too, is "given in the impossibility of the one," and always already was "the exhaustion of the very idea of the one." Pregnancy is already the undercommoning of reproduction, since the reproduction of Man as it is has always proven to be impossible, even with all the disciplinary violence in the world. If we truly want to do anthrogenesis *otherwise*, we can further avow ourselves to the unwatchable,

128 Bey, *Anarcho-Blackness*, xx.
129 Bey, *Trans Black Feminism*, 215
130 Harney and Moten, *All Incomplete*, 122.

ungovernable shared sociality of birth, before the call to order manifests itself. One mother told me how she was giving birth, fully in the rhythm of her contractions, together with her husband who was holding her as she was bearing down and leaning on to him, together engaging in a communal pushing, which was interrupted as soon as the nurses and midwives from the hospital "heard" her bearing down, and they forced her onto the bed, putting her legs in the stirrups, pushing the husband aside, while screaming at her how and when to push. She dissociated, and the undercommon sociality in which they were birthing her child was disrupted and overridden with policy as they captured her.

Doing anthrogenesis *otherwise* would mean to stay in the undercommons, refusing the call to order, but tune into the undercommoning groove as midwives, and then all be together in the undercommons militantly, as abolitionists, to deepen the opaque autonomy of anthrogenesis. Such as in the case of the women prisoners, who built a shield of opacity to resist the enclosure of Debbie Africa who secretly gave birth in prison, by making so much noise around her cell that her labor and the cries of the baby went unnoticed for days, so that she could birth freely and she and her baby had more time to spend together.[131] Marquis Bey stresses that we not only tap into the undercommons—which they characterize as both "justice," "non-utopic utopia," and a "sanctuary"—for care, community, revolution, and sociality, but that the undercommons taps into us, and that we must let it change us, the undercommons is not "a place you enter but a groove that enters you."[132] The undercommon "insurgency" makes "its own demands […], stealing life so it can steal more life,"[133] and therefore seems to be the perfect non-place for doing anthrogenesis *otherwise*. "Undercommoning" anthrogenesis, as a verb, a practice, would mean what birth attendants have already known forever, namely to let pregnancy be, and only ever intervene to answer a call of autonomy, and only tune in and become part of the event of birth if it is in such a way that it also shares your life, so that we know, together, when to push, when to sigh, and when to roar.

131 Gumbs, *Undrowned*, 34.
132 Bey, *Anarcho-Blackness*, 27–28
133 Ibid., 31.



PART IV

Reimagining Reproduction

Intermezzo. Boring and Undisturbed Reproductive Futures

The artist Asia Bordowa describes the boring future of abortion as a future where abortion is seen as a normal experience, where the legitimacy of abortion is not constantly questioned and where abortion activists can devote their time to something else. Artistic and activist imaginal politics are important parts of the reimagination of issues that are steeped in epistemic and moral injustice. When we reimagine reproduction for a reproductive justice to-come, we can reimagine a new future, we can hack or make explicit stories that form us from the past. When asked about the future of abortion, we dream of it being boring; with abortion pills free of stigma, available at gas stations and in vending machines.

Having abortion pills readily available in one's house would blur the boundary between being and not-being pregnant, making room not only for a flourishing of self-determination but also for a more personal kind of sense-making when it comes to the relationality of oneself and one's fertility. Abortions must be boring, not to minimize the experience, but because when abortion is boring in society, there will be room for personal sense-making. It would no longer be taboo in the community and this openness would take away the isolation of the experience. Instead, it would be something normal, part of daily life, of chilling and caring for friends, in between gossip and love lives.


...Petrol at #5 and also vegan hot-dog and abortion pills...
SPECIAL OFFER
BITE
asia bordowe

Asia Bordowa, *The Boring Future of Abortion*, 2022[1]

1 Translation from Polish: "So, I come on Saturday, we do your abortion and I tell you everything about my new girlfriend!" "Great, come at 12.00, I will take my mife on Friday at 12.00. Can't wait for all the gossip!"

Natalie Lennard, *Birth Undisturbed Series*, *Aquadural*, 2017-2028

When you ask midwives how they see the future of childbirth, they, similarily say, "undisturbed." *Birth Undisturbed* is a series of photographs of fictional childbirth scenes by the artist Natalie Lennart. Of course, undisturbed is "boring" as well, in the same sense that "boring" also means "undisturbed"—free from policing or any call to order. With Lennart, this sometimes consists of making the hidden nature of birth explicit, as with one of the most famous but nevertheless rarely depicted births in the world: the birth of Jesus, or with a true underwater birth.

Both reimagination projects aim to abolish all the necessary disturbance of abortion and birth, dismantle over-medicalization, criminalization, and medical gatekeeping. In place of disciplinary laws come intimacy, privacy, and community. In this last part, another attempt at reimagination is orchestrated, focusing on both key relationships. The first two chapters reimagine the relationship between the (potentially pregnant) person and their community of care, in our case the midwife. First relationality itself is both studied and enacted in the form of a fictional symposium, based on empirical data, and then, a somatophilic relation with the reproductive body is sketched, through the conceptualization of "midwifery thinking." The last chapter is a reimagination of the relationship between the person

Natalie Lennard, *Birth Undisturbed Series*, *The Creation of Man*, 2017-2028

and their capacity for pregnancy, which has consequences for our traditional configuration of the subject. Both these reimaginings aim to be boring, and undisturbed, and should provoke similarly visceral scenes as the ones above, albeit in text.

10 Specter(s) of Care: A Symposium on Midwifery, Relationality, and Reproductive Justice to-Come

Rodante van der Waal[1]

Abstract

Nearly 2500 years ago, Plato wrote of a symposium about love. This symposium was attended by Socrates, the founder of "maieutic" philosophy, a name owing to the comparison of his profession to that of his mother, a *maia*, meaning midwife in ancient Greek. The kind of relational continuity of care that midwifery could have represented in ancient times is something that we have long lost. The symposium below, written 2500 years later, is an attempt to reconceive of *care* for fertility, abortion, pregnancy, and parenthood. Through a combination of hauntology, critical fabulation, and decolonial empirical methodology, *a specter of care* is staged in the figure of midwife Phaenarete, Socrates's mother, who engages in dialogue with current day midwives and mothers.

Keywords

Symposium, hauntology, critical fabulation, Édouard Glissant, decolonial empirical methodology, obstetric violence.

1 A prior version of this chapter was published as Rodante van der Waal, "Specter(s) of Care: A Symposium on Midwifery, Relationality, and Reproductive Justice to-Come," *Frontiers: A Journal of Women's Studies* 44 (2) 2023: 98-123: https://muse.jhu.edu/article/902528.

Waal, van der, R., *Birth Justice. From Obstetric Violence to Abolitionist Care*. Amsterdam: Amsterdam University Press 2025
DOI: 10.5117/9789048562398_CH10

The Specter of Midwifery Care

> *Being haunted draws us affectively, sometimes against our will and always a bit magically, into the structure of feeling of a reality we come to experience, not as cold knowledge, but as transformative recognition.*
> —Avery Gordon

As Saidiya Hartman famously said, care is the "antidote to violence."[2] But there is a discrepancy between what we imagine care to be and how care is practiced, given that our most important institutions of care perpetuate various forms of violence.[3] Current systems supposedly delivering care are in fact just as violent as they are safe, and are just as exclusive to some people as they are inclusive of others. Often, this has to do with a lack of relational care. Relationality, or the way we are *together* rather than as separate entities, ultimately structures the scope, accessibility, and potential of care, for it transfigures who is worthy of being related to, and hence demarcates who is part of a common "humanity."

Relationality has been analyzed thoroughly in care ethics and broader theories on care. The focus, however, has mostly been either on the ontological nature and phenomenological experience of relationality or on the place of relational care within political society.[4] It has rarely been theorized as a political force that can either be constitutive of a radically different world, or reproduce the violence of the hegemonic world in which we live. Relationality can make care an exemplary praxis of being human together *otherwise*—"human" here understood in Sylvia Wynter's conception of the term as a transgression of the exclusionary hegemonic subject of Man. But relationality can also be the affective materiality through which the

2 Saidiya Hartman, *In the Wake: A Salon in Honour of Christina Sharpe*, BCRW Videos, Streamed live February 2, 2017, at Barnard College, Vimeo, 1:34:41, https://vimeo.com/203012536.

3 Harriet Washington, *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present* (New York: Harlem Moon, 2006); Khiara M. Bridges, *Reproducing Race: An Ethnography of Pregnancy as a Site of Racialization* (Berkeley: University of California Press, 2011); Sameena Mulla, *The Violence of Care: Rape Victims, Forensic Nurses, and Sexual Assault Intervention* (New York: NYU Press, 2014); Loretta Ross and Rickie Solinger, *Reproductive Justice: An Introduction* (Oakland: University of California Press, 2017); Dána-Ain Davis, *Reproductive Injustice: Racism, Pregnancy, and Premature Birth* (New York: NYU Press, 2019).

4 Eva Feder Kittay, *Love's Labor: Essays on Women, Equality and Dependency* (New York: Routledge, 2019); Joan Tronto, *Moral Boundaries: A Political Argument for an Ethic of Care* (New York: Routledge, 1993); Joan Tronto, *Caring Democracy: Markets, Equality, and Justice* (New York: New York University Press, 2013); Catriona MacKenzie and Natalie Stoljar, *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self* (Oxford: Oxford University Press, 2000).

bio- and neccropolitical racialization of late neoliberal capitalism is carried out via willful neglect, forced separations, or toxic authoritative relations. Because of the decisive role relationality has in determining whether care is indeed the *antidote* to violence or whether it is by contrast itself violent, relationality in care should be understood as a revolutionary question and hence as a matter of justice to-come.[5] If it is violent, it is the vehicle through which oppression is reproduced. But if it is not, it lends care the possibility to radicalize the communal connectivity and dependency through which we are human together, and transgress the exclusionary borders of our subjectivity. In this case, care could indeed be the antidote to violence through which we can build a different world.

In this essay, I put relationality center-stage; not as an ontological, epistemological, or a phenomenological question, but as a *revolutionary* one. I hence understand relational care as possibly holding the potential of restructuring the world, while at the same time being the connective affectivity that can be captivated and disciplined to restrict potential for living *otherwise*. The type of care that informs the case study on relationality here is midwifery. Midwifery—accessible and continuous care within one's own community during fertility, pregnancy, childbirth, and postpartum—is an ancient and deeply relational practice defined by continuity of care, equality between care giver and care receiver, slow time, and emotional safety. While it has been mostly appropriated into the obstetric institution, midwifery still has a distinct philosophy of care that stands in stark opposition to obstetric care. Obstetric care is characterized by medicalization and industrialization, severing almost all relational aspects that are present in the philosophy of midwifery, leading to obstetric violence, obstetric racism, inaccessible abortion care, and disproportionate mortality and morbidity rates in marginalized groups.[6] Many studies have shown that the relational

5 Bini Adamczak, *Beziehungsweise Revolution. 1917, 1968 und kommende* (Berlin: Suhrkamp, 2021).

6 Critical Midwifery Studies (CMS) Collective Writing Group, "A Call for Critical Midwifery Studies: Confronting Systemic Injustice in Sexual, Reproductive, Maternal, and Newborn Care," *Birth* 49 (2022): 355–359; Elizabeth Newnham, Lois McKellar, and Jan Pincombe, "Paradox of the Institution: Findings from a Hospital Labour Ward Ethnography," *BMC Pregnancy Childbirth* 17, no. 2 (2017); Sheena Byrom and Soo Downe, *The Roar behind the Silence: Why Kindness, Compassion and Respect Matter in Maternity Care* (London: Pinter and Martin, 2015); Dubravka Šimonović, "A Human Rights-Based Approach to Mistreatment and Violence Against Women in Reproductive Health Services with a Focus on Childbirth and Obstetric Violence, Note by the Secretary-General," *Report of the Special Rapporteur on Violence Against Women* (New York: United Nations, 2019); Jean Donnison, *Midwives and Medical Man: A History of the Struggle for the Control of Childbirth* (London: Historical Publications LTD, 1999); Meghan Bohren et al.,

philosophy of midwifery could be a solution to a myriad of problems in maternity health and care. Midwifery can prevent emotional, physical, and psychological trauma caused by reproductive and obstetric violence, as well as preterm birth through the building of a trusting relationship which reduces stress and anxiety.[7] Culturally attuned midwifery and maternity care can lower the morbidity and mortality rates that mothers and babies in marginalized communities suffer and defy obstetric racism.[8] But the historical expropriation of community-based autonomous midwifery has prevented the biomedical, psychological, and epidemiological evidence in its favor from affecting a critical assessment and a substantive change in the way we care for birth. Instead, the evidence in favor of community-based autonomous midwifery is doomed to exist only as what I call in this essay a specter of midwifery care.

A specter is something that is widely feared as a potentially dangerous occurrence that must therefore be prevented. It was made famous in philosophy, political theory, and revolutionary struggle through Marx's "spectre of communism,"[9] and Derrida's defense of it a century and a half later, in *Specters of Marx*.[10] According to Derrida, the specter of Marx is feared by the hegemonic powers of capitalism, which is why those who want a better, less violent, and more just world must stay faithful to the specter as an inherited call for justice. The only reason we should still be haunted by the specter of Marx, is, in Derrida's words, for a "justice to-come": "If I'm getting ready to speak at length about ghosts, inheritance, and generations,

"How Women are Treated During Facility-Based Childbirth in Four Countries: A Cross-Sectional Study with Labour Observations and Community-Based Surveys," *Lancet* 394 (2019): 1750–63; Saraswhati Vedam et al., "The Giving Voice to Mothers Study: Inequity and Mistreatment During Pregnancy and Childbirth in the United States" *Reproductive Health* 16 no. 1 (2019): 77.

7 Vedam, "The Giving Voice to Mothers Study"; Jane Sandall et al., "Midwife-Led Continuity Models versus Other Models of Care for Childbearing Women," *Cochrane Database of Systematic Reviews* (2016); Jill Alliman, "Strong Start in Birth Centers: Socio-demographic Characteristics, Care Processes, and Outcomes for Mothers and Newborns," *Birth* 46, no. 2 (2019): 234–43; Molly Altman et al., "Information and Power: Women of Color's Experiences Interacting with Health Care Providers in Pregnancy and Birth," *Social Science & Medicine* 238 (2019).

8 Brad Greenwood et al., "Physician–Patient Racial Concordance and Disparities in Birthing Mortality for Newborn," *Proceedings of the National Academy of Sciences* 117, no. 35 (2020); Alicia Suarez, "Black Midwifery in the United States: Past, Present and Future," *Sociology Compass* 14 (2020); Jennifer Almanza et al., "The Impact of Culturally-Centered Care on Peripartum Experiences of Autonomy and Respect in Community Birth Centers: A Comparative Study," *Maternal Child Health Journal* 26, no. 4 (2021): 895–904.

9 Karl Marx/Friedrich Engels, *The Commnuist Manifesto* (London: Pluto Press, 2008), 31.

10 Jacques Derrida, *Specters of Marx: The State of the Debt, the Work of Mourning and the New International* (New York: Routledge, 2006).

generations of ghosts, which is to say about certain others who are not present, or presently living, it is in the name of justice."[11] As Avery Gordon in her interpretation of Derridean hauntology puts it:

> To be haunted in the name of a will to heal is to allow the ghost to help you imagine what was lost that never even existed, really. That is the Utopian grace: to encourage a steely sorrow laced with delight for what we lost that we never had; to long for the insight of that moment in which we recognize, as in Benjamin's profane illumination, that it could have been and can be otherwise.[12]

Below, midwifery is similarly staged as a specter, embodied by Phaenarete, by whom we are haunted in the name of a reproductive justice to-come.[13] In Plato's *Symposium*, Socrates and his male companions spoke about love. While Socrates's mother Phaenarete must have known a great deal about love, she did not get a chance to speak her mind on the matter. Phaenarete is currently only remembered through Socrates's famous comparison of his philosophical method, maieutics, with his mother's profession—*maia* meaning midwife in ancient Greek.[14] Although the Socratic method was hence originally inspired by a praxis of *relational care* for sexual reproduction, it turned out to become the birthplace of Western thought and the individuated subject that comes with it.[15] Western philosophy thus started with the praxis, albeit not the voice, of Phaenarete, but subsequently abandoned the relational aspects of its heritage. And according to Toni Morrison, partly appropriating and partly abandoning something or someone, thereby not allowing it to live or die fully, is exactly the stuff of which ghosts are made.[16] So, while the men kept on talking, conquering, and institutionalizing, the world they created—a world increasingly characterized by violence—has been haunted by *a mother*, Phaenarete, and her relational praxis of midwifery care, ever since.

Borrowing from and subverting both Plato's *Symposium* and Socrates's maieutic method, this essay is a reimagination of what relationality can be were

11 Derrida, *Specters of Marx*, 3.

12 Avery Gordon, *Ghostly Matters: Hauntology and the Sociological Imagination* (Minneapolis: University of Minnesota Press, 2008), 57.

13 Ross and Solinger, *Reproductive Justice*.

14 David Sadley, *The Midwife of Platonism* (Oxford: Oxford University Press, 2004).

15 Sophie Lewis, "Free Anthrogenesis: Antiwork Abortion," *Salvage Zone*, accessed November 14, 2022, https://salvage.zone/free-anthrogenesis-antiwork-abortion/.

16 Toni Morrison, *Beloved* (New York: Vintage, 2004).

it to effectuate a reproductive justice to-come. Since "relation is not lived absolutely (it would deny itself) but must be felt,"[17] and since "relation" also means "narration" in French—an important detail for the Martiniquan philosopher of relationality Édouard Glissant—this exercise in reimagination is carried out in the form of a symposium as well. A symposium in which midwives and mothers think through the problematic of relationality in midwifery, in the presence of the specter of relational care embodied by midwife, mother, and ghost Phaenarete, and alongside the work of Glissant, to evoke a postcolonial poetics of relationality that can imagine reproductive justice.

A Note on Method and Positionality

In *Decolonial Feminist Research: Haunting, Rememory, and Mothers*, Jeong-Eun Rhee develops a methodology for qualitative research based on a study of the specter of our m/others, aiming to see what was destroyed, which traumas determine us but are forgotten, what has been lost but is worth fighting for, and how our ghosts can show us another way forward.[18] Rhee argues that if we are to take decoloniality and hauntology seriously, we need new empirical methodologies of "affective connectivity as decolonial feminist onto-epistemology"[19]—or, in other words, a felt relation to what is and is not there. As a feminist thinker, Rhee's object of analysis is the maternal, which is why she takes her own relation to her deceased mother as the starting point of an auto-theoretical study. Similarly, I center midwives as feminist subjects in a dialogue of "affective connectivity" with the specter of midwifery care. In doing so, I follow Derrida's notion that "what seems almost impossible is to not to speak always of the specter, but to speak to the specter, to speak with it, therefore, especially to make or let a spirit speak."[20] Derrida argues that "theoreticians or witnesses, spectators, observers, intellectuals, and scholars believe that looking [at the specter] is sufficient" which is why they are "not always in the most competent position to do what is necessary: speak to the specter."[21] Midwives, however, in contrast to scholars, have no choice but to speak to the specter, as they continue to try to practice relational care despite historical and current-day prosecutions and continuing expropriation. This essay thereby performs an affective

17 Édouard Glissant, *Poetic Intention*, trans. Nathanaël (New York: Nightboat Books, 2010), 17.
18 Jeong-Eun Rhee, *Decolonial Feminist Research. Haunting, Rememory, and Mothers: Futures of Data Analysis in Qualitative Research* (London: Routledge, 2021).
19 Rhee, *Decolonial Feminist Research*, 7.
20 Derrida, *Specters of Marx*, 9.
21 Ibid.

connectivity where a praxis and theory of care can work in tandem by staging care workers, who have been impeded and silenced by the overwork and disempowerment endemic to the medical industrial complex, as the primary thinking subjects at the center of a theoretical debate on care.

"All the characters and events are real, none have been invented," writes Saidiya Hartman in her book *Wayward Lives, Beautiful Experiments*.[22] Following Hartman's method of "critical fabulation," the symposium below is based on empirical data, albeit not archival sources such as in Hartman's case, but the lives and thoughts of five midwives and two mothers. A *fabula*, according to Mieke Bal, is "a series of logically and chronologically related events that are caused and experienced by actors."[23] Semi-structured in-depth interviews taken in 2020, lasting one and a half to two hours, and homogenous (e.g., consisting only of mothers, midwives, doulas, or midwives in training) and heterogenous focus groups (a mix of the groups listed above) lasting three hours, were analyzed through thematic and narrative analysis and used as *fabulae*, the basic elements of the story and argument. The characters in the symposium are hence based on the lives, thoughts, and interviews of the participants in my research, but the symposium itself is a fiction. Following Hartman's methodology, where direct quotes from the archives are written in italics, in the symposium below, the things that the characters did actually say themselves (albeit sometimes in slightly edited form) in interviews, focus groups or informal settings are similarly in italics.[24] All participants have received the opportunity to object to the way they were depicted or the way their quotes were used, and none of them did.

The "critical" part of "critical fabulation" consists of the synthesis of the *fabulae* into a theoretical exploration informed by critical theory, which in turn informs the narrative and theoretical argument. The symposium therefore works as a synthesis of the analysis of empirical data and a critical theoretical study; a transdisciplinary attempt at transgressing the strict methodologies of both qualitative research and theory. While Hartman's need for critical fabulation stems from the limits of the archive in providing access to the lived experience of the *past*, the need for a hauntological critical fabulation in the enactment below stems from the limit of ontology, phenomenology, and ethics to access a revolutionary *future*—that is, a future that would be able to facilitate a justice that is no longer to-come.

22 Saidiya Hartman, *Wayward Lives, Beautiful Experiments: Intimate Histories of Social Upheaval* (New York: W. W. Norton, 2019).

