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Locating Abortion and Contraception on the Obstetric Violence Continuum

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Abstract

This article builds upon existing feminist literature on obstetric violence in the context of childbirth to argue that there is a continuum of obstetric violence which also includes that perpetuated in relation to pregnancy prevention and termination, as well as antenatal healthcare and birth. This structural violence is highlighted in relation to conscientious objection, the reporting of people suspected of illegal abortions by their healthcare providers, and contraceptive coercion. Recognising the limitations of criminal and human rights approaches to obstetric violence, this article takes Martha Fineman's vulnerability theory as the foundation for the transformative structural change of healthcare institutions.

Keywords: obstetric violence, vulnerability theory and healthcare institutions, access to abortion, contraceptive coercion, conscientious objection.

1. Introduction

Obstetric violence has emerged as a term within feminist activism and theory to take account of the structural harms perpetuated against people giving birth. In this article, I seek to expand upon the emerging literature which has recognised obstetric violence as also taking place within the delivery of abortion services. Drawing upon scholarship which has interpreted obstetric violence as encompassing a range of acts and omissions, I argue that there is a continuum of obstetric violence which is not restricted to the birthing context. There are harms perpetuated by healthcare providers in the provision of abortion and contraception (or lack of) that must be recognised as part of this continuum alongside that which occurs in the antenatal and birth contexts. This article considers conscientious objection, healthcare providers' role in the criminalisation of abortion, and contraceptive coercion as forms of obstetric violence, in which the embodied agency of the patient is dismissed and undermined. As legal approaches to obstetric violence are limited in addressing the structural and often more subtle forms of obstetric violence, I offer an approach premised upon Fineman's vulnerability theory aimed towards changing the culture of reproductive healthcare from medical gatekeeping towards care and support.

2. The Nature of Obstetric Violence

The language of obstetric violence has emerged within feminist activism and scholarship as a way of capturing the structural and gendered harms perpetuated against birthing people by healthcare providers. This is an expansive interpretation of violence, encompassing physical

abuse and mistreatment, but also verbal abuse, bullying, intimidation, discrimination, coercion, dehumanising treatment, and forms of epistemic violence such as silencing and gaslighting (Chadwick 2018; Pickles and Herring 2019; Cohen Shabot 2019; Mayra et al. 2021). Scholars have located the structural nature of obstetric violence in the medicalisation of childbirth, in which birthing bodies are viewed as biomedical objects in need of intervention, so the subjective embodied experiences of childbirth are afforded insufficient attention (Chadwick 2018). Further, within this biomedical framing, birthing people are viewed in conflict with, or as a potential threat to, the foetus – and healthcare providers become agents charged with protecting the foetus at the expense of the birthing person's needs, values, concerns, and desires (van der Waal and van Nistelrooij 2022; Benbow and Hall 2022). This framing can manifest in a range of harms – dismissing requests made by the birthing person, undermining their consent, coercion, and physical violation (Benbow and Hall).

Further, Halliday (2019) considers whether birthing people who do not acquiesce to medical advice can be forced to comply with what is viewed as the correct 'choice'. Pregnant people's refusals to consent to obstetric interventions such as caesarean sections in England and Wales and the US have been overridden in order to safeguard the foetus (Halliday 2016). The pregnant person is deemed to lack the capacity to consent or withhold consent, and their best interests are always interpreted as requiring the safe delivery of the foetus (Halliday 2016). This denial of the autonomy of the birthing person in defence of the foetus may be more overt in, for example, the US context in states with foetal protection laws (Goodwin 2020). Goodwin explores the case of Angela Carder, a pregnant woman in the US who was denied chemotherapy for her cancer as it may have harmed the foetus. Carder had an early caesarean section authorised by the Court against her will in the best interests of the foetus, but both the foetus and Carder subsequently died (Goodwin 2020, 92-96).

In contrast with these invasive acts of violation, Pickles (2019) identifies instances of obstetric violence by omission. Evidence-based guidelines which frame all women's lives and experiences as homogenous indirectly silence pregnant people, whose voices and individual contexts are not seen as relevant to their care (Pickles 2019). Other scholars have also pointed to the silencing or suppression of embodied subjective knowledge – that is, how a pregnant person uniquely knows their own body, pregnancy, and needs (Chadwick 2019). The foetus is positioned as a separate patient, threatened by the embodied knowledge of the pregnant person, and the healthcare provider's role is to protect the foetus – thus framing embodied knowledge as a threat to the delivery of evidence-based obstetric healthcare. Gaslighting also features here, as pregnant people are manipulated into disbelieving their own embodied knowledge throughout pregnancy and birth (Cohen Shabot 2019). In the Indian context, scholars have highlighted how pregnant people are conditioned to make certain decisions around birth and to endure or comply with obstetric violence – such as opting for a caesarean section in order to avoid humiliation or abuse (Mayra et al 2021; Mayra et al 2022).