23 Saidiya Hartman, "Venus in Two Acts," *Small Axe* 12, no. 2 (2008): 11.

24 Hartman, *Wayward Lives, Beautiful Experiments*.

Identifying as a white, cisgender, middle-class, autonomous community midwife (she/they), who works both within the obstetric system as well as against it, and who is haunted by the specter of midwifery care, was not a matter of choice, in the same way that it was not for Rhee.[25] Rather, through a constant entanglement with a desire to care differently, and a deep frustration shared between pregnant people, parents, and fellow midwives of not being able to relate to each other *otherwise*, my awareness of the specter grew stronger and stronger with each birth I accompanied, oppressing the need to speak directly to what has been haunting us: to that relationality that we feel in each birth, but that stays invisible, unspoken, and, all too often, unrealized.

Specter(s) of Care

A Symposium on Midwifery, Relationality, and Reproductive Justice To-Come

> *To be born into the world, is at last to conceive* (*to live*) *the world as a relation: as a composed necessity, a consenting reaction, a poetics* (*and not a morality*) *of alterity.*
> —Édouard Glissant[26]

List of Characters

- Marianne, a white solo-practicing independent midwife and mother (she/her)
- Vivian, a Black solo-practicing independent midwife (she/her)
- Frances, a white community midwife and mother (she/her)
- Azadeh, a midwifery teacher and academic of color (no preference)
- Sallie, a white community midwife and mother (she/her)
- Adrienne, a white mother and artist (she/her)
- Claudia, a Black mother and singer (she/her)
- Phaenarete, a white midwife and mother

Frances quickly walked out of the hospital in Amsterdam. She had just finished her shift and could not wait to catch some fresh air.[27] It was 7 in

25 Rhee, *Decolonial Feminist Research*.

26 Glissant, *Poetic Intention*, 15, 31.

27 Frances (she/her) is a white Dutch independent community midwife who has worked as such in Amsterdam for thirteen years. She accompanies 30 births a month with her team of four midwives in their own practice.

the morning and getting light. Trying to wrap her head around what had happened that night, she sat down at the top of stairs outside. The early morning buzz, doctors and nurses running in to collect their uniforms, the palpable nerves of the students, all passed by her. Her thoughts were caught between scenes of the birth she accompanied, a water birth where the mother was able to catch her baby in her own hands, and an intense conversation in another labor room.

A couple of minutes later, Sallie, her fellow midwife who was taking over her shift, came running up the stairs.[28] "Hey, Frances, did it go well?" she shouted.

"Yes," Frances replied after a while, "but something strange happened." "Oh, you mean during the birth?" Sallie's tone of voice immediately switched.

"No, it is not that, the birth went well. But when I arrived at the birth center with a woman in early labor, I saw a couple of our colleagues running into the hallway. Their cheeks were red from the wind outside, and they were completely lost in their own thoughts."

"Hmm, strange, they came in as a group?"

"Yes. They told me that they had all received a phone call about half an hour earlier. The woman on the other end of the line had said something about a birth in the birth center, but the reception was bad and every few seconds they lost connection again. So, they had all decided to come in case something was wrong."

"And this woman rang multiple midwives?"

"Yes! When we entered the pink hallway of the birth center, she was standing in the middle, very old, and so thin and white that I could almost see through her. She ushered us in and said: 'Welcome, my friends, thank you for coming so quickly. This really is the benefit of meeting with midwives on call: you pick up your phones in the middle of the night and arrive within 30 minutes. We are gathering for a different reason than usual, however. Not to support someone giving birth, but to talk and think about midwifery care.'"

"How bizarre," Sallie said. "I am curious whether they are still there. I will go upstairs to help the parents shower and go home. Everything went well with the birth, you said, right?"

"Yes, yes, the birth went well. But wait a second, I haven't even begun my story. The parents are doing fine. They are enjoying their baby and are not in a hurry."

"Okay. Tell me then! What happened to you? You look like you have seen a ghost." Sallie sat down next to Frances on the crowded stairs.

28 Sallie (she/her) is a white Dutch independent community midwife who has worked as such in Amsterdam for thirteen years; she works in the same practice as Frances.

"Well, that is just it: I think I did. When the parents were settled in, I sneaked into the hallway and saw the midwives entering a labor room. There was a big couch, dimmed light, and someone had given birth not long before. The birthing stool was still standing in the middle of the room, and the bathtub was full of pink water. It looked like the room was left uncleaned—I could smell it even in the hallway. How to describe that deep smell after labor? Is it milk? Iron? Jasmine?"

"They were having a meeting in an uncleaned room?" Sallie interrupted.

"Yeah, strange, is it not? Then I heard someone say: 'Hey everybody, I'm Adrienne.[29] This room reminds me of the one I gave birth in a couple of years ago. *I was a 33-year-old woman, about to have a baby, but I had never seen a birth, never smelt, or tasted birth*, as I now feel it in the air of this room.[30] *When my children will be pregnant, I will advise them to be present at someone else's birth, or to at least try to get a glimpse of it*, like we do now. *I really stumbled into birth, sensing that I had entered a territory for which I was ill-equipped and inexperienced, and I would not wish that for anyone*.'"

"Hmm. And who were those midwives?" Sallie asked.

"Well, one of them was Vivian, can you believe it? Our former student!"[31]

"Really?" Sallie replied, baffled. "Of course, I remember Vivian, what did she have to do with it?"

"I don't know. But she was the one who immediately responded to this woman, Adrienne, saying something like: 'In this space still filled with birth, I can feel the laboring people and midwives of the past. I could swear that I can sense *all those midwives killed in the European witch hunts and the granny midwives of the US South who were forced out of their profession by obstetricians*.[32] But I can also grasp *the love of midwifery and that of people consenting to let birth overtake them*.'"

"And the old woman immediately affirmed what she said," Frances told Sallie: "'We should familiarize ourselves more with birth as a space haunted by ghosts, mothers, midwives, and births of the past—it could teach us something,' Vivian replied to Adrienne. All the while, I was standing at

29 Adrienne (she/her) is a white American artist, living in the Netherlands. She participates in multiple think tanks on obstetric care in the Netherlands and makes art that questions the way we give birth today. She is a mother of two.

30 All direct quotes from the interviews and focus groups are in *italics* and were translated and slightly edited by me.

31 Vivian (she/her) is a Black Surinamese Dutch independent caseload midwife of two years in Rotterdam. She trained as a doula before becoming a midwife.

32 Silvia Federici, *Caliban and the Witch: Women, the Body, and Primitive Accumulation* (New York: Autonomedia, 2004); Annie Menzel, "The Midwife's Bag, or, the Objects of Black Infant Mortality Prevention," *Signs* 46 (2021): 283–309.

the door peeking into the room. The towels that were wrapped around the baby were lying on the bed, full of vernix, and the placenta was in a bowl in the sink. 'Who was the midwife here tonight leaving a room messy like this? Was it you maybe?' Vivian joked to the old woman.

Everybody laughed and she replied, amused: 'No, I have not been practicing for over two and a half millennia. I asked the midwife who worked here tonight to leave the room uncleaned. I thought that it might be good to meet in the presence of a real postpartum, where the materiality of birth is still pressing against the walls and settling in the blankets of the unmade bed. That way we can smell and experience birth, exploring our topic with the help of what all your senses tell you about the fears and desires of your praxis. For me, it is also good to remember what it felt like, and to get a glimpse of how you birth these days. So, immediately after the parents went home, I asked you all to come here. Let us now sit down now. On the table I have arranged for tea and grapes. Please have some while I quickly explain my reasons for calling you to this symposium.'"

Frances kept talking quickly. She needed to tell the story to Sallie to see if she would believe what had happened; if what she had experienced could possibly have been real: "As I peeked into the room from the hallway, I saw them throw their coats and sweaters in the corner and sit down in the middle of this uncleaned birth-room and take a cup of tea.

Then the old woman started explaining emphatically: "I have invited you here because I know that all of you still know about the art of midwifery, which is more and more appropriated by the obstetric way of managing childbirth. I have haunted you in your practices for many years—you must have felt me—but it was not enough. Throughout the centuries, I have seen the suppression of the relational and communal way that midwives care for childbirth. Most recently in the witch hunts, slavery, the prosecution of traditional and granny midwives in the colonies of Europe, in the emergence of the obstetric institution, the industrialization of birth, and now in the untenable working conditions dictated by neoliberal capitalism. And I have concluded that feeling the presence in midwifery of the old idea of relationality as a specter, both as fear and desire, will not do for much longer: it is not going to change anything in these dire times. It is not enough. So I have used all my powers to become present—although I doubt I have strength for more than one night—so that we can make the specter that contains our desires a reality, and reimagine the relationality of our care.'"

"I could not help myself any longer," Frances recounted to Sallie, who looked rather puzzled. "I checked one more time on the laboring woman, who was still doing perfectly fine on her own, and I gathered my courage

and decided to enter the room and see if I could participate. I had to see this woman who now was introducing herself as 'Phaenarete,' the mother of Socrates and a midwife from ancient Greece."

"I can't believe it."

"No, me neither. But it's funny how the brain works. At that moment I just went with it. I knocked on the door and stepped into the room. 'Phaenarete? Hi, I'm Frances,' I stumbled, and then explained that I was accompanying a birthing couple in one of the rooms next door and that I could not help but overhear her reasons for coming here tonight. I told them that *I believe birth is a crucial experience, and that even though the birth of my own son did not go quite the way I had hoped, I still felt empowered because I was able to give birth to him on my own terms, and that I could do with that for a year, or that I might even be still living on that*. I told them how mothers tell me that they experience *enforced passivity, lack of control, repudiation from the staff, violence even, and that birth can be traumatic*. That I agonize daily over whether I, as a midwife, am resistant to or complicit in this violence. That *I try to unlearn the paternalistic training that I have internalized and resist thinking that I know what is good for her and try to relate to her otherwise*. And then, finally, I asked if I could participate in the discussion." But before Phaenarete could even reply, the mother, Adrienne, responded. She said, in a low, angry, but understanding voice:

"For me, *the whole confrontation with the obstetric system was bizarre*. I can only imagine how it must feel to work within it. *When I became pregnant, I thought that I had given childbirth a lot of attention, a lot of care and effort, that I could really do it, but once I entered the system of midwifery care, everything I felt and thought failed me. It was not even that I had a fight with the midwives or that we had a misunderstanding, but rather that we did not speak the same language, it was as if we had no relation at all. We were an actual mismatch, as if I was not allowed to be 'in relation' with anyone. I could not function as a thinking, feeling woman in the world of childbirth, there was no place*."

Adrienne explained further: "*Everyone had good intentions. But nobody was able to see me as an active participant in my labor. All the things I thought were true were being questioned, resulting in confusion, shame, self-doubt, and the sensation of losing ground under my feet—no one related to me. In my experience, it felt much more like I was being disciplined or corrected than cared for*. To change that, we would have to imagine a new kind of relationality that is fundamentally undogmatic and unresentful, I would say, and then *rebuild our whole maternity care system just to support that relation*. But what kind of relation should that be, that can resist all the violence and separation that is inscribed into our care by the world we live in?'"

Frances looked at Sallie: "And from that moment on I was part of the conversation."

"So Phaenarete just let you in the room?"

"Yes, without giving it a second thought. I told them what we also often talk about together. How I feel in my own hands *the presence of an excessive control that we in the maternity care system have over the laboring body. About how my hands are the memory of my many years of praxis, of all the births that I have accompanied*, of *my insecurity in the first years, the many cuts that I have made out of fear—something I never did in the last few years and will never do again*. But my hands remember. They know of the paternalistic tendency of wanting to minimize her power, foreclosing her capability to give birth. They still remember the determination to pull, cut, or scream the baby out of her—to deliver the mother *of* her baby. *But then, at the same time, I feel the presence of something else: the possibility of care, the possibility of being in relation with women, and sometimes, more and more often, it does materialize*. The other midwives recognized this strongly."

When Frances wanted to tell further, a pregnant woman walked past them on the stairs, sighing away her contractions, with a midwife walking next to her. "We are almost there. It is going well. We have time. You are doing great," the midwife repeatedly whispered while they walked in. Passing by Frances and Sallie, she smiled: "Going home? Tough night?"

"According to Phaenarete," Frances continued to Sallie while smiling and nodding to the midwife who passed by, "the figure of the midwife has a ghost-like presence, with one foot in an expropriated past, and another in an obstetric system that she did not design. Rather than longing back to a form of care that might have existed in a distant past, however, she wanted us to imagine a form of relationality of care suited for the future which can guarantee reproductive justice for all."

Sallie stared into the busy street in front of the hospital a while. "So, if I understand correctly, she is haunting us to challenge us to reimagine the way we relate to pregnant people to ensure reproductive justice for everyone?"

"Yes, I think so."

"Who were the other midwives?" Sallie asked, "Was there anybody I know?"

"Well, there was Marianne.[33] A quiet midwife whom I do not know. She was knitting on the couch and only started to speak when we were talking about the relationality of midwifery: '*For me, midwifery is being present with women during childbirth*,' she said, '*I knit my way through it in the corner*.'"

33 Marianne (she/her), MSc., is a Dutch independent caseload midwife of 20 years in the Dutch countryside.

"Knitting?" Sallie asked with a smile, "I am always happy to hear that others still do that as well."

"Yes." Marianne explained that knitting connects her both to the moment as well as to births and midwives from the past, since it is something that midwives have always done where she comes from: "Knitting consists of *being present while it also slows down my impulse to react, to intervene, to see what is going on* (*for instance if the head is already visible*), *and it helps me to not manage birth*—because my hands are doing something else, something rhythmical—*but to follow the woman into the flow of her birth. All my senses are open, as are hers. I listen very carefully, sometimes I see something. I encourage, I ask a question when I hear some fear in her voice, I make sure she feels supported by me, and is not alone*. Midwifery is a two-way street of trust in which not only the mother trusts the midwife, but in which the midwife must also trust the mother.[34] *It should be a partnership in which the midwives' power is only exercised together with the mother. In these times, we are focused so much on doing something, on handling things, that this idea of care as doing nothing, as just being present with somebody in their process, has become subversive. I believe it is the lost art of midwifery care. For when I do nothing, it is she who can birth*. I only knit a room of trust and safety and make sure it is not broken."

"Then Phaenarete said to her jokingly, 'You remind me of Penelope who, waiting for Odysseus, managed to keep the suitors off her body by weaving a shroud, which she took apart again at night. I did not know that weaving is still used by women as a ruse to protect against the violence of the patriarchy!'"

Sallie chuckled, "So, it was quite a pleasant gathering?"

"Well, yes, in a way," Frances said hesitantly. "But not long afterwards the discussion became more heated. We spoke about relationality and care in our own practice, and Phaenarete pressed us towards a philosophical understanding of what relationality in care was exactly and asked how to reconceive of this specter we are haunted by but can never realize. Then Marianne made a plea to understand it as a kind of sisterhood: '*I believe that midwifery's relationality is based on a common sisterhood or womanhood. It does not matter where somebody is from, underneath we are all women and that is where we can relate. I am a woman, she is a woman, we are the same eventually, we are family, we are sisters*. If we reestablish and affirm this

34 See Mavis Kirkham's edited collection *The Midwife-Mother Relationship* (2010) for a wonderful collection of essays on this topic. Mavis Kirkham, ed., *The Midwife-Mother Relationship* (London: Palgrave, 2010).

global sisterhood, we can get the familiarity of the old community back. We must again regain a certain indistinguishability[35] between mothers and midwives to attempt to break the authoritarian border between those who care and those who are cared for. *We are the same, we are both women, and that can cross all differences*.'

But then Claudia, the other mother who was there, jumped in, quite firmly disagreeing:[36] "I do not believe in a common sisterhood. *I had very kind community midwives and a homebirth, but I was not listened to at all. I did not get all the information I needed. The only reason why I had a good birth experience and why my postpartum depression was discovered afterwards, was because I had a Black doula. The white midwives did not understand what I needed. They could not tell me anything about my body, nor did they connect with me in the process of pregnancy and childbirth—they could not handle me being 'different.' Through my doula I felt the presence of my lineage, of my culture, but with my midwives I only felt a wall—we did not have any kind of connection*."

It went back and forth for a while on whether something like universal sisterhood exists and then Azadeh stepped up."[37]

"Azadeh? The one we went to school with?" Sallie asked puzzled.

"Yes, I forgot to tell you, but she was there too. She immediately started to talk politics, as always: 'Marianne, this kind of *essentialism will not help us to reestablish relationality with all the different parents at all. While it tries to include women, it is actually very exclusionary. Not all women have the same problems or experiences just because they share a certain biological disposition and not even all people who are pregnant identify as women!*'

And Claudia took over again, explaining that premodern care was indeed based on the relationality of the community and a sense of sameness, but that we now have quite a different context of care in our postcolonial, globalized world. "Rather than relying on discourses of 'sameness,' we must find a way to base relationality on 'difference,'" she said: "For the simple reason that *we are not the same, neither do we want to be the same, nor do we experience pregnancy in the same way, nor are we all women*. I understand the intuition to try to conceptualize relationality as a new kind of indistinguishability, especially against the backdrop of the professionalization of care and the

35 This is a known idea in midwifery, and was, for instance, the plea of the president of the International Confederation of Midwives, Franka Cadée, at multiple conferences in 2020.

36 Claudia (she/her) is a Black Kenyan singer, now living in the Netherlands and a mother of one.

37 Azadeh, PhD (she/they) is an Iranian Dutch midwife, currently working as an academic and a teacher at the midwifery academy.

power and paternalism that comes with it. But the question must be what kind of relationality can really be in relation to everyone without propagating a universal idea of Man. How do we understand that our liberation depends on each other, which is why we should all be in relation, without eliminating difference? If we base the relationality that is essential to care on sameness, *we will still, consciously or subconsciously, only be able to care for our own."*

To which Marianne replied concerned: "But was our *autonomous praxis of midwifery care not taken from us by medical men and the emerging patriarchal institution of obstetrics exactly because we are all women*?[38] And should we therefore not *fight as women*? Are we not erasing ourselves otherwise?"

Azadeh answered: "*Our autonomy was taken because midwifery is a care profession in which mostly women work. But it is important to recognize that this gender dichotomy has been a way to oppress all people who are not cis men. The category 'woman' as we know it now was invented to justify our oppression*. So women should be understood as a social class rather than as a biological category. Midwifery is part of the exploitation of *low-paid care work as romanticized feminine 'labor of love,'* a free contribution to the accumulation of capitalism in the form of social reproduction. *Calling this 'womanhood' distracts from the reality of what care work is today. If we want a different world in which care is not marginalized, undervalued, and underpaid, we must not fall back into a naturalization or romanticization of care, or of womanhood*. If we aim to realize relational care rather than have it present only as a cherished ideal that haunts us in a fundamentally uncaring and violent society, we should work towards relating to each other in fundamentally different ways—maybe in a kind of sympoetic relationality."

"A what? A sympoetic relationality? Oh, I can completely imagine what Vivian would have said!" Sallie laughed, knowing her old student all too well.

"Indeed," Frances affirmed, "Vivian could not wait to say her part!": "I fully agree with Azadeh," Vivian replied, "*The big crisis of our time is the inability to care for anything or anybody that reaches beyond our direct kin or who we*

38 Chandra Mohanty argues against this kind of "sociological essentialism" where a universal sisterhood is forged not on the basis of a common biological identity, but on the basis of a common source of oppression. While the source of oppression may be common, she argues, like in the case of capitalism or patriarchy, the way oppression works is specific to each location. With her "politics of location" she calls for a solidarity that is not based on sameness, but on difference. See: Chandra Mohanty, *Feminism without Borders: Decolonizing Theory, Practicing Solidarity* (Durham, NC: Duke University Press, 2003). Please note that there is a heated discussion going on in the field of midwifery concerning gender-neutral language and an increasing number of "gender-critical" and transphobic midwives.

can imagine as kin. If we want to fight oppressive categories, we cannot follow the same logic of identities, we cannot hearken back to a relation of midwifery based on an essentialist notion of womanhood. The challenge is to find a way to avow that we are, in fact, different. But this difference does not have to mean that we are separated and not in solidarity with each other.

In my opinion, *the problem with obstetric care is that it functions by virtue of an appropriation and instrumentalization of the laboring body*. A small part of relationality is captured in an authoritative paternalistic relation, and the rest of what relationality could be is excluded. *Through this strict distinction of what a relation of care can and cannot be—merely professional and not one of love, for instance—, the care worker pretends to be irreproachable, a stance belied by the high rates of trauma, and they cannot be fully present as themselves in their relationship*. The only way to get out of this problematic is to acknowledge the borders of what we call 'relation' and try to surpass them. The answer cannot be to draw a new border based on gender identity or biology, as we see now happening around us in a conservative, gender-critical trend taking hold of midwifery. Instead, the challenge is to counter the oppressive strategies of essentialist and binary identities, appropriation, instrumentalization, and exclusion. How, you ask? *Through love, I say. To me, midwifery is love. That is the basis. And care is only one aspect of love, only one thing that can, and must, grow out of love, next to, for instance, commitment and knowledge, like bell hooks says. Love, in the definition of hooks, is the will to extend oneself for the purpose of nurturing one's own and another's spiritual growth*. It is the power we need to be *self-critical and vulnerable in order to dismantle the restrictive relation we now uphold*.'"

Sallie was hesitant. She felt ambivalent about all of this. It sometimes seemed like there was a huge distance between the thought and praxis of midwifery care. She knew that Frances had always felt that way too, but something about her seemed more convinced, more engaged, than usual. She had a sparkle in her eyes.

"Azadeh and Vivian insisted that we conceive of a relationality of midwifery not based on any notion of essence," Frances continued. "And in that sense, they also took seriously what Phaenarete was trying to tell us: to be with the ghosts of the past and the communal relationality that is haunting us, but, at the same time, not long back for something—a something that we might have never had. Instead, she pushed us once more to realize the specter of midwifery for the future, for a reproductive justice to-come. It was then that she started to talk about 'creolization.'"

"Creolization?" Sallie asked curiously.

"Yes, apparently it is a concept from the philosopher Édouard Glissant. He based it on the creole languages and cultures of the Caribbean that emerged after the transatlantic slave trade. The idea refers to a kind of relationality that consists of more than the mixing or encountering of multiple identities. Instead, the 'identities' that 'creolize' are fully taken up in the relationship, creating something new together—like a new language, a new culture, or a new people. Phaenerete then explained that creolization is different from cultural mixing or *métissage*. In contrast to the mixing of two entities into a new closed entity, creolization is an open movement, always diffracting, leaving from one place, stumbling upon the other, and breaking into pieces like a wave or a spectrum of light. It fragments instead of concentrates, and relates to the other without erasing itself or its own memory in the continuous fabrication of new patterns.[39] It is like the diffraction of two waves bursting into each other, sharing and constituting a new relation that knows of them both. According to Glissant, affirming creolization means being radically in relation without claiming any origin or essence. Only if we affirm that we all live in a co-constitutive relation with each other, and hence continuously develop a different world together through our shared relationality, can we find a way out of the violence in whose afterlife and reproduction we still live."[40]

"I do not fully understand," Sallie interrupted.

Vivian had an insightful example: "An old midwifery friend once told me about 'connective ways of knowing.' This was knowledge that could not be studied in books but was created in the intimate contact between mother and midwife during childbirth.[41] With each birth, the knowledge of both mother and midwife grows and changes. Connective knowledge is dependent on the possibility of establishing a deep and intimate relationship during birth. When the midwife is receptive and takes care of the maternal by making space, and when the maternal is receptive in her willingness to be open, to transgress, there is a moment, a certain time, in which it is possible to come into relation with everybody present. In that moment, new knowledge emerges. *That is why I learn as much from the people I accompany through*

39 Birgit Kaiser, "Worlding CompLit: Diffractive Reading with Barad, Glissant and Nancy," *Parallax* 20 (2014); Édouard Glissant, *Poetics of Relation* (Ann Arbor: University of Michigan Press, 1997), 33–34.

40 Glissant theorizes creolization on the basis of an origin story, namely the transatlantic slave trade. He compares the slave ship to a violent womb, aiming to show that the idea of any other origin is something that is forever lost. See: Glissant, *Poetics of Relation*.

41 Ólöf Ásta Ólafsdóttir, "An Icelandic Midwifery Saga Coming to Light: 'With Woman' and Connective Ways of Knowing" (PhD diss., London: Thames Valley University, 2006).

birth as they do from me. Relationality is, and this is what creolization shows, I think, based on difference, rather than sameness, otherwise there is nothing to diffract, no new creolized way of being together. We thus come closest to the full potential of relation in the creolization of difference without origin, rather than in rootedness, sameness, or essentialism."[42]

Marianne, surprisingly, affirmed this: "I do recognize that process of communal, spiritual, completely diffracted, and intertwined knowledge making. *I recall that all those different threads of knowledge, all those birthing people, all those different experiences, were essential* for my relationship with the mothers as a whole."

And Phaenarete added: "Hmm, yes, we are getting a step further. It now sounds to me as if we can only have reproductive justice if we are able to be in relation to everything that the maternal is and could be, to the totality of all its possible forms. Glissant captures a similar thought in his concept of the 'Whole-World.' For Glissant, the totality of this concept should not be understood as an imperialist universalistic tendency, but as the totality of all relations; the totality of the multiplicity of all difference. As long as we do not strive to be in relation to the totality of relations, whilst acknowledging that we will never be able to grasp the world in its totality, we deprive the world of a part of itself. Maybe we could say the same about the maternal. If we do not strive to be in a creolized relation to all that the maternal is and could ever be, to the 'Whole Maternal,' so to say, we deprive the maternal, and all of its children, of a part of itself. And, consequently, we deprive ourselves of what we could be, as we limit the potential of possible ways of being human. So we, as midwives, must be in relation to the maternal that is both familiar and unfamiliar, to what we can see and cannot see, to what is clear to us and what is opaque. Are you still following me? Well, I can say that at least you all know how to be in relation to what you cannot see—it is the only reason I am able to haunt you today!"

"So, she really is a ghost?"

"Yes. She must be."

"I do understand what Phaenarete means when she says that we as midwives have a 'sense' for it—*I also think that midwifery is a certain openness*," Sallie confessed.

"Yes, me too."

"*When I start a 24-hour shift*," Sallie explained, "*I am at home, not knowing how the shift is going to be or who is going to call. I am in an open relation to* what can indeed feel like the whole world, *to whoever is going to call me. I*

42 Glissant, *Poetics of Relation.*

feel the relationship with the specific mother I am with in all my fibers; I feel what I can and cannot do, what her boundaries are, as if my whole being is in relation and changes through her—which is also why it is such an intense experience. And that relation forms me and diffracts again when I am with someone else. But it is exactly through that expression of what has become my singular knowledge, my voice, my way of being present that has developed in relation to all of them, that I am always open to the totality of relations, to whoever is the maternal, beyond the specific parents I am with."

Frances replied: "*Yes, indeed, I recognize a constant practice of patience, a deep kind of patience that I have with nothing else. This not-doing but watching, this letting-it-come time and again is a practice of being relational. But this practice also consists of being able to be received, or taken up, by birth.* Every time I went next door to the laboring woman during our conversation, *I fully entered the space of birth. It is not a process that happens only within the body of the one who gives birth.* Instead, the tentacles of birth take up every corner of the room, leaving traces like those we could still feel lingering in the room where we began our conversation. *That energy takes me in, every time anew*, diffracting me into her, and her into me—we both share the event of birth, everyone present lives through it, and we are born into the world together as a new relation."

Sallie nodded: "*Rather than being an authoritative professional identity who knows what must happen, midwifery is to practice a relation to whatever is going to come.* A relation with the maternal in the broadest sense, with what we indeed can and cannot see, *taking it seriously both in her presence and absence, her future and her past, her force and vulnerability, her trauma and healing, her sameness and difference, her transparency and opacity, her known and unknown sides, in what she is and what she could be.* I can see how it builds new relations and how it shows a revolutionary glimpse of living otherwise."

"Yes, yes," Frances responded passionately, happy that Sallie was getting more and more engaged. Vivian took it even a step further:

"It is a relationality that allows itself to explode. This explosion is not a scattering of oneself but a consensual sharing that insists on the impact of everyone's opaque particularity and the acknowledgement of the wounds of the past that brought us here.[43] Relationality understood in this way would thus not mean to give up one's self-understanding or the ways one individually identifies, but to gain the ability to create a relationality in which everyone is *both respected and can be undone by the other without losing oneself.* As such, *it goes further than two individuals having a relationship, as in the traditional understanding of the mother-midwife relationship. It comes closer to a form of*

43 Ibid.

making love, since it is an active *making*, and becoming, of relation. Maybe midwifery is nothing more than an ever-developing relationality with the maternal. Maybe if we *resist the subjectification of the midwife as a healthcare professional, in doing so we resist the objectification of pregnant people*. In other words, there is no typical midwife, no typical pregnant person. If that relationality is continuously made, kept intact and safe, then we have reproductive justice, here and now. This must be the poetic intention for reproductive justice of midwifery: the intention to create a relationality in which birth can be free, self-determined, safe, and full of love."

And then Phaenarete said something a bit more personal: "My son and I often spoke about my work as a midwife. We used to say that I was a midwife of the body, while he was a midwife of the mind. He would always stress that he was barren. In our times, only barren women could be midwives, either when their fertile period lay behind them or if they had no children of their own. In the same vein, he would stress that he had no knowledge of his own. Of course, that was not completely true, but the point was that he avoided any truthclaims, for he felt that he was unable to give birth to wisdom, since that was not his task. Instead, he was someone who could help others do that. Yes, this kind of empty receptivity now sounds problematic, I know. But maybe the idea of barrenness as the condition of possibility for knowledge can still tell us something about midwifery. Maybe, indeed as Vivian says, that midwifery is nothing more than a relation."

Azadeh slightly disagreed, however: "I see where you are going, but I think it is a misunderstanding that a midwife cannot have an identity but be only the empty receptacle of the relation. The midwife in fact has to express their own identity, otherwise we, again, deprive the world of a part of itself, as Glissant would say. *Or we will function as the empty core through which the relation must be constituted, and then we are again an empty center, a professional institution of care that is the beginning and end of relationality surrounding sexual reproduction. To me that feels like a fake neutrality and an illusion of objectivity; a form of professionalization that is less innocent than it looks. If we are all ourselves, in all our opacity, then no one is the center, no one is the secret norm, no one is the supposedly empty room for relationality.* As Glissant says, we must persist in the density of our opacity, for that is how we become most expressive, and our relation most fecund.[44] Relationality surrounding sexual reproduction will not be

44 "The poetics of relation assumes that to each is proposed the density (the opacity) of the other. The more the other resists in his thickness or his fluidity (without being limited to it), the more his reality becomes expressive, and the more fecund the relation." Ibid., 18.

formed from periphery to center, but only between peripheries, *abolishing the institutionalized quasi-objective center of sexual reproductive care*—then, the network of relation is allowed to explode.[45] Maybe we could reimagine being barren, the traditional emptiness of receptivity, as a Glissantian openness which lies in an excess of opacity, able to conceive of and make space for the other's knowledge, without necessarily understanding it, and unlearn dogmas, institutional logic, and demarcated identities, to actively pursue the opacity of our relation to childbirth, that transforms us every time anew, like a pregnancy."

Vivian added: "So, following a Glissantian poethics of care would mean to accept our relationality in the most affirmative way possible. By embracing the opacity of the other who has the right to be not understandable to us. And, at the same time, we have the right to persist in our own opacity, since we must constitute a relationality that is fecund for each other without appropriation, origin, essentialism, or fake neutrality—all run the risk of colonial universality. So, in other words, *we might not need to all be able to speak the same language but we need to have a community in which everyone can speak their own.*[46] *And what is more, we can no longer afford to exclude certain genders, identities, languages, cultures, and forms of the maternal,* not only because it is unjust, but because we deprive humanity of a part of itself if we deprive it of its multiplicity of possible mothers. Reproductive justice for all is hence bound up with the liberation of the 'Whole Maternal,' everything it is and can be, and means the liberation of being human otherwise.

We are in relation, whether we want to or not, as fluidity and difference, and we can either affirm this relationality, or we can forcefully separate, determine, and demarcate who we are and who we belong to, which would perpetuate violence. To affirm our relationality is to affirm our difference without separation,[47] which is the enactment of reproductive justice. To do that, we need to dare to deconstruct the identity of both mother and midwife—its essence, its culture, and its sex—and diffract into an everchanging relationality that dares to be receptive and opaque. Being in relation is a process that must continuously and consciously reassess, renegotiate, confront, and engage with ambiguity on a deep level; the level

45 Ibid.

46 "What is necessary here for one and other, communities heavy with history and despoiled communities, is not in effect a language of communication (abstract, flayed, "universal" as we know it) but on the other hand a possible community (and, if possible, regular) between mutually liberated opacities, differences, languages." Ibid., 44.

47 Denise Ferreira da Silva, "On Difference without Separability," in *32nd Bienal de Sao Paulo. Incerteza Viva*, ed. Jochen Volz et al. (Sao Paulo: Bienal Sao Paulo, 2016), 57–65.

of the distinction between self and other, and take seriously how these borders are indeterminate, shifting, and permeable."[48]

"I never thought about it in these terms," Sallie agreed. "But it might be, in fact, how I care as well. *I am receptive to the opacity of each parent, otherwise I cannot connect. And for that I must be constantly willing to challenge my own principles, resentments, and frustrations*. I have to each time again accept the birth and get rid of my selfish fear of sinking into it, to transmute reflective solitude into shared inflection.[49] *That is why it is so challenging, you constantly have to tune in with what you might not fully understand*."

"Yes, I see what you mean. Adrienne also said something about this at the end of the conversation: '*During my pregnancy, everybody was trying to understand my choices, but in their attempts, I was disavowed, everything that was different about me was neutralized. Their need to understand me took something from me, a certain freedom, a confidence, leaving me irrational and unintelligible. Yet their job was never to understand me, but only to support me*.'"

"Yes, indeed, our job is not to understand, but to support. You know, *I can be fully in relation with someone and still not know her*," Sallie said tentatively. "I recognize that," Frances responded, "*everybody always remains unknown in a way, there are always the things people say and the movements they make during labor that I could have never predicted. Even if you are at the birth of a friend, you do not know how you are going to relate to each other during birth. And we need to learn to accept that. That is also what midwifery is; you do not understand someone fully, and you never know how a birth is going to go. But despite this opacity and uncertainty, this lack of sameness, you still follow them into the depths of their labor*."

"Hmm, indeed, and what did Phaenarete answer to this all?" Sallie asked.

"Well, then we started to hear moaning next door, and I think Phaenarete was also happy to conclude our conversation. She must have felt her strength withering away; she was becoming more transparent by the second and said: 'My dear friends, do you hear the woman in the other room? I think that is the sign that we must end for tonight. It is your time to go to sleep, and my time to retreat again into the cracks of time. But we will continue, do not worry, sometime very soon. Thank you all for speaking to me, a spirit, a specter even, while being on call in the middle of the night. We

48 Michael Monahan, *The Creolizing Subject. Race, Reason, and the Politics of Purity* (New York: Fordham University Press, 2011).

49 "To accept (deep within oneself) this relativized world, to overcome the selfish fear of sinking into it, to transmute reflective solitude into shared inflection – is that not the more exact way of truly accomplishing one's own methods, one's vocation, one's poetics?" Glissant, *Poetic Intention*, 24.

have reconceived of relationality as an ever-evolving diffractive wave, or fabric, with the opacity of mothers, parents, midwives, and births past and present. The totality of which we can think of as the "Whole Maternal"; as everything sexual reproduction is and could potentially be. Through relationality we must remake the world. This is why care, being a poetics of relation, can be the antidote to violence: while finding ourselves in a violent world, we can remake the connectivity it consists of in a way that makes it possible for us to be human together *otherwise*, by unleashing all our possible mothers, and hence realize a relation to the 'Whole Maternal' in which reproductive justice is no longer 'to-come.'"

"As the moaning next door became louder and louder, I quickly ran to the birth," Frances said. "*She was bearing down in the bathtub, growled her baby out and then fished her daughter out of the water.* During pregnancy, she was quite shy, so I did not expect her to birth her child with so much power and self-determination. But she just did. *See, we never know beforehand*."

"*That's why I do this job—to sometimes see that*." Sallie sighed.

"You know what, Phaenarete even offered to assist me with the labor next door!" Frances grinned, "Talking about getting real."

"What, 2500 years after her last birth?"

"Yes, I told her that I could handle it myself."

11 Somatophilic Reproductive Justice: On Technology, Feminist Biological Materialism, and Midwifery Thinking

Rodante van der Waal, Inge van Nistelrooij, Deborah Fox, and Elizabeth Newnham[1]

Abstract

One of the major strands of feminism concerned with reproduction, represented in this chapter by Shulamith Firestone, is tied to a belief in technology as *the* means to achieve reproductive justice. We offer a perspective on achieving reproductive justice from a different position based on another age-old materialist doctrine, but one that is largely neglected by feminism: that of midwifery. Midwifery's epistemological standpoint can be characterized as a somatophilic techne that aims to think *with* the body rather than fix it. There is, however, a tendency in midwifery towards anti-technological essentialism. This essay aims to redirect this tendency to the more promising materialist doctrine of midwifery as well as Firestonian feminism, reimagining this materialist stance as somatophilic "midwifery thinking."

Keywords

Shulamith Firestone, reproductive technology, reproductive justice, medicalization of birth, biological determinism.

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Introduction

Within feminism, there is long-standing debate over whether technology can help us achieve reproductive justice or whether it is more prone to perpetuate reproductive injustice. Shulamith Firestone, most notably, designed a technological revolutionary program to take charge of reproduction, giving rise to a techno-affirmative feminist tradition to free us from the dangers of pregnancy and childbearing.[2] But when we look beyond the tradition of white feminism and its positive understanding of technology as that which brought us techniques such as abortion and contraception, we see in the testimonies of feminists of color a history of forced sterilizations and hysterectomies. It is, therefore, important to always remember that reproductive technology has also been used as a tool for colonial governments to maintain eugenic control over people's bodies.[3] Technology is, like most things, not inherently good or bad. Rather, it can be used in both liberatory as well as oppressive ways. Technological inventions have contributed to bodily self-determination, but they have also contributed to a lack of self-determination and the reproduction of injustice. The term "reproductive justice" was coined to address this very point: it was developed to fight against the unjust use of technology in the form of forced contraception, abortions, sterilization, and hysterectomies—all medical-technological instruments used for necropolitical oppression.[4] Therefore, reproductive justice is defined as 1) the right to have children; 2) the right not to have children; and 3) the right to raise children in safety, freedom, and dignity.[5] And, as explicated by the women of color reproductive justice collective, SisterSong, 4) the right to bodily self-determination.[6] As such, the reproductive justice movement can be understood as a specific reaction to reproductive technology, which makes the first two rights both possible *and* threatens them. Any feminism that understands grand-scale technology as the primary solution to reproductive justice must question its position through the examination of these historical misuses.

Midwifery has always had a unique and unacknowledged position in the feminist debate on reproductive technology. Within late modernity, its

2 Shulamith Firestone, *The Dialectic of Sex: The Case for a Feminist Revolution* (New York: Verso, 2015 [1970]).

3 Francoise Vergès, *The Wombs of Women: Race, Capital, Feminism* (London: Duke University Press, 2020).

4 Loretta Ross and Rickie Solinger, *Reproductive Justice: An Introduction* (Oakland: University of California Press, 2017).

5 Ibid.

6 See: www.SisterSong.net.

specific knowledge regarding the relational and physiological support of pregnant people has been marginalized globally. What did remain of midwifery practice and theory became a very specific, situated, non-hegemonic standpoint; both appropriated by the obstetric institution and holding on to autonomous existence outside of it.[7] As such, midwifery has been able to develop a thorough critique of technology by centring the medicalization of birth against the grain of the more popular techno-affirmative feminist movement. In its critique, midwifery has mostly been specific and materialist, focusing on specific technologies and their effects. In its critique of the fetal monitor, for instance, it understands the instrument as forming a hermeneutic relationship with humans and the world. The monitor helps us to gain a new understanding of the fetal world, just as a telescope may provide a new understanding of the galaxy. But this new knowledge that allows us to see the fetus separate from the maternal body has had major cultural implications, not least for the pro-life movement.[8] Here, midwifery scholarship asks: How does technology mediate the care for birthing people and their babies? What are the benefits and the risks? And: How does this specific technology reshape birth? In this way, an individual technology, such as a particular fetal monitor, is the starting point for a materialist and critical standpoint. As such, it lays bare that reproductive technology has already fundamentally reshaped the process of pregnancy and labor, but does not work as well as we might think, and turns out to be more complex than a techno-affirmative stance might have us believe.

When it comes to birth, the number of intreventions needed to prevent one death or one serious disease is often high, while the iatrogenic effects can be serious. For instance, even the Netherlands, a culture famously resistant to over-medicalization, now has a 36% induction of labor rate, meaning that birth is brought on by medical means, rather than left to occur spontaneously.[9] This rate is higher in many other high-income countries. For instance, in Australia, the latest figures show that almost half

7 Critical Midwifery Studies (CMS) Collective Writing Group, "A Call for Critical Midwifery Studies: Confronting Systemic Injustice in Sexual, Reproductive, Maternal, and Newborn Care," *Birth* 49 (2022): 355–359.

8 Barbara Rothman, *Recreating Motherhood* (New Jersey: Rutgers University Press, 1989); Trudy Dehue, *Ei, foetus, baby: Een nieuwe geschiedenis van de zwangerschap* (Amsterdam: Atlas Contact, 2023); Barbara Duden, *Disembodying Women: Perspectives on Pregnancy and the Unborn* (Cambridge: Harvard University Press, 1993).

9 Hajo Wildschut and Anna van Seijmonsbergen-Schermers, "In blijde verwachting…hoezo? Over medicalisering en bevallingservaringen in de geboortezorg," *Cahiers Geschiedenis van de Geneeskunde en Gezondheidszorg* (2023, forthcoming).

of people giving birth for the first time had their labor induced (44%).[10] Over-medicalization also has a racist and colonial component, affecting the Global South and marginalized people more. In South Africa, for instance, the cesarean section rate is 76% and in the USA, Black people are 21% more likely to have a cesarean section.[11] At the same time, marginalized people often suffer from under-medicalization, being denied the care they need.[12] Midwives daily witness the life-saving effects of well-used technology, which needs to be deployed more often for marginalized people due to systemic racism. Thoroughly recognizing the influence of technology in the birthing space, midwifery can therefore be understood to have a unique potential, due to its materialist standpoint, to engage with the design of future technologies in a way that facilitates reproductive justice. We could understand midwifery and Firestonian feminism as both departing from a biological materialism, since both recognize the problems, inequalities, and the vulnerabilities that the reproductive body presents to half of the population. But while Firestonian feminism sees technology as the way to save us from this injustice, and hence locates the injustice fully in biology itself, midwifery is wary of technology contributing to further reproductive injustice. As such, midwifery locates reproductive injustice not in nature, but in the way we deal with nature—believing that the right relational care for reproductive bodies is the best way to achieve reproductive justice, rather than any technological fix.

Apart from a situated critique of technology, midwifery has also developed a more reactionary movement, however, that has become at times essentialist through its dedication to natural birth, and consequently anti-medical, and anti-technological, and lately increasingly anti-trans, and anti-gender.[13] From an ideology that developed out of the radical hippie movement that revived midwifery in the US in the 1970s and remained restricted to the margins of midwifery for a long time, it is gaining the support of midwives with the resurgence of radical feminism in the UK, Australia, and the US. Radical

10 Australian Institute of Health and Welfare, *National Core Maternity Indicators, 2023.* Last modified July 13, 2023. https://www.aihw.gov.au/reports/mothers-babies/national-core-maternity-indicators.

11 Dána-Ain Davis, "Uneven Reproduction: Gender, Race, Class, and Birth Outcomes," *Feminist Anthropology* 4, no 2 (2023): 152–170.

12 Suellen Miller et al., "Beyond Too Little, Too Late and Too Much, Too Soon: A Pathway towards Evidence-Based, Respectful Maternity Care Worldwide," *The Lancet* 388 (2016): 2176–2192.