Obstetric violence is perpetuated at both the individual and structural level. Individual healthcare providers perpetuate harm towards pregnant and birthing persons, but this is a systemic issue which takes place within the structures of biomedical power and gender-based violence. This form of violence is not simply medical violence but is a gendered phenomenon (Pickles and Herring 2019). Patriarchal ideals around women's primary role as childbearers and childrearers influence the dismissal of pregnant people's embodied subjectivities (Herring 2019), and assumptions that women have natural caregiving instincts are pervasive in pregnancy and birthing contexts. I take the perceived sex binary to be socially constructed, but the idea that there is a sex binary has influenced essentialist stereotypes – particularly around women reverting to 'natural' or 'biological' processes and instincts (Chadwick 2022,

231). This feeds into the script that mothers would always prioritise the needs and wellbeing of the foetus above their own, and that those who would not are deviating from this role. Healthcare providers in the obstetric context uphold and reinforce these gendered narratives by prioritising this protection of the foetus, either assuming that this is in line with the pregnant person's best interests or acting as a corrective where the pregnant person would divest from their 'natural' maternal role. Moreover, Cohen Shabot and Korem (2018, 385) have identified how these norms around what a 'good altruistic mother' should do act as a gendered shaming mechanism which is a key part of obstetric violence, as it makes it difficult for the birthing person to fight back or resist.

Chadwick (2021, 111) adopts a definition of obstetric violence as a form of violence perpetuated against 'reproductive subjects'. I follow this definition, recognising that the gendered stereotypes imposed on 'women' also enact harm on pregnant people beyond the boundaries of this gender category. Specific forms of obstetric violence may be perpetuated against trans, non-binary, and gender-expansive people as a direct result of their non-compliance with the perceived sex/gender binary, and thus their stereotypical reproductive roles. Mavuso (2021, 78) argues that de-anchoring cis women from pregnancy not only enables us to recognise the reproductive violence enacted against gender diverse people with uteri, but also enables us 'to reckon with the ways that these assumptions about pregnancy and parenthood, and gender and sex' underpin obstetric violence. Thus, obstetric violence must be recognised as a gendered violence which is concerned with stereotypes and assumptions around women and motherhood, but which extend beyond women.

In addition, it is important to frame obstetric violence not only as a gendered phenomenon, but one which intersects with the existing inequalities faced by pregnant people from already marginalised groups (for example, on the basis of race, class, disability, queerness) (Chadwick 2018). Van der Waal et al (2022) identify obstetric violence as a

racializing violence, recognising pervasive anti-Black obstetric racism as the afterlife of slavery. They refer to the appropriation of Black women's bodies in US slavery, where 'breeding' practices were carried out to increase the population of enslaved people (van der Waal et al 2022). Other scholars have highlighted how the obstetric violence faced by Indigenous pregnant people is rooted in colonial histories of assimilation or 'civilising' missions (Dawson and Suntjens 2022). These historical racialised, gendered, and colonial norms continue to be perpetuated through obstetric institutions. Further, while violence and mistreatment during birth has been identified across the world, there are global and local inequalities which exacerbate obstetric violence (Chadwick 2018). Chadwick (2018) points to evidence of widespread obstetric abuse in the Global South, and focusing on South Africa, that this is much more likely in the public maternal healthcare sector. Thus, experiences of obstetric violence are not homogenous but differ across relational, socio-demographic, economic, global, regional, local, cultural, and historical lines. Obstetric violence not only reflects these existing lines of marginalisation, but also amplifies them (O'Brien and Rich 2022).

a. Relationality and Embodiment in Pregnancy

Van der Waal and van Nistelrooij (2022) have identified the severing of the relationality between pregnant person and foetus as a key issue in obstetric violence. They refer to Kingma's concept of the foetal container model of pregnancy, in which the foetus is perceived as a separate entity captured inside the pregnant person (van der Waal and van Nistelrooij 2022, 1192; Kingma 2019). This is exemplified in anti-abortion imagery which presents a free-floating foetus, where the womb is simply an empty vessel, disconnected from any pregnant person (Petchesky 1987; Young 2005). This narrative extends into birthing

contexts where the safe removal of the foetus from its container is the primary focus. In contrast with this model, van der Waal and van Nistelrooij (2022) identify how the pregnant person and foetus are relationally intertwined; they are not two separate entities, but neither are they one.