13 Karleen D. Gribble et al., "Effective Communication about Pregnancy, Birth, Lactation, Breastfeeding and Newborn Care: The Importance of Sexed Language," *Frontiers in Global Women's Health* 3 (2022).

feminism offers midwifery an ideological position that is unfortunately able to bring together multiple axes of oppression from which midwifery suffers: the marginalization and expropriation of their profession with the rise of medical men; the naïve and experimental use of technology on women's bodies whose detrimental effects midwives have experienced and continue to experience on a daily basis; and the continuation of not being taken seriously, neither in their critique of over-medicalization and obstetric violence, nor in their own knowledge about pregnancy and childbirth. Together with its continuous underfunding, the marginalization of the midwifery profession is causing untenable working conditions, as well as high burnout rates. It is therefore not surprising that some are tempted to connect the oppression of women in childbirth and the women who help them with the supposed "erasure" of women by so-called "gender ideology," the "rise" of trans people, and the "takeover" of the world by technology.

Gender and technology become intimately connected in midwives' version of radical feminism, as gender transition is understood as a form of over-medicalization and thus as consistent with a patriarchal tendency to appropriate and medicalize women's bodies. These essentialist ideas jeopardize midwives' loyalty to the ethical principle of reproductive justice, however, which is at this moment most acutely felt in a resistance to gender-inclusive language in maternity care.[14] There is a serious risk that radical midwifery will develop into a reactionary ideology that, caused by anger about its own marginalization, misunderstands another marginalized community as a threat, and simplifies a complex system of nature, culture, and technology as an ideological dichotomy between "nature" and "technology." This would be a major loss, since midwifery, at the same time, has more to offer when it comes to the facilitation of reproductive justice than most feminist movements, due to its practice of mutual aid and radical care in the sphere of reproduction.

What we aim to do in this chapter is bring together the revolutionary vision of Firestone—including its techno-affirmative and sex-abolitionist position—of reproductive freedom *for all*, with midwifery's unique vision of reproductive freedom as something to be achieved in a somatophilic relationality of care, i.e., a form of care that aims to work with nature rather than against it or adopt an anti-nature stance like xenofeminism.[15] We

14 Gribble et al., "Effective Communication"; Kathryn Webb et al. "Trans and Non-Binary Experiences of Maternity Services: Cautioning against Acting without Evidence," *British Journal of Midwifery* 31, no. 9 (2023): 512–518.

15 Laboria Cuboniks, *The Xenofeminist Manifesto: A Politics for Alienation* (New York: Verso, 2018), 15.

believe this to be possible, since both Firestone, embedded in a feminist Marxist tradition, as well as midwifery, start from a materialist doctrine. Below, we will critique *and* delineate the potential of both Firestonian feminism and midwifery thought and practice when it comes to the usage of technology in reproduction. Afterwards, we will develop what we coin "midwifery thinking" in which we embed a materially grounded, somatophilic usage of technology for reproductive justice in a specific midwifery way of being-with the lived realities of reproductive processes.

Technology and Reproductive Justice

There is a rich tradition in feminist theory that connects technology to the abolition of reproductive injustice. Arguably, this tradition is most fiercely represented during the second feminist wave by Shulamith Firestone, who believed that reproductive technology could save us from the unjust disposition that reproduction posed to bodies capable of pregnancy.[16] The xenofeminist slogan "if nature is unjust, change nature," is a contemporary configuration of the Firestonian idea that reproductive injustice is primarily located in nature, namely in the biology of the body.[17] Firestone was a Marxist feminist, and was hence inspired by the revolutionary philosophy of communism. She complements Marx and Engels's historical materialism with a biological materialism, arguing that we are not only oppressed by capitalism, but by the biology of sexual reproduction as well. This is similar to Simone de Beauvoir's theory in *The Second Sex* that it is the burden of reproduction that is partly responsible for making the female sex a captive of the reproduction of humankind, while the male sex consists of individuals who can transcend humankind.[18] In line with Enlightenment thought and the development of science, Firestone situates the injustice of which the female sex suffers in their biology. Pregnancy and childbirth are classified as dangerous and barbaric processes that make people with uteruses incomparably more vulnerable than others, hence constituting two classes of people: those with and those without a uterus. The way to dismantle this inequality is therefore the abolition of "sex." Reproduction can then be handled through ectogenesis and there would no longer be people with a uterus, hence freeing humankind of this biological class war. In a move

16 Firestone, *The Dialectic of Sex*.

17 Laboria Cuboniks, *The Xenofeminist Manifesto,* 0.

18 Simone de Beauvoir, *The Second Sex*, trans. Constance Borde (New York: Vintage, 2011 [1949]).

similar to traditional Marxism, Firestone takes reproduction seriously as an industrial enterprise, and as something we can and must take power over. Technology is seen as revolutionary for people with a uterus: it progressively provides more and more control over reproductive bodies to deal with the uterine injustice we are born with, to eventually rid ourselves of it through technology.

The strong suit of Firestone's theory is that it pushes us not only to take over the means of production, but the means of reproduction as well. This follows from her biological materialist doctrine, which makes it possible to take seriously the risks, vulnerabilities, and burdens that indeed come with fertility. Also, and almost unknowingly so, the abolition of sex can be understood as a very trans-affirmative point, striving indeed for reproductive justice for all, no matter how you identify. But her materialist doctrine developed into——and this is where it differs from Marxism—a rejection of the materialism it is grounded on, which is echoed in the "anti-nature" stance of contemporary xenofeminism. In Marxism, we see a total rejection of capitalism as an unjust system of sustaining human life, but there is no outright rejection of economy or value as such, and neither do we find there a total rejection of nature.

While Firestone rightfully critiques Marxism for its lack of understanding that nature does not mean the same for everyone, we can wonder if a rejection of it in the case of reproduction would indeed lead to reproductive justice. Especially because a total rejection of nature is not so easy to achieve, and the steps along the way that aim to control reproduction more and more through technology, are not as successful as perhaps believed in the 1970s; nowadays, it is widely recognized that "over-medicalization" is a form of obstetric violence which interrupts the hormonal physiology of birth that has—if all goes well—salutogenic effects. Reproductive technology also makes it possible to continue the logic of capitalism in which people with a uterus are objectified and used as material resources for the reproduction of human life.[19]

Contemporary feminists such as Donna Haraway and Sophie Lewis, and xenofeminism take up different aspects of Firestone's thought in relation to reproductive justice. Haraway inherits Firestone's fascination for biology and technology, taking further her optimistic view of technology as that which will not only free us from the strain of reproduction, but can also bring humankind as a whole to another level, since we would be in control

19 Barbara Rothman, *In Labor: Women and Power in the Birthplace* (New York: W.W. Norton & Company, 1991 [1982]).

of reproduction and able to tweak it where it is unjust.[20] Haraway did not develop this within the communist framework of revolution but takes up the idea of technology within the framework of evolution, conceptualizing the symbiosis of technology and biology as "re-evolution."[21] As such, she dismantles the differentiation between nature and culture, speaking of "natureculture."[22] And there have indeed been some successful symbioses of nature and culture when we look at reproductive justice. Contraception and abortion are medical technologies that have generally given people back control over their bodies, and hence given them access to reproductive freedom—something that could rightfully be celebrated as a continuum between animal and machine and as an iteration of cyborg feminist reproductive justice. As such, the symbiosis of biology and technology can lead to a revolutionary change when it comes to nature's captivity of people with a uterus, by putting them in charge of sexual reproduction and simultaneously enhancing the health and freedom of the human kind as a whole.

But we must also remember—and the same counts for Firestone's problematic neo-Malthusian conception of the betterment of the human race through reproductive technology—that the development and implementation of contraception and abortion by the leading feminists of the time, such as Marie Stopes in the UK, Margaret Sanger in the US, and Guadalupe Arizpe de la Vega in Mexico, went hand in hand with eugenic ideas defined by the classism and racism behind who should and should not have children. Stopes's contraceptive cervical cups were called "pro-race" and "racial," hinting at the betterment of humankind.[23] Sanger is infamous for her experimentation with the pill on people of color who never gave their consent.[24] And De la Vega was determined to have lower-class people birth fewer children to solve the population and poverty problem of Mexico, thereby affirming the stereotype of hyper-sexual Latina women in the process, while enriching herself from the industrial labor of proletarian

20 Donna Haraway, *The Companion Species Manifesto: Dogs, People, and Significant Otherness. Vol. 1* (Chicago: Prickly Paradigm Press, 2003).

21 Sarah Franklin, *Embodied Progress. A Cultural Account of Assisted Conception* (London: Routledge, 2022).

22 Haraway, *The Companion Species Manifesto.*

23 Nora Heidorn, "Touching Matters of Care (Birth Rites Collection, 2022)," last accessed March 18, 2024, www.Noraheidorn.com/Touching-Matters-of-Care.

24 Dorothy Roberts, "Margaret Sanger and the Racial Origins of the Birth Control Movement," in *Racially Writing the Republic: Racists, Race Rebels, and Transformations of American Identity*, ed. Bruce Baum and Duchess Harris (Durham: Duke University Press, 2006).

mothers working in her husband's textile factory.[25] Contraceptive techniques such as abortion, sterilization, or hysterectomies were often performed on people of color without their consent.[26]

As Ruha Benjamin points out, technology is not free of discrimination or inequality. Often, it tends to exacerbate the inequalities that are already ingrained within society. For instance, algorithms used within the judiciary system that are supposed to be more objective than the judges turn out to be just as racist as the judges, but are much more difficult to call out or address as they are covered within the quasi-objectivity of technology.[27] Similarly, a pulse oximeter, which is used everywhere in medicine, from the emergency room (ER) to midwifery, cannot read oxygen levels of dark-skinned people as well, generally over-estimating them, leading to health inequity and poorer outcomes, reflecting systemic racism.[28] Since technology unseeingly reproduces a system of apartheid, Benjamin terms this kind of technology the "new Jim Crow"—asserting that although, unlike her grandmother, she can walk into the main entrance of the hospital since the "whites only" signs are no longer there, she is still subjugated to a segregated system through medical technology.[29]

While technology can certainly be used to achieve reproductive justice, we must acknowledge that the way in which technology is designed and used is also responsible for the production of reproductive injustice, particularly because technology is not "neutral"' but is conceived, created, and used in ways that uphold existing structures of power.[30] This underpins Benjamin's claim that reproductive justice has been, and still is, way beyond our reach despite huge technological advances.[31] Although cyborg reproduction facilitates reproductive justice in some ways, it remains messy, complex, and unjust in other ways. We must therefore recognize that the fusion of natureculture can unconsciously reproduce eugenic logics embedded in society. The first pillar of reproductive justice, "the right to have a child"—the answer to white middle-class feminism's fight for legal technological

25 Lina-Maria Murillo, "Espanta Cigüeñas: Race and Abortion in the US-Mexico Borderlands," *Signs: Journal of Women in Culture and Society* 48, no. 4 (2023): 795–823.

26 Ross and Solinger, *Reproductive Justice*; Vergès, *The Wombs of Women*.

27 Ruha Benjamin, *Race After Technology. Abolitionist Tools for the New Jim Code* (Cambridge: Polity Press, 2019); Ruha Benjamin, *Viral Justice: How We Grow the World We Want* (Princeton: Princeton University Press, 2022).

28 Ibid.

29 Benjamin, *Viral Justice.*

30 Howard Waitzkin, *The Second Sickness: Contradictions of Capitalist Health Care* (London: The Free Press, 1983).

31 Benjamin, *Viral Justice*.

abortifacients—is seriously threatened by contraceptive technology when it falls into the wrong hands. The contraceptive Depo-Provera has famously been used in various countries without consent, and Angela Davis devoted a whole chapter in her classic, *Women, Race, Class*, to the forced and pushed use of anti-reproductive technologies such as sterilization, contraception, and abortion.[32] Technology by itself cannot be understood to necessarily lead to reproductive justice, which is why Firestone herself also strongly emphasized that repro-tech within racial patriarchal capitalism would have dramatic consequences.[33]

Of contemporary feminists, Sophie Lewis stays most close to Firestone's revolutionary commitment. Relying on the premise that capitalism can only function through reproductive injustice—a reiteration of the critical insight of Marxist feminism that capitalism feeds on the free and naturalized labor of care and pregnancy—she envisions the road to reproductive justice as necessarily a revolutionary one. Not only because a post-capitalist world supports the organization of resources in a way that would facilitate reproductive justice, but, most importantly, following both Firestone and Silvia Federici, because she sees it as a strategy for revolution: when we reappropriate the means of reproduction, and enforce reproductive justice, capitalism will necessarily fall. The question is then how to forge a gestational revolution, and one way to do that is through what Lewis calls "communist amniotechnics."[34] An example of this is her plea for "full surrogacy now" in which we let go of the configuration of children within a capitalist property (and inheritance) logic, and instead regard all children as people in and of themselves, no matter to whom they are born, keeping ectogenesis open as a reasonable option.[35] The question remains, however, whether the tweaking of biological reproduction would indeed lead to a revolution or whether it would be more likely to construct reproduction in such a way that it fits more easily within a capitalist system. Similarly, but with more emphasis on technology as the main tool, xenofeminism, following Firestone, regards technology as the primary means to effectively facilitate reproductive justice. According to xenofeminism, we should affirm rather than reject Enlightenment's project of rationality, technology, and the body as a mechanic system. This means embracing the grand-scale possibilities it can offer us and embark on a determined, global rational

32 Angela Y. Davis, *Women, Race, Class* (New York: Vintage, 1983).

33 Firestone, *The Dialectic of Sex*.

34 Sophie Lewis, *Full Surrogacy Now. Feminism against Family* (New York: Verso, 2019).

35 Ibid.

project to technologically change the aspects of sexual reproduction that can be regarded as unjust.

Apart from the danger of technology falling into the wrong hand or being incorporated within a racial capitalist world, techno-affirmative approaches present us with another problem of technology which is often disregarded, namely that many reproductive technologies are often not very effective but do have iatrogenic consequences. Despite the invasive nature of the emotional changes that come with in-vitro fertilization (IVF), it has a low success rate, as does intrauterine insemination (IUI).[36] Technological ubiquity and normalization leave a major mark on the experience of our bodies and lives (for instance the years-long continuation of IVF cycles), and it creates expectations.[37] It is quite difficult to resist the pull of IVF when a child is desired. Similarily, having an abortion rather than using hormonal contraceptives is increasingly seen as irresponsible behavior.[38] With regards to childbirth, technology is responsible for such a strong interference with the natural process of birth, that it creates a different set of risks, and a different process of birth altogether.[39]

For instance, in 1968, maternity care was transformed by the advent of the cardiotocograph (CTG), a technology that enabled, for the first time, a continuous reading of the fetal heart rate and maternal uterine activity during labor and birth, known as electronic fetal monitoring (EFM). EFM is a technology globally used in childbirth, despite the fact that there was no evidence to support its introduction, that it does not appear to lower rates of perinatal mortality, and that it is associated with increased cesarean section rates.[40] Because EFM effectively restricts both movement and other options for managing labor, such as water immersion, it has major consequences for the ontology of childbirth. For over 50 years, we have been grappling with a machine that is difficult for mothers to wear and difficult

36 Emily Jackson, *Revisiting Reproductive Autonomy* (lecture, Cambridge University, 8th Annual ReproSoc Lecture, 2022); Franklin, *Embodied Progress*.

37 Franklin, *Embodied Progress*.

38 Ibid.

39 Elizabeth Newnham, Lois McKellar, and Jan Pincombe, "Documenting Risk: A Comparison of Policy and Information Pamphlets for Using Epidural or Water in Labour," *Women and Birth* 28, no. 3 (2015): 221–227.

40 Zarko Alfirevic et al., "Continuous Cardiotocography (CTG) as a Form of Electronic Fetal Monitoring (EFM) for Fetal Assessment during Labour," *Cochrane Database of Systematic Reviews* 2 (2017); Kirsten Small et al., "'My Whole Room Went into Chaos Because of that Thing in the Corner': Unintended Consequences of a Central Fetal Monitoring System," *Midwifery* 102 (2021): 103074.

for midwives to use, and is a barrier to physiological processes in labor.[41] As a result, there is a lack of knowledge on the unmonitored physiology of childbirth, a lack of maternal authority and freedom in birth, and a lack of emotional care and support during childbirth, but most importantly, it undoes the relationalities present in childbirth. Rather than focusing on the mother, the midwife now directs her attention to the heartbeat of the baby, establishing a relationship between health care worker and child without the interference of the mother. This restructuring of relationality in birth reduces the mother's ability to contribute her own knowledge of the baby's wellbeing, as well as her authority on the matter. As Barbara Rothman points out, the separation of the pregnant subject between the mother as a container and the future child has been ongoing since the beginning of modernity.[42] But before the rise of reproductive technology this separation could not be materially realized since the fetus could not be reached independently. It is through technology that the fetus can now indeed be lifted from the body of the pregnant person, making it no longer necessary to consult the experiences and knowledge of the mother to reach the child. This not only furthers the separation of mother and fetus, but it also furthers the separation between the laboring person and their community of care. Since the midwife can now have a direct relation to the child mediated by technology, the mother becomes increasingly less an active agent in birth to whom it is genuinely important to relate.

Rothman has extensively theorized this consequence of the technologization of birth as the separation of the fetus from the maternal body.[43] In making the fetus visible through ultrasound, medicine was able to bypass the maternal body and expertise, and to emphasize the maternal body as a site of risk.[44] Following Rothman, Peter Paul Verbeek studied the impact of the routine use of antenatal ultrasound, exploring the influence upon perspectives of the fetus as an entity separate from its mother.[45] Mediated by the ultrasound machine, the fetus becomes a potential "patient" even

41 Annemarie Lawrence et al., "Maternal Positions and Mobility during First Stage Labour," *Cochrane Database of Systematic Reviews* 10 (2013).

42 Rothman, *Recreating Motherhood*.

43 Ibid.

44 Duden, *Disembodying Women*; Elizabeth Newnham, Lois McKellar, and Jan Pincombe, *Towards the Humanisation of Birth. A Study of Epidural Analgesia and Hospital Birth Culture* (London: Palgrave MacMillan, 2018).

45 Rothman, *Recreating Motherhood*; Peter Paul Verbeek, "Obstetric Ultrasound and the Technological Mediation of Morality – A Postphenomenological Analysis," *Human Studies* (2008): 11–26

before it can survive outside the uterus: "[W]e can say that for the medical professional the mother becomes an *environment* and the infant a *patient* by virtue of the mediation of the medical ultrasound technology."[46] The fetus is no longer embodied with its mother as it may have been in the pre-ultrasound era,[47] but rather constitutes the notion of the maternal-fetal conflict, as it is only able to depict the child separately from its mother.[48] Antenatal ultrasound further paves the way for the fetus to be regarded as an independent entity in very early pregnancy, which is one of the most important tools in anti-abortion activists' fight against abortion. In combination with EFM, which enables us to hear the fetal heartbeat and watch its patterns on a screen, the notion constituted by ultrasound technology that the fetus is a separate entity is reinforced again in the birth space. The well-being of the *fetus* is the focus of EFM monitoring, and the machine itself requires significant ongoing attention from the midwife for it to work effectively.[49] With centralized monitors, doctors and midwives do not need to be in the room of the birthing person to read the EFM, hence facilitating the industrialization and dehumanization of birth. Central EFM monitoring systems lead to surveillance of the EFM traces of all people in labor without doctors, midwives or nurses being present in the room, further reducing the need for an embodied relationality. The advent of EFM has resulted in a deterioration in the way some healthcare professionals care for birthing people, by privileging supposed (since the machine does not work so well) fetal wellbeing over the mother's needs and the way in which her labor may progress without intervention.[50] EFM itself becomes an actor in the network of care, fundamentally changing that network, and hence the nature of birth.[51] Therefore, we must study each repro-technology and ask how it reconstitutes reproduction and if it is indeed for the better, if it indeed enhances the facilitation of reproductive justice.

46 Rothman, *Recreating Motherhood*; Verbeek, "Obstetric Ultrasound"; Michael Van Manen, *The Birth of Ethics. Phenomenological Beginnings on Life's Beginnings* (London: Routledge, 2021): 29.

47 Duden, *Disembodying Women*.

48 Rodante van der Waal and Inge van Nistelrooij, "Reimagining Relationality for Reproductive Care: Understanding Obstetric Violence as 'Separation,'" *Nursing Ethics* 29, no. 5 (2021): 1186–1197; Rothman, *Recreating Motherhood*; Van Manen, *The Birth of Ethics*.

49 Deborah Fox et al., "Harnessing Technology to Enable All Women Mobility in Labour and Birth: Feasibility of Implementing Beltless Non-Invasive Fetal ECG Applying the NASSS Framework," *Pilot and Feasibility Studies* 7, no. 1 (2021): 214–214.

50 Small et al., "My Whole Room Went into Chaos Because of That Thing in the Corner."

51 Bruno Latour, *Reassembling the Social: An Introduction to Actor-Network-Theory* (Oxford: Oxford University Press, 2005).

The case of the misoprostol abortion pill, for instance, provides a very different reproductive reality. Due to its high level of effectiveness and safety, we can say that it indeed changed reproduction in a revolutionary way with regard to reproductive freedom and justice. The abortion pill is so safe in the first trimester that it needs no medical oversight and can be self-managed at home. Since its first use in underground activist networks in the 1980s in Latin America, it has changed the reality and the possibilities of abortion drastically, making dangerous back-alley abortions a thing of the past, at least in the first trimester.[52] Pills can be mailed safely by post to places where abortion is criminalized, and people are no longer dependent on clinics, doctors, or national healthcare services to get an abortion.

Misoprostol has even more promising qualities: one pill per week could be a form of contraception, thus blurring the line between contraception and abortion. The medication could potentially redefine, or abolish, the borders of the start of life, hence giving the authority on this matter back to pregnant people, on whom the signs of the start of life have always depended. Before the usage of ultrasound, fetal life was determined on the basis of the experience of quickening and other external "signs" of pregnancy, which could only be felt by the mother, and a miscarriage before quickening was not understood as the loss of a potential child, but simply as the return to one's normal cycles.[53] Since the existence of the ultrasound and other technologies, such as blood testing for human chorionic gonadotropin, a return to one's cycle is already considered to be an abortion at five weeks' gestation, rather than at 20 weeks, as it was in the past. The way that misoprostol reshapes the reality of reproduction by blurring the lines between being pregnant and not being pregnant and thereby giving freedom and authority on the matter back to people with the capacity for pregnancy, can thus be understood as revolutionary when it comes to the advancement of reproductive justice. Rather than resulting in a dissolution of relationships, as in the case of EFM, the abortion pill can be understood as a reconstitution of the relationships between the person and their capacity for pregnancy, and their community of care. The relation between the pregnant person and their capacity for pregnancy becomes more autonomous and self-determined, since a self-managed medical abortion at home generates the potential to organize this event freely with the least possible interference of medical authority. And it furthermore gives mutual aid and radical care networks a

52 Margaret MacDonald, "Misoprostol: The Social Life of a Life-saving Drug in Global Maternal Health," *Science, Technology, & Human Values* 46, no. 2 (2021): 376–401.

53 Dehue, *Ei, foetus, baby*.

lot of possibilities to reconstitute the relationship between pregnant people and their community of care, in a way that is not dependent on doctors and medical institutions. During the care for the abortion itself, the pregnant person is not a passive body out of which the embryo must be extracted, but care consists of support for the pregnant person who is actively laboring the abortion. Here technology reshapes reproduction in such a way that it enhances self-determination and thus reproductive justice.

While Firestone was very aware of the problems of reproductive technology within patriarchal capitalism, the tradition of techno-affirmative thought she gave rise to is less visibly conscious, sometimes framing technology as a solution in and of itself. But we lose something with an all too optimistic stance on technology, namely another possible path towards reproductive justice: that of a "somatophilic techne."

Midwifery and Reproductive Justice

Midwifery, a feminist profession that assists pregnant people relationally, also has a clear vision of reproduction and reproductive justice, albeit one that is less well-known within feminist theory. Midwifery's vision of reproductive justice can be described as almost oppositional to Firestone's. In order to achieve reproductive justice, midwifery has established a strong critique of technology which interferes, in its opinion, with respectful and humane care, as well as justice in birth.[54] Midwives have called out the use of technology during childbirth since the eighteenth century, when in 1760 the midwife Elizabeth Nihell complained that "the men use their instruments unnecessarily, resulting in maternal and neonatal infant morbidity and mortality, puerperal fever, and extraordinary birth injuries," classifying this practice as "meddlesome midwifery," the frontrunner of "interventionist obstetrics."[55] At the same time, there has been a traditional exclusion of midwives when it comes to training in technological skills. Midwives were not allowed into medical schools and early midwifery manuals were often written by doctors, who designated levels of technological skill according to profession.

Today, midwives in most places cannot use the instrument for vacuum-assisted birth, or prescribe contraceptives and abortifacients, as these

54 Robbie Davis-Floyd, "The Technological Model of Birth," *The Journal of American Folklore* 100, no. 398 (1987): 479–495; Rothman, *Recreating Motherhood*.

55 Barbara Rothman, *A Bun in the Oven: How the Food and the Birth Movement Resist Industrialization* (New York: NYU Press, 2016): 72.

technologies are exclusively for medical practitioners.[56] The intertwinement of the advancement of the obstetric institution and obstetric technology furthermore expropriated midwifery care, while appropriating midwifery knowledge from many communities, including Black and Indigenous ones. The combination of the exclusion of midwives from technology, while framing all technology as "progressive" has also been a major factor in the marginalization of midwifery, and the justification of this marginalization. Technology was key to the industrial revolution, in which ancient, tribal, and Indigenous knowledges—including midwifery knowledge—were both appropriated and undermined as archaic or outdated, and industrializing processes were revered over embodied and seasonal or rhythmic practices.[57] As such, technology is used within the capitalist apparatus of power, with technological and profitable fixes seen as more cost-effective than other low-technological practices, such as midwifery.[58]

Midwives did of course always use technology. Midwives collected, and passed down their own skills and knowledge base, such as the practice of "being-with" women, knowledge of medicinal herbs and techniques for labor, and of support of emotionally safe labor. This might seem straightforward, but is a fundamentally different practice of birth, and hence of reproduction, than that of the obstetric institution, which is historically characterized by obstetric violence and obstetric racism.[59] Midwives have a wide range of what is considered normal, while obstetrics has charts that say that cervical dilation has to progress by one centimeter per hour. This is representative of the different way that midwives use technology: to assist and facilitate a physiological process, rather than intervene with it. As such, they also aim to "control" nature, and correct it, when necessary, but through the understanding of reproductive justice as bringing nature to its best work, rather than taking over from it. Rather than a forceps, a midwife might use a rope hanging from the ceiling to support an upright birth position; rather than EFM, a midwife would listen intermittently to check the baby's heartbeat with a doptone or Pinard stethoscope, and only increase this form of monitoring when there is reason to worry; rather than an epidural,

56 Ibid., 74.

57 Stephen Hill, *The Tragedy of Technology* (London: Pluto Press, 2018); Newnham, McKellar, and Pincombe, *Towards the Humanisation*.

58 Waitzkin, *The Second Sickness*; Newnham, McKellar, and Pincombe, *Towards the Humanisation*.

59 Jean Donnison, *Midwives and Medical Men: A History of the Struggle for the Control of Childbirth* (London: Historical Publications, 1988); Jean Towler and Joan Bramall, *Midwives in History and Society* (London: Croon Helm, 1986).

a midwife would try hot water, continuous support, and massage first, which has proven to reduce the request for epidurals.[60] Midwives use the birthing ball to make space in the pelvis and help the fetus descend, the bathtub and movement for pain management, the birthing stool as a position in which to optimally push, and safety and dimmed lights for the increase of oxytocin or, if necessary, medication to increase contractions.

All these technologies are focused on activating the birthing person, increasing their freedom of movement, intuition, knowledge, agency, and control, enhancing the relationality between pregnant people and their fetuses, and between pregnant people and their midwives. There is hence a difference between specific technologies that either assist or enhance a "natural" process or take over from nature. Synthetic oxytocin induction and epidural analgesia, for instance, prohibit the making of natural oxytocin, which also has short- and long-term emotional consequences because synthetic oxytocin does not have the "side-effect" of the experience of love as natural oxytocin does.[61] Forceps pull the baby out, minimizing the role of the mother, while a birthing stool helps the mother to push. A bathtub increases endogenous natural oxytocin rather than inhibiting it. This does not mean that in some cases forceps, vacuum extraction or synthetic oxytocin are not beneficial or lifesaving, but these are technological tools that constitute different reproductive realities, which are not necessarily more just.

Midwives have been developing and working with technology in various forms for hundreds of years in their use of craft knowledge, knowledge of how to support physiology, such as upright positions for birth, and managing complications with medicinal herbs.[62] Later came the use of artefacts of technology, such as the Pinard stethoscope, invented in 1895 to enable listening to the fetal heartbeat, which is still used by clinicians and taught to midwifery students worldwide. Intermittent auscultation, with either a Pinard or a hand-held battery-operated doppler ultrasound device, has remained the recommended method of monitoring fetal well-being in labor for healthy people at term who have no clinical or iatrogenic risk factors,[63]

60 Newnham, McKellar, and Pincombe, "Documenting Risk."

61 Sarah J. Buckley, "Executive Summary of Hormonal Physiology of Childbearing: Evidence and Implications for Women, Babies, and Maternity Care," *Journal of Perinat Education* 24, no. 3 (2015): 145–153.

62 Towler and Bramall, *Midwives in History and Society*; Donnison, *Midwives and Medical Men*.

63 Debrah Lewis and Soo Downe, "FIGO Consensus Guidelines on Intrapartum Fetal Monitoring: Intermittent Auscultation," *International Journal of Gynecology & Obstetrics* 131, no. 1 (2015): 9–12.

and probably also for women who do have complex pregnancies.[64] For midwifery, reproductive justice can therefore be understood as enacted by a somatophilic technology—a techne that loves and supports the body, facilitating the laws of nature, enabling nature to flow in the safest and best possible way.

Rothman therefore understands midwifery as a counterculture, a movement of artisanal workers, of "artisans" of birth resisting industrialization, revaluing home-made, patient, handcrafted, personalized practice, just like the slow food movement. She understands the knowledge and practice of midwifery not as just being patient or doing nothing, but as a specific skill set, we could say, as a specific "techne"—as skills, craftmanship, art—of birth:

> Whether it is knowing when a woman should be up and walking and when it will tire her out, when a partner needs encouragement to support the woman and when she needs some space from that partner, grasping immediately just what angle will help a stuck baby turn, or understanding which positions for that woman and that baby at that moment in second stage will help ease a baby out and avoid surgery—*those* are the skills that make a midwife.[65]

These skills have been documented in various ways in midwifery literature, as "the art of doing 'nothing' well"[66] and more recently as "watchful attendance."[67] The somatophilic technology of midwifery encompasses the physiological, psychological, emotional, cultural, and spiritual aspects of each pregnant person's needs. The reciprocal trust that is engendered in the context of this relationship is critical to people's sense of emotional safety, and the neurohormonal processes of her labor and birth.[68] In contradiction to xenofeminism's "when nature is unjust, change nature," midwifery's main idea is to lay bare and get to know nature in such a way that its best configuration can come to the fore—midwifery's *forte* is hence to be with nature relationally and respectfully as a way of enacting reproductive

64 Small et al., "My Whole Room Went into Chaos Because of That Thing in the Corner."

65 Rothman, *A Bun in the Oven*, 17

66 Holly Kennedy, "A Model of Exemplary Midwifery Practice: Results of A Delphi Study," *Journal of Midwifery & Women's Health* 45, no. 1 (2000): 4–19.

67 Ank de Jonge, Hannah Dahlen, and Soo Downe, "'Watchful Attendance' during Labour and Birth," *Sexual & Reproductive Healthcare* 28 (2021).

68 Ibone Olza et al., "Birth as a Neuro-Psycho-Social Event: An Integrative Model of Maternal Experiences and Their Relation to Neurohormonal Events during Childbirth," *PLOS ONE* 15, no. 7 (2020).

justice—exactly because midwives know that interference with nature does not necessarily lead to justice. One of its critical insights is that interfering too much with the natural process of birth, at this moment in time, could lead to more reproductive *injustice*—in the form of physical and emotional and psychological unsafety—rather than justice.

Midwifery and Its Anti-Technological Stance

The history of midwifery knowledge and practice is fraught with well-documented tensions between the dichotomy of physiology/midwifery and medicalization/obstetrics, "both constitutive and demonstrative of power dynamics."[69] While we believe midwifery's unrelenting critique of over-medicalization to be right, and indeed to forge a path to reproductive justice, it is of essential importance to recognize that there is also a reactionary tendency present within midwifery which radicalizes the midwifery perspective on reproduction as a somatophilic relation to nature into a separatist argument that is aligning with radical trans-exclusionary feminism. Just as technology can reproduce oppression, an ideology that prioritizes "nature" as such can turn transphobic and racist.

In making claims to "natural" birth—both as resistance and as an identity for (mostly) well-off white women—women of color in marginalized communities not only suffer the effects of not being able to access adequate or safe medical treatment, but they are also exoticized as people who birth "naturally," and this includes the appropriation of Indigenous practices.[70] This is also evidenced as a response to class: Grantly Dick Read noted his encounter with a young, working-class woman whose labor he attended to, for whom childbirth did not hurt because she did not know it was supposed to—sparking his natural birth method.[71] Suggesting that "the closer to nature" one's identity is constructed, the less of a peril "natural birth" is, denies that we have long been living in a natureculture continuum. On top of that, it denies the very well-known fact that pregnancy and birth are,

69 Candace Johnson, "The Political 'Nature' of Pregnancy and Childbirth," in *Coming to Life*, ed. Sarah Lachance Adams and Caroline R. Lundquist (New York: Fordham University Press, 2012), 199; Heather Cahill, "Male Appropriation and Medicalization of Childbirth: An Historical Analysis," *Journal of Advanced Nursing* 33 (2001): 334–342; Elizabeth Newnham, "Birth Control: Power/Knowledge in the Politics of Birth," *Health Sociology Review* 23, no. 3 (2014): 254–268.

70 Johnson, "The Political 'Nature' of Pregnancy and Childbirth."

71 Grantly Dick Read, *Childbirth without Fear: The Practices and Principles of Natural Childbirth* (London: Pinter and Martin, 2013 [1947]): 5.

for "normal physiological processes," potentially extremely painful and dangerous, no matter where you come from, especially for marginalized people who are, in contradiction to this theory, more often in need of medical technological assistance because of the effects of systemic racism, and least able to access them. In resisting the dominance of the medical discourse, as an identified mechanism of social control, we can identify a reactionary harkening back to nature and a tendency towards biological essentialism.

Radical feminism is an American school of thought that has a small body of theorists but that can count in recent years on a very broad popular following, not least within midwifery circles. It confusingly understands patriarchy as a mix of both biological determinism and social constructivism. According to radical feminists such as Mary Daly, Janice Raymond, Kathleen Stock, Julie Bindel, and Sheila Jeffreys,[72] female oppression can be traced back directly to male testosterone, male sex chromosomes, and the penis—a biologically deterministic argument that roots the oppression of women in male biology. Additionally, it asserts that this biological male dominance has led to a socially constructed idea of femininity—e.g., a big-breasted, blonde, blue-eyed, submissive, nurturing, weak, irrational woman—which does not align with how women actually, or naturally, are, but which discursively shapes women. According to radical feminism, the task is therefore to liberate female biology from the dominance of male biology and its oppressive discourse of femininity. This strange mix between social constructivism and biological determinism makes it possible to affirm women on the one hand, while being severely femme-phobic on the other, especially when it comes to "changing" female nature in the form of make-up, tattoos, plastic surgery, etc., as well as when it comes to gender transition.

It is understandable, however, how this type of thought is a logical ally to midwifery's critique of reproductive technology. Since the aim is to liberate oppressed female biology from male dominance, the existence of both femininity and trans femmes or transvestite femininity, as well as the medicalization of childbirth, are all regarded as things that bury "true female biology" even more. This view then becomes exacerbated into a fear

72 Mary Daly, *Gyn/Ecology: The Metaethics of Radical Feminism* (London: Women's Press, 1978); Janice Raymond, *The Transsexual Empire: The Making of the She-Male* (Boston: Beacon Press, 1979); Janice Raymond, *Doublethink: A Feminist Challenge to Transgenderism* (North Geelong: Spinifex Press, 2021); Kathleen Stock, "Entering the Parallel Universe of Transactivism," accessed December 12, 2022, https://kathleenstock.substack.com/p/entering-the-parallel-universe-of; Julie Bindel, *Feminism for Women: The Real Route to Liberation* (London: Constable, 2021); Sheila Jeffreys, *Unpacking Queer Politics: A Lesbian Feminist Perspective* (New York: Polity, 2003); Sheila Jeffreys, *Gender Hurts: A Feminist Analysis of the Politics of Transgenderism* (New York: Routledge, 2014).

of "female biology" being eradicated or erased, developing into an irrational fear of technology and the medical establishment, or anyone working within it, and a fully anti-technological anti-medical stance, that can and does result in dangerous medical situations. This irrational fear is the basis upon which trans women become constructed as the "other," keeping a fiction of a united community of biological females intact, revealing the philosophy of radical feminism as a theory based on a psychological fear of extinction, rather than a rational and sincere project to liberate us all from patriarchal oppression and gender-based violence.[73]

In midwifery, there is a similar tendency to follow the lines of radical feminism into a construction of medicalization and technology as the "dangerous other," to create a female midwifery community, just like radical feminism. As a consequence, trans people are understood to be subjected to severe processes of medicalization, and hence as a danger to the biology of female birth, and "nature" is constructed as something that cannot be unjust, hence alienating people who had a difficult, traumatic, or fatal birth experience. Apart from the fact that it is obviously a moral fallacy to believe that whatever nature does to birth is just, even if it ends dramatically, it is interesting that, where Firestonian feminism goes wrong precisely due to the assertion that reproductive *injustice* lies in biology, midwifery goes wrong due to the equation of nature and reproductive *justice*. The latter is also an obvious mistake, since, of course, the only reason we can even begin to achieve reproductive justice *via* nature, or bring nature to its full and safest potential, is because of the technological and scientific progress we have made with regards to hygiene, housing, and overall health that has made nature or "natureculture" relatively safe.

This strand of midwifery is increasingly risking the unique potential of the somatophilic techne of midwifery due to the ideology of radical feminism, propagating an irrational, dogmatic belief in nature, while turning its strong vision of reproductive justice to be achieved through a practice of thinking with the body, into a naive religion of the "natural" body. This establishes a specific type of violence in childbirth, distinct from obstetric violence, in which birth is made unsafe, or birth care exclusionary, on the basis of harmful ideology. Midwifery here adopts the violent exclusionary thought

73 Patricia Elliot and Lawrence Lyons, "Transphobia as Symptom: Fear of the 'Unwoman,'" *Transgender Studies Quarterly* 1, no. 3–4 (2017): 358–383; C. Heike Schotten, "TERFism, Zionism, and Right-Wing Annihilationism: Toward an Internationalist Genealogy of Extinction Phobia," *Trangender Studies Quarterly* 9, no. 3 (2022): 334–364; Alyosxa Tudor, *"Terfism is White Distraction: On BLM, Decolonising the Curriculum, Anti-Gender Attacks and Feminist Transphobia," Engenderings* (2020).

of radical feminism, in the sense that it is anti-trans (transition also being a form of medicalization and thus part of the conspiracy against female nature), and increasingly anti-abortion (also a form of medicalization), racist (because the essentialist biological woman has always been a white one) and it even ends up affirming misogynist stereotypes in which all women are intuitive child bearers and mothers. Influenced by radical feminism, this strain of midwifery is no longer a guardianship of physiology in the name of reproductive justice, but is radicalizing into being the guardian of "nature" itself. As such, it severs the relations that are important to facilitate justice. Rather than being loyal to the pregnant person, there is a loyalty to the "natural" process of birth. Radical feminist midwifery becomes the reactionary opposite of xenofeminism's slogan "when nature is unjust, change nature" into the conviction that nature *cannot* be unjust, and should never be changed.

This is no longer in line with the first two principles of reproductive justice, and it risks losing the unique potential of a specific midwifery configuration of reproductive justice and reproductive technology. Of course, there are many queer and trans midwives, and there are many midwives who are opposed to the ideology of radical feminism, but some of the most prominent figures of the midwifery community do adhere to this ideology. Therefore, it is important to articulate and make explicit the specific techne of midwifery and understand its strong suit as aligning nature neither with reproductive *justice* nor with *injustice*, but as working with nature to achieve the cultural goal of reproductive justice in a true natureculture continuum. Bringing together the somatophilic techne of midwifery and aligning it with Firestone's ultimate aim of gestational autonomy and self-determination, we then arrive at a reconfiguration of reproduction that is neither anti-nature nor anti-technology, but that uses nature in a continuous practice of care in which reproductive justice is embedded within a practice of relational care. We propose that a specific somatophilic techne, which we understand as "midwifery thinking" can facilitate reproductive justice.

Midwifery Thinking: A Somatophilic Techne for Reproductive Justice

What exactly do we understand the "techne" of midwifery to be? Rothman has theorized this as artisanship and skills,[74] and Newnham has

74 Rothman, *A Bun in the Oven*.

identified the need to define a specific "midwifery technology."[75] Here, drawing on the work of Sara Ruddick, we aim to further develop the techne of midwifery, not only as a different set of skills, but as a different way of thought, one that is characterized as preservative love, nurturance, and the constitution of relationships, in which certain skills can be used when needed in a specific practice.

Care ethics proposes to think in practice.[76] It is only when people involved in a caring practice think with what presents itself in that practice that a specific technology can be analyzed and critiqued. It is basic to care ethics that any idea of "the good" cannot be decided from a detached point of view. This is also true for achieving reproductive justice. Reproduction is deeply relational and can only be understood from within those relations. Walker has characterized this kind of relational ethics as "collaborative" and "expressive," meaning that understandings are expressed of what is ethical within practices, which are always performed collectively.[77] It is from these collaborative practices that a midwife, for instance, gains understanding of her identity as a midwife; through her relations with pregnant people and colleagues and sets of values at play in these practices.[78] The practice of care ethics by healthcare workers generally focuses on four categories of ethical care: relationship, context, attention to power, and caring practices.

The practice of midwifery is directed to the concrete responsibilities that emerge there. Central is that the need of the laboring person for midwives comes first, and that responsibilities can only develop in relation to those needs, which is fundamentally different than a paternalistic sense of responsibility in which healthcare workers decide for pregnant people what their needs are or should be. Midwives draw upon everything they know of nature, technology, and the person(s) in front of them in order to establish a relational midwifery practice in which they do nothing more *and* nothing less than thinking with the pregnant person. The specific techne of midwifery hence develops as a response to what the specific laboring body needs, and is inherently relational. Rothman discusses this as:

75 Newnham, McKellar, and Pincombe, *Towards the Humanisation*.

76 Joan Tronto, *Moral Boundaries. A Political Argument for an Ethic of Care* (New York: Routledge, 1993); Sara Ruddick, *Maternal Thinking: Toward a Politics of Peace* (Boston: Beacon Press, 1989); Margaret Urban Walker, *Moral Understandings: A Feminist Study in Ethics* (2nd ed.; Oxford: Oxford University Press, 2007).

77 Walker, *Moral Understandings*.

78 Ibid.; Kate Buchanan et al., "Care Ethics Framework for Midwifery Practice: A Scoping Review," *Nursing Ethics* 29, no. 5 (2022): 245–257.

> The midwife can understand all of the science and the evidence, and yet say that on this particular day, with this particular woman, her particular life story and her particular body, and this particular baby in the position it is, truly knowing and understanding all of what is going on, this is the moment for this particular bit of pressure.[79]

This entails that midwives are experts in Tronto's elements of ethical care: attentiveness, responsibility, competence, responsiveness, and trust/solidarity; being able to see and listen to signal the need, being able to take responsibility for answering to this need, doing the care work this entails, and again listening to the laboring person to see whether the care indeed responded to the need, within a setting that ensures continuity, solidarity, and trustworthiness.[80]

The biological materialism in which midwifery is embedded should not be understood as a biological grounding, but as a focus on the way in which the laboring body comes about in the "natureculture" continuum of the practice that is care. Midwifery thought, including the development of its somatophilic techne as well as its critique of overmedicalization, is rooted in the materialist doctrine of a fundamentally relational practice of care defined by Tronto's five phases. It is within the relationality of this praxis that the possibility of a somatophilic techne arises, as this relationality of care itself consists of a loving dialogue; something that can only take place if one listens, responds, and again listens. A somatophilic techne can only emerge within this constellation of care and consists of a way of thinking rooted in practice in which skill, artisanship, knowledge, and technology are used.

Somatophilic techne in the case of reproduction as a "thinking in practice" can be developed by drawing upon Ruddick's idea of "maternal thinking."[81] For Ruddick, being a mother is not an essentialist notion, but a characteristic of maternal practice. "Practices are collective human activities distinguished by the aims that identify them and by the consequent demands made on practitioners committed to those aims."[82] Mothering therefore *is* meeting the aims of the practice of mothering. And since the aims of mothering are constitutive of that practice, anybody can perform this practice by

79 Rothman, *A Bun in the Oven*.

80 Tronto, *Moral Boundaries*; Joan Tronto, *Caring Democracy. Markets, Equality, and Justice* (New York: NYU Press, 2013).

81 Rothman, *Recreating Motherhood*.

82 Ruddick, *Maternal Thinking*, 13–14.

serving those aims, which are threefold: "preservation, growth, and social acceptability."[83] The consequent demands made on the practitioners are preservative love, nurturance, and training for social acceptability.[84] If we follow Ruddick's logic and translate it to midwifery practice, we could consider midwifery practice as similarly distinguished by three aims, namely "preservation of people with the capacity for pregnancy," "(un)becoming 'motherandchild,'" and "relations that support reproduction and reproductive freedom."[85] These aims can be understood as corresponding to the concept of reproductive justice, in which they all come together. Reproductive justice consists of the right to have a child, the right to not have a child, and the right to parent the children we have in safe and dignified environments. The first two come to the fore in the first two aims, the third one in the last aim. The aims of midwifery practice can thus be understood as a grounding in practice of the overarching aim of reproductive justice. The consequent demands for praxis made on the basis of these aims can be conceived of as "preservative love," "nurturance," and "constituting supportive relations."[86]

Like Ruddick's claim that all children need preservation, we can claim the same for pregnant and laboring people. Pregnancy is a developmental state that renders all involved vulnerable. Pregnancies require care if they are to be preserved; both pregnant persons and fetuses can be lost without the required care. At the same time, some pregnancies can be life-threatening and will need to be aborted, or they are simply unwanted. Contraception and abortion are also forms of care that preserve the health and wellbeing of people with the capacity for pregnancy. Preservation, however, is not enough. Ruddick's addition of "love" here is essential, as it refers back to the first element of care ethics. For Ruddick, "attention is at once an act of knowing and an act of love."[87] We have seen how mere preservation of health in obstetrics, abortion clinics, and contraceptive practices can take the form of paternalistic preservation of pregnant people, which includes non-consented interventions and obstetric violence. Although this form of preservation results in a healthy mother and baby, it can be physically and psychologically traumatic. It is love,

83 Ibid., 22.

84 Ibid., throughout parts I and II.

85 These aims are amended from Inge van Nistelrooij, who first came up with the concept "midwifery thinking" and its corresponding aims and demands. The concept of "motherandchild" comes from Anne Enright. See: Inge van Nistelrooij, "Humanizing Birth from a Care Ethics Perspective" (Keynote lecture, Critical Midwifery Studies Summer School, 2022); Anne Enright, *Making Babies. Stumbling into Motherhood* (New York: W.W. Norton & Company, 2004).

86 Van Nistelrooij, "Humanizing Birth."

87 Ruddick, *Maternal Thinking*, 122.

and hence somatophilic preservation, that turns preservation from merely sustaining biological safety into the flourishing of the potential embedded in the body and mind. Love, in the definition of bell hooks, is an intention and a practice, not something that comes automatically or instinctively. It is a choice to let go of power and domination, and instead turn to affirmation of and care for the other, which is, according to hooks, the definition of love. Love is "the will to extend one's self for the purpose of nurturing one's own or another's spiritual growth."[88] Preservative love captures an essential element of midwifery practice and the thought that emerges from it; it is the extension of the midwife into a safe presence in which someone can labor freely, while the midwife makes sure the labor is preserved well and that complications can be identified and acted upon, or it is the presence in which someone can explore to keep a pregnancy, or abort, or think about and experiment with contraception and menstruation cycles.

As a consequence, within the midwifery practice of preservative love, we can think of technology used here as something that thinks *with* natural processes during childbirth—preserving it in a loving way so that it can come to its full potential. For instance, the sense of choice and control and emotional safety during birth enables the endogenous production of key hormones that progress labor, including oxytocin and endorphins, and prevents the production of stress hormones such as adrenaline that can block endogenous oxytocin. The success of this neurohormonal process is a key influence on whether the woman will experience a physiological vaginal birth, minimizing the need for medical intervention and increasing the likelihood of a positive birth experience.[89] From this perspective, we could engage with speculative reproductive futures, like Wondermash is doing in their project *Birth Futures*.[90] We could imagine vibrating bulbs in labor baths to stimulate orgasmic birth, for instance, or holograms in the shape of a humming cocoon of soft red silk that can be formed around the pregnant person at the press of a button to facilitate privacy and a sense of safety in any setting, or a space with pain-reducing vibrations and lights that the pregnant person can step in and out of to be fully in control of their own pain management.

But pregnancy and labor are also physical experiences of transformation which require nurturance. The fetus and baby need to be nurtured in order to

88 bell hooks, *All about Love* (New York: Harper Collins, William Morrow, 2018 [1999]).

89 Olza, "Birth as a Neuro-Psycho-Social Event."

90 See the website of Wondermash for more information about their project: https://www.wondermash.eu/projects/birth-futures.

"foster growth,"[91] and a similar demand concerns the mothers: their "growth" (physical, emotional, intellectual, and also as "multiplied vulnerability") requires care and nurturance as well, so that mothers are enabled to navigate the changes and challenges that their transformed life offers. Midwifery is not only about babies being born; it is also the nurturance of an unbecoming of the plural unit of motherandchild, in case of abortion, miscarriage, sterilization, contraception, and stillbirth. Unbecoming motherandchild, in whatever way, is a form of growth and transformation as well, for it realizes and directs attention to the plurality of the fertile body. Sometimes huge loss is experienced in a wanted pregnancy after which the pregnant persone never feels the same individuality again, or the experience of infertility or wanted sterilization catalyzes a transformation or affirmative acceptance consisting of existential change in which the person in question relates to the (im)possibility of motherandchild as an ontological condition. Rothman accuses feminism that values rationality highly, such as xenofeminism, of an intertwined theoretical disdain for the "significance of the body," and with that, of a disdain for physical work in the preference for "mental work."[92] The same counts for the physical work of giving birth, as well as the midwifery support for it. But in the nurturing support for this physical work, and in the physical work itself, lie a potential for growth, since it is specifically the physical experience here that is potentially transformative—perhaps even one of the most intense transformative experiences of contemporary society. All these becomings and transformations need nurturance, often physically but also emotionally and spiritually.

And finally, mothers and babies need others to support them. Rather than Ruddick's third aim of social acceptability, and training children for it, a midwife's responsibility and aim should be the other way around: namely to make the world and a community a safe place for pregnant people, people with the capacity for pregnancy, and mother and child. Through the care of midwives, new relations within the community can be constituted (via group care or the attention of other family members) and the midwife is an advocate for their rights, care, and respectful treatment. A birth seldomly leaves others (partners, friends, next of kin) unaffected; they also become a (grand)parent, sibling, aunt or uncle, and their relational network shifts. Room has to be made in others' lives as well, to care for and support the mother and child, to grow attached, to become related. They furthermore need materialistic and social support in the form of safe

91 Ruddick *Maternal Thinking*, 19–21, 82–102.

92 Rothman, *Recreating Motherhood*, 35.

housing and environments in which they can care for their children, access to healthcare, healthy food, education, and childcare support. And the same goes for people who need an abortion or do not want to get pregnant; they also need access to a community in which abortion pills and contraceptives are free and easily accessible, where they can get time off from work during their abortion or menstruation, and they need to be able to live stigma-free in societies in which a broad range of discourses exist on the experiences and meanings of abortions and contraception so that they can engage in sense-making practices regarding their own fertility. It is here that midwifery aligns with Tronto's fifth phase of care; the solidarity in providing care in such a way that its existence is trusted. Midwives' responsibility here is to safeguard continuity of care, of trustworthy systems, policies, institutions, so that pregnant persons can rely on care to be there, and do not have to struggle for each care need to be met.

It is typical of maternal practice, Ruddick contends, that mothers *think*.[93] For even though the aims of the practice are clear, they require that mothers attune them to each particular and unique child. Not every child needs the same kind of nurturing or social training; some need more protection or correction than others in order to become themselves and flourish both individually and socially. Views regarding flourishing also differ between and within historical times and cultural contexts. Mothers therefore need to think about what each unique child wants, about what they want to adopt and reject in social patterns of their context, and how they want their child to behave toward them. Therefore, the goals of mothering may be simultaneously relevant and conflicting from time to time. This also pertains to midwifery practice. The demands form the aims of relational midwifery practice, but midwifery is attuned to the particular needs of each pregnant and laboring person. The ways in which mothers transform, adjust, adapt, and grow, and also the manifold ways in which others are involved, require that midwives think about general goals and how they are best served in particular contexts.

We see this coming to the fore in different kinds of practice. For instance, the queer midwifery practice Refuge Midwifery provides IUI practices for queer families in their homes, and provides antibiotics in childbirth at home for GBS positive people.[94] Black-owned independent midwifery practices are able to provide better maternal and neonatal outcomes than the obstetric

93 Ruddick, *Maternal Thinking*, 17–23.

94 See the website of Refuge Midwifery for more information: https://www.refugemidwifery.com.

institution through better risk assessment and medical testing on the basis of knowledge and trust.[95] Midwives carry technology to the homes of clients so that they do not have to leave their house, such as devices to treat high bilirubin levels, to give oxygen to new-borns, to take blood or swabs in the privacy of the person's bedroom. Independent midwives often use WhatsApp as a way to be easily accessible to clients for non-urgent questions, as well as other secure apps for deliberation with pediatricians and obstetricians, so that clients do not have to come to the hospital. Anecdotally, midwives may practice this frequently on request, examples being assisting with artificial insemination, checking for amniotic fluid in queries of released membranes, and conducting examinations (speculum, wound, infant) at home and at the mother's request.

The practice of preservative love of the capacity of pregnancy, the nurturance of either the becoming or unbecoming of mother and child, and of the affirmation or constitution of social relations, are all relational and it is within these relations that specific needs of the specific person arise, are recognized, and evaluated, and that responsibility is taken for them, to ensure pregnant people's care needs are met within society. The latter is what can be understood as the specific strains of care work—or care cycles—that are woven into the practice of midwifery care. This requires a lot of thinking and interpretation, and it is here that a techne consisting of skills, artisanship, experience and evidence, medicine, and techniques is used. As becomes clear in the three demands to practice above, the aims that constitute reproductive justice cannot be met without technology. But when technology is always in a specific practice of preservative love, nurturance, and broader relationality, a specific somatophilic techne develops, in which a love for the body with the capacity for pregnancy guides technological intervention within a practice that has reproductive justice as a general aim. It also becomes clear, however, that when there is a dogmatic belief in nature as being reproductive justice in and of itself, this negates the aim for reproductive justice that discursively forms the practice and thought of midwifery. The rights to have and not have a child and to nurture children in safe environments correspond to the practical aims and demands of

95 Jennie Joseph and Stephan Brown, *The JJ Way: Community-Based Maternity Center. Final Evaluation Report* (Orlando: Visionay Vanguard Group, 2017); Keisha Goode and Arielle Bernardin, "Birthing #blackboyjoy: Black Midwives Caring for Black Mothers of Black Boys During Pregnancy and Childbirth," *Maternal Child Health Journal* 26 (2022); Leseliey Welch et al., "We Are Not Asking Permission to Save Our Own Lives: Black-Led Birth Centers to Address Health Inequities," *The Journal of Perinatal & Neonatal Nursing* 36 (2022); Suarez, Alicia, "Black Midwifery in the United States: Past, Present and Future," *Sociology Compass* 14 (2020); Benjamin, *Viral Justice*.

preservation of people with the capacity for pregnancy through preservative love, nurturance of the (un)becoming motherandchild, and the constitution of relational networks that support reproduction and reproductive freedom.

Firestones' feminist tradition of repro-tech and midwifery's somatophilic techne can both be understood as rooted in a materialist doctrine. Where feminist repro-tech must be wary of not understanding reproductive biology as reproductive injustice, midwifery must be resistant to any pull towards treating biology and nature as just in itself. Both these tendencies actually dismantle its materialist grounding and also its potential of situating critique, thought, and the usage of technology in specific material practices. We have argued that feminist midwifery has something to offer the feminist movement here, namely an articulation of a specifically situated thought in practice, in which a somatophilic techne is developed. It is our conviction that the design, development, and deployment within the contours of what we have coined "midwifery thinking" in which a "somatophilic techne" is used, will reground care for reproduction in a materialist understanding that aims for reproductive justice.

12 "When the Egg Breaks, the Chicken Bleeds": Unsettling Coloniality through Fertility in Lispector's *The Passion According to G.H.* and *The Chronicles*

Rodante van der Waal, Kim Schoof, and Aukje van Rooden[1]

Abstract

In our study of *The Passion According to G.H.*, supported by fragments from the *Chronicles*, we show: (1) how the passion of G.H. is the passion of a specifically *colonial* subject; (2) how fertility is an essential link between subjectivity and coloniality; and (3) how Lispector reconfigures fertility as a possibility of being deeply affected by the world. We argue that Lispector's project must be understood as concerned with the revolutionary question of dismantling the colonial subject and its world through pregnancy and fertility. As such, Lispector reimagines the relation between the person and their (capacity for) pregnancy.

Keywords

Birth, relationality, pregnancy, Édouard Glissant, Sylvia Wynter.

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Introduction

About chickens and their relationship with other chickens, about people and especially their pregnancy, about the egg, I have written my whole life.
—Clarice Lispector[2]

In Clarice Lispector's 1964 novel *The Passion According to G.H.*, the first-person narrator, G.H., famously transgresses her subjectivity. After G.H.'s maid has left, she sets out to clean the room for the next maid and discovers a cockroach in the room—a confrontation that G.H. comes to experience as the perishing of her subjectivity. The observation that will serve as the point of departure of this essay concerns the colonial subjectivity of G.H., i.e., the specificity of the subject that perishes. As Lucia Villares lays out in *Examining Whiteness*, G.H. is often understood not as a clearly situated subject, but as a universal one—a treatment typical for white characters. By better grasping the specificity of the subject that perishes in *The Passion*, however, a new distinct potential of Lispector's philosophical project surfaces. While it is often interpreted as an attempt to express a pre-discursive experience, and as having been intended to stage an encounter with the raw matter of life beyond thought and language—with a pre-symbolic neutrality that echoes philosophical discourses on the immanence of being, albeit possibly feminine—,[3] the specificity of the perishing subject is capable of permitting a different reading of *The Passion*: not as a work concerned with pre-discursive existence, but with the refusal of a colonially defined subject, its dissolution through an experience of fertility, and the opening up of the possibility to subsequently conceive life otherwise. When *The Passion of G.H.* is taken seriously as the passion of the colonial subject, Lispector's philosophy hence reveals itself not as primarily ontological, as aiming to work through the question of being, but, instead, as revolutionary, aiming to dismantle the coloniality of being in favor of another relation to the world.

2 Clarice Lispector, *De ontdekking van de wereld. Kronieken* [*Chronicles*], trans. Harrie Lemmens (Amsterdam: De Arbeiderspers, 2016), 342–343 – our translation.

3 Fernanda Negrete, "Approaching Impersonal Life with Clarice Lispector," *Humanities* 7, no. 2 (2018): article 55; Hélène Cixous, *L'heure de Clarice Lispector; précédé de, Vivre L'orange* (Paris: Des Femmes, 2008); Hélène Cixous, *Readings: The Poetics of Blanchot, Joyce, Kafka, Kleist, Lispector, and Tsvetayeva*, trans. Verena Andermatt Conley (Minneapolis: University of Minnesota Press, 1989); Tace Hedrick, "Mother, Blessed Be You among Cockroaches: Essentialism, Fecundity and Death in Clarice Lispector," *Luso-Brazilian Review* 34, no. 2 (1997): 41–57; Adam Joseph Shellhorse, *Anti-Literature: The Politics and Limits of Representation in Modern Brazil and Argentina* (Pittsburgh: University of Pittsburgh Press, 2017).

For the Martiniquan philosopher Édouard Glissant, the exemplary alternative to a colonial relation to the world is "creolization"—a form of relationality that approximates a being in relation with the "Whole-World" as a "non-totalitarian totality of relations."[4] Glissant understands creolization as a violent process most radically represented by the diffraction of identities through the displacement of enslaved people in the transatlantic slave trade.[5] Creole cultures, however violent their origin, present a different, more horizontal, way of relating to each other and the world than colonial European cultures that protect the "purity" of their language and culture. Instead of an atavistic colonially defined relation to the world, as for instance represented by the French language, creolization contains a different kind of poetics of relation that reconfigures our being in the world—the development of which was Glissant's life-long project.[6] Choosing a different approach but having a similar aim, the Brazilian philosopher Denise Ferreira da Silva develops a range of strategies for the "hacking" of the subject, thereby aiming to overcome the coloniality that defines both our world and our subjectivity.[7] Through reprogramming "the code in the living thing" and causing "mayhem in their self-reproductive capacity" the subject could be released into the "end of the world,"[8] meaning its decolonization as the "unknowing and undoing of the World that reaches its core."[9] After the dissolution of the colonial subject and its world, we can attempt to imagine life and the world otherwise: as a "plenum" of "difference without separability."[10] For both Glissant and Silva, dismantling the coloniality of being requires a fully reconceived relation between the subject and the world, and, in different ways, the transgression of both. Staging our reading against the theoretical backdrop of Glissant and Silva, we do not wish to conflate the distinct philosophical projects of Glissant, Silva, and Lispector,

4 Édouard Glissant, *Treatise on the Whole-World*, trans. Celia Britton (Liverpool: Liverpool University Press, 2020).

5 Édouard Glissant, *Introduction to a Poetics of Diversity*, trans. Celia Britton. (Liverpool: Liverpool University Press, 2020); Édouard Glissant, *Poetics of Relation*, trans. Betsy Wing (Michigan: University of Michigan Press, 1997).

6 Glissant, *Poetics of Relation*.

7 These strategies include blacklight, Black feminist poetics, being in the raw, Black ungendered female flesh.

8 Denise Ferreira da Silva, "In the Raw," E-Flux, last modified September 2018, www.e-flux.com/journal/93/215795/in-the-raw, 4.

9 Denise Ferreira da Silva, "Toward a Black Feminist Poethics," *The Black Scholar* 44, no. 2 (2014): 81–97.

10 Denise Ferreira da Silva, "On Difference without Separability," in *32nd Bienal de Sao Paulo. Incerteza Viva*, ed. Jochen Volz et al. (Sao Paulo: Bienal Sao Paulo, 2016).

but show that, when read in dialogue with these thinkers, the perishing of subjectivity thematized by Lispector in *The Passion* and the *Chronicles* can be seen as a similar attempt to dismantle the coloniality of being, although she uses a different strategy: a radical reconfiguration of fertility.

The "constant evocation of fecundity" in the work of Lispector has been noted before, but it has mostly been understood in an essentialist sense, as a pre-discursive generativity or hospitality typical of woman- and motherhood.[11] If we understand this world to be a colonial one, however, we must see that fertility is instrumentalized through a politics of reproduction that determines the demography of the colony.[12] The ubiquitous control of people through (neo)eugenics, pro- and anti-natalism, and reproductive genocide exposes fertility as an essential link between coloniality and subjectivity, a link that ensures the reproduction of the colonial subject and its world. Fecundity is hence not an innocent or pre-discursive given, but an appropriated capacity for the reproduction of whiteness and the continuation of white supremacy. With this in mind, we will argue that fertility in Lispector's thought should not be understood as relying on a naive conception, but, on the contrary, as a rather complex concept: fertility functions in Lispector's work as something that is to be reconfigured from one form to another via itself—"fertilizing my dead fertility" as she describes it.[13] The reimagination of fertility proves to be transgressive as it has the dismantling of the colonial subject as its consequence. To put it in Lispectorean terms: "when the egg breaks, the chicken bleeds"[14]—pregnancy being, indeed, the locus of its *passion*.

11 Hedrick, "Mother, Blessed Be You."

12 In the settler-colonialism of the Americas this is illustrated by the forced sterilization and hysterectomies of indigenous people, while enslaved Black people were forced to reproduce up to the late nineteenth century: Deirdre Cooper Owens, *Medical Bondage: Race, Gender, and the Origins of American Gynecology* (Athens: University of Georgia Press, 2018). An example of non-settler colonial control of reproduction by a European nation state is the forced abortions in the 1970s of Black people in the French overseas territory La Réunion, in contrast with the forced pregnancies of white women in France: Francoise Vergès, *The Wombs of Women: Race, Capital, Feminism* (London: Duke University Press, 2020). A current example is the pro-natalism of the Israeli state concerning its Jewish citizens, while deploying a violent ani-natalist policy directed at Palestinians both in Israel and the occupied territories, resulting in a wide gap of maternal (nine times higher) and neonatal mortality (six times higher) rates between the populations: WHO, "Health Conditions in the Occupied Palestinian Territory, Including East Jerusalem, and in the Occupied Syrian Golan. Report by Director-General," last modified November 5, 2020, apps.who.int/gb/ebwha/pdf_files/WHA73/A73_15-en.pdf.

13 Clarice Lispector, *The Passion According to G.H.*, trans. Idra Novey (New York: *New Directions*, 2012), 79.

14 Lispector, *Chronicles*, 198.

In the first part of this chapter, we map the way *The Passion* stages G.H.'s subjectivity as distinctly colonial and appropriative; concepts that we will define by referring to the work of Silva.[15] With reference to Glissant's thoughts on filiation and Silva's understanding of miscegenation in Brazil, we then show how fertility plays a crucial role in the reproduction of the white colonial subject, and how this is captured in *The Passion*. In the second part, we study how the Lispectorean reconfiguration of fertility in both *The Passion* and the *Chronicles* implies the dismantling of colonial subjectivity, moving from an appropriative relation to the world to one that is so receptive that it causes the subject to perish.

Instinctively Killing the Other: Whiteness, Reproduction, and Colonial Subjectivity

"An Inexplicable Rage": Colonial Subjectivity

From early in *The Passion*, Lispector accentuates the colonial subjectivity that determines G.H.'s situatedness. G.H.'s apartment is described as "that house where in semi-luxury I live" and is usually kept by a maid, although the maid resigned the day before the story begins.[16] One morning, G.H. muses about her apartment and the way it expresses her social identity:

> The apartment reflects me. It's on the top floor, which is considered an elegance. People of my milieu try to live in a so-called "penthouse." It's much more than an elegance. It's a real pleasure: from there you dominate a city.[17]

At a certain point, she starts making plans to clean the maid's room, assuming that it "must be filthy," to "ready it for the new maid."[18] Her expectation of finding the maid's room, located at the "bas-fond" of the house, stained by "the darkness of dirt and [...] junk"[19] could be interpreted as "just" another classist trope substantiating G.H.'s bourgeois subjectivity—although the emphasis on the maid's Blackness also makes this trope explicitly racist.

15 Silva, *Towards a Global Idea*.
16 Lispector, *Passion*, 24.
17 Ibid., 30.
18 Ibid., 35.
19 Ibid., 38.

When G.H. enters the maid's room and, to her astonishment, finds it clean and bright, she is overwhelmed by rage, and struggles to remember the maid's name and face, even though the maid had only left the day before:[20]

> I saw her black and motionless face again, [...] her fine and delicate features barely discernible against the closed-off blackness of her skin [...] It wasn't surprising that I'd used her as if she had no presence: beneath her small apron, she always wore dark brown or black, which made her entirely dark and invisible [...]: she was flat as a bas-relief stuck on a board.[21]

The racist tropes of Janair's supposed indiscernibility and invisibility and G.H.'s "use" of her "as if she had no presence" both articulate G.H.'s whiteness and situate her as a bourgeois woman. The location of the house from which you can "dominate the city" as well as the appropriation of Janair to the point of invisibility accentuate the coloniality of G.H.'s relation to the world.

As Denise Ferreira da Silva[22] theorizes, modern white subjectivity is established through its colonization of the world. With the start of Europe's large-scale colonial enterprises, people slowly became differentiated between European "universal" subjects, recognizable by their whiteness, and "Europe's others," i.e. "subaltern" subjects recognizable by their being of color. Silva terms the colonial process that constituted this differentiation "the scene of engulfment" in which everything non-European, i.e., land and people, was appropriated for the accumulation of European power, capital, and science. Through the cultivation of a colonial relation to the world, enacted in practices of conquest, genocide, and extermination, the white subject "engulfed" everything that was other and thereby came into being as allegedly "universal."[23] Insightful of the objective laws of nature but himself occupying a transcendental position to these, the universal subject was constructed as the only one capable of self-determination and thus the only one in possession of "interiority."[24] "Europe's others" were engulfed in and thereby appropriated by the supposed universality of white subjectivity, becoming characterized as fully "outer-determined" and "affectable" instead of in possession of interiority. The "subaltern subject" was deemed to have no self-consciousness and to be only knowable by the

20 Ibid., 41.

21 Ibid., 42.

22 Silva, *Towards a Global Idea*.

23 A similar process of expansion and homogenization is described by Glissant in terms of "atavism" and "generalization." See: Glissant, *Introduction to a Poetics*; Glissant, *Poetics of Relation*.

24 Silva, *Towards a Global Idea*, 255.

universal subject instead of by themselves.[25] This differentiation meant that the white modern subject of interiority was indeed powerful and "universal," but also fully *closed off from the world*, hardly able to be affected by the world, caught in an atavistic, appropriative, and colonial relation to it. The modern subject hence became incapable of—as is often thematized in Lispector's work—truly *living with* (*in*) its surroundings.

It is this colonial relation to the world that *The Passion* articulates through the character of G.H. When G.H. enters Janair's former room and discovers that Janair "arranged the room in her own way, stripping it of its storage function as brazenly as if she owned it,"[26] G.H. is confronted with Janair's self-determination and thus with the subjectivity of somebody she had thought to be completely "engulfed" within herself. G.H. then comes to the realization that she may not have been the only subject in her house after all, but that her maid, whom she perceived as fully outer-determined by her, was in fact not fully engulfed by her, possessed interiority, and was able to see her from her own positionality: "Janair was the first *truly outside person* of whose gaze I was becoming aware."[27] The discovery of Janair's interiority and self-determination threatens G.H.'s own subjectivity, which, being derived from a colonial relation to the world, is dependent on the engulfment of Janair. This threat to G.H.'s subjectivity instinctively throws her into an "inexplicable rage" that comes "naturally" and makes her want to "kill something."[28] She fantasizes about violating the room where Janair lived, "throw[ing] water into the wardrobe to flood it up to its mouth."[29] Through symbolically killing Janair, G.H. imagines herself able to reappropriate, or quite literally reengulf, the room: "As if already seeing a picture of the room after being transformed into me and mine, I sighed with relief."[30]

We hence locate the inciting incident that marks the beginning of G.H.'s transgression of subjectivity even *before* her confrontation with a cockroach in the closet, namely in G.H.'s unexpected confrontation with Janair's subjectivity, and G.H.'s ensuing rage. This centering of G.H.'s discovery of Janair's subjectivity enables us to understand G.H.'s transgression in light of a crisis of colonial subjectivity, articulating the central confrontation in *The Passion*, as one not between G.H. and the cockroach, but primarily between a universal and a subaltern subject.

25 Ibid., 117, 255, 257–59.
26 Lispector, *Passion*, 71.
27 Ibid., 41, our italics.
28 Ibid., 45.
29 Ibid.
30 Ibid.

"A Dying Mulatto Woman": Sexual Reproduction and Coloniality

Throughout her work, Lispector critiques, albeit often implicitly, that women are instrumentalized to reproduce. An explicit critique can be found in the story "The Chicken and the Egg," which first appeared in the *Chronicles*. In this story, the chicken is instrumentalized by the reproduction of what is repeatedly described as a very white egg—so much so that the chicken "only exists on behalf of the egg."[31] According to the narrator, "the chicken is stupid, idle and short-sighted," and not worth much beyond "being a means of transport for the egg."[32] Using the chicken as a metaphor, this story serves as a feminist critique of the instrumentalization of lives for reproduction. In what follows, we show how fertility, coloniality, and subjectivity are bound together to ensure the reproduction of the colonial world, and how this comes to the fore in *The Passion*.

The instrumentalization of fertility is typical of the modern Western conception of humanity. As Glissant explains, Western communities are based on an ideology of atavistic filiation, which protects the "root-identity" of the community by differentiating between "kin" and "others." Only those who are considered "kin" are granted a place in the community and can inherit the community's assets. Both the reproduction of the community and the justification of its territory are guaranteed through the genealogical origin story of a chain of filiation. As Glissant writes: "The retelling (certifying) of a 'creation of the world' in a filiation guarantees that this same filiation—or legitimacy—rigorously ensues simply by describing in reverse the trajectory of the community, from its present to this act of creation."[33] Consequently, in this Western ideology of filiation, miscegenation is constructed as a great danger to the community, as it threatens the chain of filiation. As Glissant points out, many canonical tragedies in Western culture are constructed precisely around this "threat" of miscegenation.[34] *The Passion* is also constructed around this threat, which is embodied by the cockroach—here the figure that ties together the problematic of coloniality and fertility.

After G.H. has broken out in a rage, she cools down and alters her plans of suffocating the wardrobe in Janair's former room, deciding to nourish and polish it instead. But when she opens the wardrobe's door, she finds herself enraged for a second time, this time by the cockroach she finds

31 Lispector, *Chronicles*, 536.
32 Ibid.
33 Glissant, *Poetics of Relation*, 47.
34 Ibid., 50.

inside. The rage that was awakened in G.H. earlier is now transposed to the cockroach, which looked to her "like a dying mulatto woman."[35] "Mulatto" is a racializing pejorative term originally derived from the Portuguese *mula*, meaning mule, the offspring of a horse and a donkey. The term refers to people of mixed African and European ancestry and therefore to a form of miscegenation that is characteristic to the demography of Brazil.[36] The cockroach, in other words, can be understood to represent either Janair's mixed-race offspring, or, more abstractly, miscegenation as such.

G.H.'s rage and subsequent inclination to kill both Janair and the cockroach are reminiscent of Brazil's specific analytics of raciality and the place of sexual reproduction within them. Silva differentiates between an analytic of raciality that produces a logic of *apartheid*, permitting only two or three categories, "white," ("colored"), and "black"—of which segregation in the United States and South Africa are prime examples—and an analytic centering around a specific understanding of miscegenation, which produces a logic of obliteration, of which Brazil is an example. Brazil's demography does not consist of a dichotomy between white and Black. Instead, the characteristic subject of what Silva terms Brazil's "miscegenated demography" is understood to be "tanned":[37] it might not be white, but its brownness is just a superficial "tan." The miscegenation caused by the rape of Black, enslaved, and indigenous women is justified through the orientalist argument that Black and indigenous blood and labor were momentarily necessary to be able to "tame" the wild, tropical country. But once settled, the goal was to obliterate all color to arrive at the nation's "true" white subjectivity. The "tanned" Brazilian subject was hence not constructed as subaltern due to its miscegenation—as it would be in a logic of apartheid—but as "almost universal." Because of the underlying aspiration to universality, an atavistic chain of filiation of whiteness was kept intact, in which "tanned subjects" are on a teleological path of "purification" towards whiteness through the eschatological obliteration of Blackness:

> a rewriting of miscegenation that also re-signified whiteness, one in which the temporal trajectory of the national subject is narrated not as the actualization of "racial purity" but as a process of "racial or cultural purification"—that is the fulfilment of the logic of obliteration.[38]

35 Lispector, *Passion*, 58.
36 Silva, *Towards a Global Idea*.
37 Ibid., 227.
38 Ibid.

The subject's trajectory towards whiteness adjusts the "error" of miscegenation through sexual reproduction, rewriting the chain of filiation in whiteness. White women's reproductive capacity is used to whiten the "tanned subject" and thus slowly obliterate Blackness—hence G.H.'s instinct to eat the roach, amounting to its full engulfment and total digestion in a white chain of filiation.[39] Simultaneously, the reproductive labor of Black women becomes fully appropriated to the point of invisibility—just as in the case of Janair.[40] Fertility links the individual to the demographic project of the nation state, and Black women's fertility specifically is used and taken up within that state to be eventually obliterated, a process we see reflected in G.H.'s engulfment of Janair and her instinct to obliterate Janair and the "dying mulatto woman" cockroach.

Locating G.H. explicitly within colonial modernity allows us to go a step further than understanding Lispector's writing merely as unconsciously racist or colonial. *The Passion* explicitly situates G.H. as a colonial racist subject alienated from the world. In her appropriative relation to the world, there is only separation, demarcation, dissolution of relationality, controlled reproduction of the same, and appropriation—exemplified by G.H.'s loneliness, her life high above the world, the lack of awareness of Janair as a person living in her house, and her murderous rage that drives her towards violent engulfment and obliteration. But instead of having G.H. affirm, or simply ignore, her privileged, powerful, and dominant appropriative relation to the world constituted by the structures of instrumentalized fertility, racialized subjectivity, and coloniality, Lispector is dedicated to radically reconfiguring the relation of the subject to the world by staging G.H.'s passion as an opening up to the world, so much so that she herself eventually perishes. This move from an obliterating kind of instrumentalized fertility to its reimagination as a fertility that dismantles modern subjectivity and conceives a different relation with the world, is what we read as Lispector's philosophical project of unsettling coloniality in favor of life *otherwise*.

39 In the *Chronicles*, this tendency of obliteration through engulfment inscribed in a logic of fertility is also expressed clearly through the desire to eat (and hence to fully appropriate): "[…] I ate [the world] with my power and with the rage that limits me […] I thought that the world was made from power and that power was the matter through which I could come near." (Lispector, *Chronicles*, 376); "I wanted to eat the world, and the hunger with which I was born, the hunger of milk – that hunger I wanted to extend in the world and the world did not want to be edible." (Ibid.)

40 By this same logic, white women's reproductive labor was also symbolically instrumentalized in the whitening of the subject by carrying out the Oedipal law of the father severing Black women from the children they cared for or mothered, as Rita Segato shows: Rita Laura Segato, *L'oedipe Noir: des nourrices et des mères* (Paris: Payot, 2014).

"Fertilizing My Dead Fertility": Unsettling the Coloniality of Being for Life Otherwise

"Life Is Living Me": Reconceiving Fertility

In much of Lispector's work, exemplarily in *The Passion*, "the actual process of life" is emphatically carried "inside me."[41] Such a carrying of "the actual process of life" or, in other instances, of "the world," is thematized frequently throughout Lispector's oeuvre as pregnancy or fertilization. After having shown how subjectivity, fertility, and coloniality are entangled in *The Passion*, we aim to expose Lispector's reconfiguration of fertility to unsettle the coloniality of being.

At one point, G.H. famously becomes truly receptive to the roach, an experience she frames in terms of fertilization: "The roach is alive, its eye gaze is fertilizing."[42] In multiple scenes in the *Chronicles* as well, the narrator is deeply affected by the outside world, which she also describes in terms of fertilization. There is one scene in which an enraged woman who perceives everything as "dry" and "infertile" finally feels the advent of a transformative experience in the form of rain. She states that "the urgency is still motionless, but something is trembling within," and before the rain falls, the "shimmer" in her eyes "changes into tears," at which point "the air finally softens."[43] Before it actually rains, the world hence rains *through her* as her tears, after which the world itself, specifically its air, softens—as it would when it rains outside. Here, something of the world, namely its rain, is received *within* her in such a way that it fertilizes her, consequently changing her, the world, and their relation. We see here a first glimpse of how, through a reconfiguration of fertility, a different relation between the subject and the world is opened up that has the potential to change them both.

After being fertilized by the roach's ovary-like eyes, G.H. states: "[I]ts eyes weren't seeing me, its existence was *existing me*."[44] This being existed by something outside of her returns in the famous second-to-last sentence of *The Passion*: "*a vida se me é*"—"[L]ife just is for me."[45] This sentiment illustrates a change in subjectivity; instead of something to be conquered or appropriated, life just *is*. Yet, the Portuguese *me* can be read as both the

41 Lispector, *Passion*, 53.
42 Ibid., 96.
43 Lispector, *Chronicles*, 49.
44 Lispector, *Passion*, 78 – our italics.
45 Ibid., 187.

direct and the indirect object in this sentence, an ambiguity which has led Fernanda Negrete to the translation "life is itself to/on me."

According to Negrete, the sentence expresses more than just a transgression of subjectivity; the formulation shows the univocal nature of life, and the narrator's burgeoning understanding of herself as part of it. Here, we move a step further again from an alienated colonial subjectivity, to a Deleuzian-Spinozist understanding of life as that in which univocal immanence constitutes difference. The notion of univocity as the condition of difference makes a horizontal relationality possible, in which the supposed transcendental nature of a universal subject is rendered meaningless. However, a reading along these lines does not fully capture the significance of the *existing* of life or the world *within* or *through* the "I" that we saw in the case of the roach "existing" G.H., i.e., the specifically *fertile* nature of the relation between the "I" and the world, or: the specific relation between G.H. and her fertility, effectuated by the world, or "lived through" the world.

G.H. seems not just to gain insight in what she calls the actual process of life or "the raw matter" of life,[46] but in fact to carry or bear it, to receive it, or even become pregnant with it. Tellingly, at one point in the novel, G.H. looks back on the period in her life in which she had an abortion and explains this experience as follows: "Pregnancy, I had been flung into the happy horror of the neutral life that lives and moves [...]. When I was walking, when I was walking, I was carrying it."[47] She thus seems to have become *receptive* to life, which is different from the realization that she *is* life. So receptive even, that she not only carries this life, but that it, as we saw with the cockroach, *exists* her,[48] or, as we saw with the rain, becomes *through* her. This specific relation between the "I" and life becomes clearest in Susanna Lindberg's interpretation of the French translation of "*a vida se me é*," "*la vie m'est*," which limits itself to the indirect object, and which means "life is living me"—note the echo of the roach "existing me."[49] In our reading, the differentiation of this latter interpretation from the other two clarifies the typical Lispectorean reconfiguration of the relation between the subject and the world: from an appropriative relation of the subject to the world, where the world is engulfed by the subject to constitute itself as self-determined, universal, and in possession, not of affectability but of interiority, we move to a being fertilized, and thus being affected, by the

46 Ibid., 93.
47 Ibid.
48 Ibid., 78.
49 Ibid.

world, and consequently a generation of their relation *otherwise*. Instead of as a study of the nature of being, we read *The Passion* as a refusal of our current subjectivity and a search for a "hack" of its nihilistic experience of the world through which it is, following Silva, unable to be truly affected by it—a fugitive search carried out through a reconfiguration of the relation between the I and the world through fertility. This search does not bring us a utopic full-fledged picture of a world beyond this one, but, in a manner both humbler and more revolutionary, it conceives the transgression of the subject and the world as we know it. The opening is found, we believe, in the refusal of instrumentalized fertility—made explicit in the middle of the book by G.H.'s recollection of an abortion she had and the eventual refusal of her instinct to eat the cockroach—and the following reimagination of fertility.

"The World Trembles within Me": Unsettling the Coloniality of Being

After being fertilized by the roach's eyes, G.H. transgresses her subjectivity: "Finally, finally, my casing had really broken and without a limit I was."[50] The perishing of the subject after fertilization is a narrative that also returns multiple times in the *Chronicles*. One scene describes a woman entering the sea: "The slow walking grows her hidden courage. And then she lets herself be flooded by the first wave. The salt, the iodine, everything fluid, blind her momentarily while she stands there dripping—surprised, fertilized."[51] Immediately after her fertilization, she is compared to a castaway: "She knows in some dark way that her dripping hairs are those of a castaway."[52] A castaway is found on a shore, far away from home, without kin, community, or genealogy, without any chain of filiation, sometimes even without knowing who they were before. The receptivity and affectability inherent in the invasive nature of fertility are here effectuated by Lispector to disrupt the chain of filiation, the subject's control of the world and the borders of the subject itself. The subject's "fertilization" by the world hence dismantles its colonial relation to it, "delivering it," in a Silvaen manner, without kin "at the end of the world[53]—its life now being fertilized, and hence *existed by*, the world.

Through the reconfiguration of fertility, the chain of filiation is discontinued and a different relation to the world—an affectable rather than an

50 Ibid., 186.
51 Lispector, *Chronicles*, 106.
52 Ibid., 107.
53 Silva, "In the Raw," 4.

appropriative one—is disclosed. G.H. says: "Existing demands of me the great sacrifice of not having strength, I give up, and all of a sudden the world *fits inside* my weak hand."[54] G.H. giving up her power so that the world fits *within* her, indicates that the conception of the "world" that is presented here entails not an appropriable thing the subject can settle in, but instead means that the world is disclosed to her in a different manner. After giving up her subjectivity, G.H.'s "I" is no longer clearly demarcated from the world: "All shall be *within* me, *if I shall not be*; for 'I' is just one of the instantaneous spasms of the world."[55]

G.H. can only be in a different relation to the world if her colonial subjectivity perishes, letting her life be fertilized and then existed by the world.[56] She no longer appropriates her surroundings, but receives them, lets them fertilize her and dismantle her, and she finally conceives the world through the sharing (it fertilizes/exists/lives *me*) of her own life. As with pregnancy, fertilization goes together with a transgression and transformation that leaves the "I" with a life *existed by* other life. The "being-existed" of one's own life by the world, by life, constitutes a radically different relation to the world than that of the colonial subject, in which the world is appropriated for its own constitution.

Here, G.H.'s transgression of subjectivity echoes Glissant, who writes: "To be born into the world is to at last conceive (to live) the world as relation."[57] The difference is the way in which the world is lived as relation. For G.H., it is lived through her own life being lived, being shared, by the world. Where Glissant writes about a poetics of relation in terms of being born to the world, for Lispector the emphasis of the relation is on pregnancy; the "world trembles *within* her," and she feels the "mother of the world," as the life in which the world is received. In one of the *Chronicles*, Lispector writes:

> Out of pure affection I felt to be the mother of God, that was the earth, the world. Out of pure affection, really, without any domination or triumph, without feeling in the least superior or equal, I was out of pure affection the mother of all that exists.[58]

54 Lispector, *Passion*, 185 – our italics.

55 Ibid., 186 – our italics.

56 A sequence of associations follows the scene in the *Chronicles* in which the protagonist feels the rain coming, a sequence that echoes Glissant's notions of the Whole-World: the protagonist thinks of India, of carnations at a cemetery, of wet wood, of rain from Malaysia. By becoming receptive to the rain, a plurality of places flow into her.

57 Édouard Glissant, *Poetic Intention*, trans. Nathanaël (New York: Nightboat Books, 2010), 15.

58 Lispector, *Chronicles*, 324.

No longer engulfing the world in domination, she is *affected* by it in such a way that she gives it her life, her flesh, her blood, her care, so that it lives *through* her.

The Passion hence plays out the threat of miscegenation that Glissant identifies in Western culture; not through literal miscegenation, but by the reimagination of the relation between the subject and fertility which dismantles the colonial subject and its relation to the world. Lispector herself often notes that there is indeed a certain threat in her work. She says about the castaway: "She knows that she has created a danger. A danger as old as humanity."[59] The castaway is indeed a danger to humanity since she represents the dismantled subject without genus or genealogy at the end of the world. *The Passion* echoes this same danger when it is mentioned multiple times that the book is not trying to take anything away from us—only some of us, Lispector implies, can see that the perishing of the subject actually *brings* us something. G.H. describes the reimagination of fertility as "fertilizing my dead fertility."[60] The former state of her fertility, appropriated and instrumentalized by the colonial world, was thus "dead," something that resonates with the alienation of the colonial subject's impossibility to live in, and be affected by, the world. The fertilization of that fertility opens something else, something threatening: a life *otherwise*.

We thus read "life is living me" to contain a specific Lispectorean philosophical insight in addition to a Deleuzian-Spinozist view on the univocity of being. Here, the relation between the "I" and the world is not one of an absolute fusion (in which the "I" and the world become one), nor of an intimate encounter (in the form of the singular plurality of a "we"), nor one of immanence (as the disclosure of the univocity of being). Instead, *The Passion* writes G.H. as *fecundated* by the world, as a result of which the colonial subject perishes, in an attempt to exist *otherwise*. While Lispector indeed moves her perspective from "my subjectivity" to "life,"[61] we understand this not only as a move from a personal understanding of "my life" to a more abstract, univocal one. Instead, we believe that Lispector was sometimes able, in line with Silva, to arrive as a castaway at the end of this world—evoked by her continuous questioning "Why this world?" that also furnished the title of her biography[62]—and there found a more

59 Ibid., 107.

60 Lispector, *Passion*, 79.

61 Negrete, "Approaching Impersonal Life."

62 Benjamin Moser, *Why This World: A Biography of Clarice Lispector* (Oxford: Oxford University Press, 2012).

revolutionary, and hence more political, possibility to generate life, and live together *otherwise*.

This different generation of life can also be found in Lispector's work itself, for instance in the choice to stage her narrator as a writer, as a subject that expresses, shapes, or creates the experiences we read about through writing. G.H. wants to bring forth, give birth, create "whatever happened to me," suggesting that the text we read is a text generated by G.H. herself.[63] For G.H., the act of writing is clearly not one of imposing meaning or engulfing it with her understanding. "Creation," she holds, succeeds "only when the construction fails."[64] "Grasping reality" is not something that can be achieved in writing. G.H.'s aim is rather to generate the world without imposing anything on it; to generate its living presence *through* her without grasping it. Thus, *The Passion* stages G.H. as continuously being fertilized by and generating the world, a phenomenon reflected in the non-linear succession of *The Passion*'s paragraphs. Each chapter opens with the last phrase of the preceding one, thereby seemingly tying the thread between one generation and the next. But it does so in a rather uncommon way: the second phrase of each chapter does not always affiliate to the first. Instead, as the last phrase of the preceding chapter comes to open the next, it seems to be freed from its function of closing the preceding chapter's story and is made receptive again to all the new meanings that the succeeding chapter potentially brings. Every chapter and paragraph in *The Passion* hence follows a logic of being-fecundated by the last chapter or paragraph, which, in its turn, gives birth to the succeeding one in an uncontrolled way.

While many interpretations of *The Passion According to G.H.* have analyzed the perishing of G.H.'s subjectivity, the specificity of this subjectivity has mostly been overlooked. In this essay, we have read Lispector's *The Passion* as the dissolution of a colonial subject. Rather than understanding Lispector's philosophy as ontological, as it is commonly interpreted, we understand it as revolutionary, i.e., as concerned with the dismantling of the colonial subject and its world, and the subsequent generation of life *otherwise* through a reimagination of fertility, since fertility functions as the tie between the colonial subject, the state, and their future. Aiming to dismantle the coloniality of being in search for life *otherwise*, Silva[65] argues that the subject and the colonial world should perish in favor of "difference

63 Lispector, *Passion*, 20.

64 Ibid., 187.

65 Silva, "On Difference Without Separability."

without separateness." Glissant,[66] on the other hand, aims to reconfigure life through our relation to the world; from a colonially mediated one to a non-totalitarian totality of relations. We have argued that a similar project of reconfiguring the relation between the subject and the world is at the core of Lispector's work, as an attempt to "unsettle the coloniality of being," to echo Sylvia Wynter. Lispector's strategy concerns a reconfiguration of fertility. In her thought, fertility resists the reproduction of the colonial subject, dissolves it through a deep affectability, and generates a different relation between the "I" and the world in which the world fertilizes and lives the "I"—making the "I" into a life shared by the world rather than constituted through an appropriation of the world. We have interpreted *The Passion* as Lispector's philosophical attempt to transgress the subject that maintained an appropriative relation to the world in order to make a place for a pregnant "I" that is *existed by* the world, and through whom life is generated *otherwise*.

66 Glissant, *Treatise on the Whole-World*.

Conclusion

Abstract
This chapter is the conclusion to *Birth Justice: From Obstetric Violence to Abolitionist Care*. In this chapter, I rehearse one of the main theses of the book, namely that reproductive injustice is the dissolution of relationality and that reproductive justice is facilitated by a healing of relations through what I call "abolitionist care." I give a short chapter-by-chapter summary and end with considerations on the indivisibility of reproductive justice: there can be no reproductive justice if there is no reproductive justice *for all*.

Keywords
Abolitionist care, reproductive justice, Gaza, Palestine, reproductive genocide, relationality.

Gaza-woman
lives where bulldozers rest on clouds.
Her hospital bed is her home's rubble,
nothing left of her husband but a bloodied beard.
Nothing around her but refrigerators in trees,
furniture defiled,
shards of a life, disfigured.
She holds onto the concrete reef
like it's a blanket, like it's Mary's sage.
There is no life without pushing, no life in siege.
Her tongue is a minaret chanting God's name
in angry prayer.
The rockets, like rain, tell her to push.
Her thighs spread, pushing out a purple sky,
rubbled and silent.
—Mohammed El-Kurd, "Three Women"[1]

1 Mohammed El-Kurd, *Rifqa* (Chicago: Haymarket Books, 2021), 43.

Waal, van der, R., *Birth Justice. From Obstetric Violence to Abolitionist Care*. Amsterdam: Amsterdam University Press 2025
DOI: 10.5117/9789048562398_CONC

I started this book with a story about my mother's labor, my own birth, roughly 30 years ago. It was a quiet and safe birth, in our home in Amsterdam, accompanied by a midwife. When the Palestinian academic and activist Shahd Abusalama was also born some 30 years ago in the Jabalia refugee camp in Gaza, it was a very different scene—described by her as "oppression, basically oppression."[2] As her mother's contractions started around 1 a.m., they had to break the imposed curfew to walk through the alleys for a kilometer to the closest clinic in the refugee camp. Her grandmother accompanied her mother with a lantern in one hand, and a white flag in the other, signaling "we are bringing a child in peace." When they encountered Israeli soldiers, they pointed a gun at her belly and said: "so you are coming to bring your terrorist child." Abusalama's characterizes her birth story as being dehumanized even when she was still an idea, when she was still only a dream.

Thirty years later, as I finish the final details of this manuscript, we are several months into the unfolding genocide in Gaza. It has cost already more than 30,000 lives, including those of more than 13,000 children, making it the deadliest war of the twenty-first century.[3] My home country, the Netherlands, is complicit, as it continues to provide moral, political, as well as material support to the Israeli government. The Dutch government has twice refused to vote at the United Nations for a ceasefire, while it keeps on delivering materials for weapons to Israel. The births of Abusalama and me, both 30 years ago, and the reality of our lives and our communities 30 years later could not be more different. It is the world, the way that it is shaped by colonialism and racial capitalism, that determines whether we, and our mothers, and our daughters, can enjoy reproductive justice and give birth in peace.

If we want to eliminate violence in reproduction and achieve reproductive justice, we can only do that if those whose births and lives are dehumanized even before they are born, have justice as well. The reproductive justice in which my mother could give birth means very little when at the same moment in time so many other labors are determined by the gravest injustices. Audre Lorde writes: "I am not free while any woman is unfree, even when her shackles are very different from my own."[4] Lorde here addresses the

2 Shahd Abusalama, *Palestine Deep Dive*, November 18, 2023.

3 See: https://www.savethechildren.org/us/charity-stories/life-for-children-growing-up-conflict-gaza; https://www.oxfam.org/en/press-releases/daily-death-rate-gaza-higher-any-other-major-21st-century-conflict-oxfam.

4 Audre Lorde, *Sister Outsider: Essays and Speeches* (Berkeley: Crossing Press, 1984).

indivisibility of freedom which captures humanity as an inseparable whole, meaning that liberation can only mean the liberation of all. Just like freedom is indivisible, reproductive justice is indivisible. Just like there can be no freedom as long as some of us are unfree, there is no reproductive justice as long as some of our lives continue to be determined by reproductive injustice. Which is why, for now, although reproductive justice exists in some undercommon otherworlds of abolitionist care, it also remains yet to-come. But the urgency with which we condemn reproductive injustice, the "haste of interpretation," as Derrida has it—justice is that which cannot wait—that makes us turn to abolitionist care, is that what gives reproductive justice a future—the promise which is also captured in its "to-come."[5]

And it is exactly because securing reproductive justice for people like me does not change much about the divisions of power and oppression in the world, that reproductive justice scholarship and activism puts the most marginalized people at the center of attention. The important lesson of intersectional feminism is that most axes of oppression not only become visible but are most effectively resisted from certain positionalities. The only way in which reproductive justice has a chance is to struggle for reproductive justice for the most marginalized. It is for this reason that this collection of chapters should not be read outside of the current genocide which has been characterized as a "miscarriage" of reproductive justice, and as "reproductive genocide."[6]

In this study, I have tried to understand both the phenomenon of obstetric violence and how we can resist it by centering reproductive justice. In part I, I laid bare how obstetric violence should be understood through the lens of obstetric racism and colonialism. Here, similarly as stated above, obstetric violence only comes into full view when all axes of oppression are taken into account. Moreover, I have studied how reproductive justice and injustice are best understood from the epistemic and normative standpoint of those who have the capacity for pregnancy, rather than from a "neutral" perspective that often echoes the configuration of reproductive justice of medical authorities, law- and policymakers, and the state. Obstetric violence, as a reproductive *injustice*, is best captured from an intersectional, as well as an epistemic and normative standpoint.

In part II, I disentangled further how patriarchal, juridical, and ideological structures—in different parts of society, in myth, in practice, and even in

5 Jacques Derrida, *Specters of Marx: The State of the Debt, the Work of Mourning and the New International* (New York: Routledge, 2006).

6 "Miscarriage of Justice," Visualizing Palestine, last modified October 2023, https://www.visualizingpalestine.org/visuals/gaza-pregnant-women.

feminist and midwifery theory, in different times, in the Old Testament, in early modernity, and in second-wave feminism—all work to keep a certain conception of reproductive justice intact. The current "partition of the sensible," as I have explained in my introduction with the help of Jacques Rancière, structurally silences the voices of persons capable of pregnancy. The hegemonic conception of justice in matters of reproduction turns people with the capacity for pregnancy into "captive maternals,"[7] appropriates the reproductive body, and disrupts its relationality. I have shown how the capture of the maternal is established and continually reproduced through the undoing of two relations: the relation between the pregnant person and their (capacity for) pregnancy and the relationship between the (pregnant) person and their community of care. Resistance to maternal captivity, as well as to obstetric carcerality and obstetric violence, just as the achievement of reproductive justice, requires healing these relations. Part II ends with a critique of the constitutive relations of the maternal in postmodernity, from Annie Erneaux's abortion in the 1960s to the Texas abortion ban in 2020. Also, in postmodernity, we see a continuous dissolution of the two key relationships that are essential for reproductive and birth justice.

Parts III and IV of this study are devoted to the activist resistance against reproductive injustice, obstetric violence, and patriarchal conceptions of justice in matters of reproduction. Based on my empirical study, I have conceptualized how activist resistance consists of the reconstitution of relationality, and of the liberation of the captive maternal through alternative practices of abolitionist care. These practices and their ethics of care can be understood as abolitionist, since they actively work to resist and undo structures of oppression that perpetuate reproductive injustice. This work concerns not only the abolition of obstetric violence or the obstetric institution, but more fundamentally, the abolition of our current world in favor of a different one. Abolitionist care has indivisible reproductive justice as its guiding light:

> *Abolitionist care* is everything that is done *to dismantle and flee from* "the world" *by fostering and defending otherworlds in which all already* live as well as possible. *These otherworlds* include all that seeks to be interwoven in a complex, life-sustaining web *of difference without separation, committed to a justice to-come.*[8]

7 Joy James, *In Pursuit of Revolutionary Love: Precarity, Power, Communities* (London: Divided Publishing, 2023).

8 This quote is modified from Tronto, Puig de la Bellacasa, and Van Nistelrooij. See: Maria Puig de la Bellacasa, *Matters of Care: Speculative Ethics in More Than Human Worlds* (London:

Abolitionist midwifery care encompasses all the care, love, thought, practice, organization, and relationality needed for the four pillars of reproductive justice—to have or not have a child, to self-determine, to raise children in safe and dignified environments. As such, it is a kind of revolutionary midwifery, echoing Alexis Pauline Gumbs's "revolutionary mothering," the "love on the front lines"[9] needed if we are to have reproductive justice for all. There is a whole network of care required to enable us to "raise up new worlds together." In part III, these specific resistant practices of midwives and mothers were studied and theorized as a form of fugitive, abolitionist care that effectively builds a new world of reproductive justice. The consequence of understanding obstetric violence as institutionalized violence that is fundamental to the obstetric institution is theorized as abolition. Abolition provides an alternative to institutions entangled with structural forms of violence, by (re)constituting autonomous social relations outside those institutions, or an undercommons. In the case of midwifery, abolitionist care offers an otherworld through the direct reappropriation and reimagination of the relations that are shattered in the obstetric institution.

In part IV, the relationship between the pregnant person and their community of care is reenacted—literally, in chapter 10, in the form of a fictional symposium based on empirical qualitative data—as a non-essentialist, creolizing relationship that is concerned with everything that mothers are and can be: that is in relation to (to borrow and tweak Édouard Glissant's notion of the "Whole World" as the "Whole Maternal") all differentiations of the maternal that revolutionary mothering might bring us. Some feminists have suggested that technology might restore reproductive justice because it could potentially free us from the hardships and risks of pregnancy and birth altogether. Chapter 11 discusses that technology and medicine are indeed instrumental in the restoration of reproductive justice, but I have contended that it is relational care that is best suited to resist reproductive injustice. The root cause of reproductive injustice laid bare in part II is not nature or the capacity for pregnancy itself, but the ideological, juridical, and material configuration of a patriarchal conception of what is justice in matters of reproduction. As such, the relationality of midwifery, as the relationship

University of Minnesota Press, 2017), 161; Joan Tronto, *Moral Boundaries: A Political Argument for an Ethic of Care* (New York: Routledge, 1993), 103; Inge van Nistelrooij, "The Fluidity of Becoming: The Maternal Body in Feminist Views of Care, Worship and Theology," in *Care Ethics, Religion and Spiritual Traditions, ed. Inge* van Nistelrooij, Maureen Sander-Staudt, and Maurice Hamington (Leuven: Peeters, 2022).

9 Alexis Pauline Gumbs, China Martens, and Mai'a Williams, *Revolutionary Mothering: Love on the Front Lines* (Toronto: PM Press, 2016).

between the pregnant person and their community of care, is reimagined as somatophilic reproductive justice, which uses both nature and technology for safe and self-determined outcomes, in the form of "midwifery thinking."

Abolitionist midwifery care is committed to reproductive justice and strives for a relationality that is trans, transnational, and transgressive of this world. Tis means, among other things, caring for pregnant men, facing responsibility for the war waged on pregnant people in Gaza, combating obstetric racism, and demanding abortion access as a fundamental part of our community care. Otherwise, midwifery is just another tool that reproduces our world as it is. Abolitionist care does not mean to close down all obstetric units tomorrow. Instead, it continuously presents us with a choice: what is the abolitionist thing to do? What is the non-reformist reform in this specific situation? The aim of abolitionist midwifery care, just as Gumbs's revolutionary mothering, is not to reproduce the subject or the world as it is, but to find a way to do midwifery, mothering, pregnancy, and fertility that is transformative: laboring towards the end of a world defined by racial capitalism in favor of being together *otherwise*.

In the final chapter, the relation between the person and their capacity for pregnancy is reimagined. In analyzing the work of the Jewish Brazilian writer Clarice Lispector and her literary conceptualization of fertility, this reimagination of relationality did not aim for the constitution of a pregnant or fertile subject, but rather for the dissolution of the subject through fertility. The relation between the person and their capacity for pregnancy is not reappropriated in a kind of reconciling of Western individual subjectivity with pregnancy and fertility, but the radical pluralization of being of pregnancy and fertility is leveraged in order to *dismantle* Western colonial subjectivity. What we are left with, then, is a relationality through which life can be gestated *otherwise*. The reimagination in the final part of both key relationships thus comes down to a reconfiguration of the relationality of reproduction, as the "Whole Maternal," "midwifery thinking," and the dissolution of the Western subject through a radical affirmation of fertility, leading to a fundamentally new relation between the human and the world—together they should invoke a reproduction *otherwise* that could be characterized as birth justice.

The reimagining of reproduction through a fictional symposium, new usage of technology, and the thought of Clarice Lispector ultimately encompasses a relationality that is to be understood not as a relationship between two individuals, but as a undivisable sociality that consists of difference, but without separation, of the "Whole Maternal," consisting of all possible forms of the (poly)maternal, of parenthood, and of the persons

who facilitate their reproductive care. The care relationship between birth workers and those with the capacity for pregnancy is grasped as one of somatophilic "midwifery thinking," in which "preservative love for those with the capacity for pregnancy," "the (un)becoming of 'motherandchild,'" and "the securing of relationships that enable reproductive freedom" are central tenets of a "somatophilic rationality." And finally, the relationship between the self and fertility is reimagined as a radical affirmation of the receptivity that fertility enables, so much so that fertility dismantles the Western, individual subject, and constitutes a life that can be shared and fertilized by the world and is, as such, characterized by plurality. In the alternative practices of abolitionist care that constitute and defend otherworlds containing the sociality of the Whole Maternal, where life is shared and receptive, and reproductive care is somatophilic and done through midwifery thinking, it might be possible to keep ensuring, and keep pushing for, a reproductive justice to-come.

When Mohammed El-Kurd writes in the poem that is the motto to this conclusion that "there is no life without pushing, no life in siege," it evokes that for life to be otherwise, for life to flourish, we must keep pushing in order to lift the siege, break all walls, exclusionary identities, and borders. I heard him read this poem, which I already knew, in the final weeks of writing, at a concert in Brooklyn. By that evening, more than 11,000 people had given birth in horrific conditions in Gaza; lacking water and food, as well as homes and hospitals to give birth in. With hospitals and medical staff being targeted, and few functioning hospitals left, it was midwives who were the last ones able to provide care during pregnancy and childbirth, constituting a lifeline in Gaza. Cesarean sections were being performed without anesthesia, and hysterectomies were done as the last resort to save a life due to either damage to the uterus or lack of blood product in case of postpartum hemorrhages. There was a shortage of contraceptives, a complete inaccessibility of abortion care, lack of menstruation pads, and lack of micronutrients essential in breastmilk, drastically worsening the condition of half of the pregnant population in Gaza already suffering from anemia. Mothers gave birth only to bury their children days later. But although the International Confederation of Midwives stated during the annual Days of Activism against Gender-Based Violence that "midwives are fighting for a world without violence against women and children,"[10] it broke my heart how many midwives stayed quiet, how many tried to

10 International Confederation of Midwives, "Position Statement: Midwives and Violence against Women and Children," last modified June 2, 2023, https://www.internationalmidwives.org/

silence those who were speaking up, and how many Western midwifery organizations refused to show any sign of solidarity with our colleagues in Palestine by not even calling for a ceasefire.[11]

In the otherworlds of abolitionist care, there is no separation between mothers here and mothers there, all are part of the undivisable Whole Maternal that is difference without separation, and all fall under the responsibility of somatophilic midwifery thinking to ensure, for the Whole Maternal, a relationality in which reproductive freedom and justice are facilited. And a fertility is practiced there that is so receptive that the colonial subject responsible for this all could be dismantled. In contrast to Western midwifery organizations, abolitionist midwifery care vows to keep pushing—it knows that justice cannot wait.

assets/files/statement-files/2018/04/midwives-and-violence-against-women-and-children-eng.pdf.

11 For instance, the Dutch organization for midwifery (KNOV) refused to call for a ceasefire, just like its English (RCM) and its American (ACMN) counterpart. The KNOV signed a letter in which support for a ceasefire was voiced in February 2024, four months into the war.

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Index

Reproductive injustice is an urgent global problem. We are faced with the criminalization of abortion, higher maternal and neonatal mortality rates for people of color, and more and more research addressing the structural nature of obstetric violence. In this collection of essays, the cause of reproductive injustice is understood as the institutionalized isolation and relational separation of (potentially) pregnant people, making them vulnerable for bio- and necropolitical disciplination and control.

The central thesis of this book is that reproductive justice must be struggled for through a radical reappropriation of relationality in community care practices to safeguard the access to knowledge and care needed for reproductive self-determination. Through empirical research, feminist and critical theory, as well as Black and decolonial studies, reproductive justice is reimagined as abolitionist care, grounded in the abolition of authoritative obstetric institutions, state control of reproduction, and restrictive abortion laws in favor of autonomous doula and midwifery practices that are truly relational.

Rodante van der Waal is a midwife and philosopher. Their academic articles have been published in *Frontiers, Angelaki, Agenda, Feminist Anthropology, Feminist Theory, PLoS ONE, Social Text, Birth, Nursing Ethics* and *Violence Against Women*.

"The Netherlands was the last industrialized country to lose independent midwifery to obstetric control, to see birth turned into one more hospital procedure done ON not BY the mother. This brilliant, sad but true, book documents the consequences."

– Barbara Katz Rothman, PhD, author of *In Labor, The Tentative Pregnancy* and most recently *The Biomedical Empire* (Stanford University Press)

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