Young (2005, 49) theorised pregnancy as a 'split subjectivity' where gestation is experienced as a change in one's body: 'I become different from what I have been'. The boundaries between pregnant person and foetus are in flux, as the pregnant person has 'a privileged relation to this other life' – the movements of the foetus are another being's movements, but only the pregnant person gets to experience them (2005, 49). Young (2005, 54) expresses that the 'pregnant subject is not simply a splitting in which the two halves lie open and still, but a dialectic'. Thus, pregnancy is an embodied state that alters the experiences and identity of the pregnant person, and they share a privileged relationship with the foetus which is unknowable to outsiders. Subsequent theorists have also identified pregnant embodiment, identities, and the liminal nature of the foetus, pregnancy, and birth (Lupton and Schmied 2012; Nash 2012; McDermott 2016; Chadwick 2018; Chadwick 2022) as an important aspect of theorising about reproductive labour.

Further, embodied experiences of pregnancy and birth are subjective, but also vary across intersectional lines and socio-economic spheres. Chadwick (2022, 231) observes how gendered notions of 'natural' processes 'continue to be weaponized as a means of denying the complex embodied labors of gestating, birthing, and procreating persons, disappearing them into the cisnormative and straightening realm of "the biological"' while also policing and denigrating the reproductive desires of marginalised people (e.g. Black, Indigenous, and poor people). In the obstetric institution, the pregnant person is isolated from their embodied and relational experience. Young (2005) identified the pregnant subject's interaction with the obstetric institution as one of alienation. The pregnant person is alienated from their own

embodied knowledge, and from their relational link to the foetus. For some pregnant people, this alienation is compounded by multiple discriminations, oppressions, or inequalities. Following van der Waal and van Nistelrooij, I identify this denial of embodied agency as both influencing obstetric violence, and constituting a form of violence in itself.

3. An Obstetric Violence Continuum

Much of the obstetric violence literature has generally focused on that occurring in the antenatal, birth, and post-partum healthcare contexts. However, some scholars have also begun to recognise the harms perpetuated against pregnant people in seeking abortion as obstetric violence. Larrea, Assis, and Mendoza (2021) identify five areas of abortion-related obstetric violence (which overlap with other forms of obstetric violence): denials of care and failure to meet standards of care; criminalisation; gaslighting; physical violence; and discrimination. Refusals to perform legal abortions may occur on an individual and institutional level, and in other cases, unnecessary medical procedures may be enforced (Larrea, Assis, and Mendoza 2021). While O'Brien and Rich (2022) view legal restrictions or prohibitions on abortion as obstetric violence enacted through reproductive governance, Larrea, Assis, and Mendoza (2022) also identify the role of healthcare providers in criminalisation, in reporting patients suspected of illegal abortion. Pregnant people may be gaslighted into doubting their decision to terminate a pregnancy by policies requiring ultrasound scans or counselling before they can have an abortion (Larrea, Assis, and Mendoza 2021; Mavuso 2021). Physical violence can include denying pain management to a patient, and discrimination – as in other contexts of obstetric violence – occurs through the

perpetuation of gendered, racialised, and class-based stereotypes (Larrea, Assis, and Mendoza 2021).

However, abortion-related obstetric violence remains under-theorised in the literature. This article seeks to contribute to and expand the emerging recognition of obstetric violence against abortion seekers and broaden our understanding of obstetric violence to also include harms perpetuated against contraceptive users. I seek to recognise obstetric violence in the pregnancy prevention and termination contexts as part of the same continuum as birth-related obstetric violence. While some theorists may prefer the terminology of 'reproductive violence' (Mavuso 2021; Chiweshe, Fetters, and Coast 2021) to refer to harms relating to abortion and contraception, I argue that it is important to emphasise the role of healthcare providers at an individual and structural level in enacting this violence. The focal point of mainstream conversations on abortion tends to be on law, policy, and governance, rather than the delivery of, or failure to deliver, abortion care. Thus, in this article I focus on obstetric violence as perpetuated by healthcare providers in conscientious objection to the provision of abortion and emergency contraception, healthcare providers' role in criminalisation, and contraceptive coercion.

As Assis and Larrea (2022, 243) have argued, abortion-related (and, I add, contraceptive-related) obstetric violence 'must be included in the umbrella concept of obstetric violence because it expands our understanding of reproductive justice'. The reproductive justice framework emphasises the interconnectedness of the rights to have children, to not have children, and to safely parent one's children (Ross and Solinger 2017). This framework was developed by women of colour in the US as an alternative to the reproductive rights movement, which was law-focused, centred individual choice, and was concerned with abortion and contraception (Luna and Luker 2013). The reproductive injustices faced by marginalised groups, particularly Black and Indigenous women, were

often side-lined in this movement. Thus, reproductive justice activists sought to highlight how some groups had historically had their reproductive capacities curtailed, for example through practices during enslavement, coercive sterilisation and forced abortion, and the removal of children from their parents (Ross and Solinger 2017; Luna and Luker 2013). These issues had not been adequately recognised within the reproductive rights frame. As recognised above, racialised violence continues in the delivery of reproductive care, and Nandagiri et al (2020) have recognised the racialised, gendered, and class-based structural violence of obstructing access to abortion. Locating abortion and contraception-related harms on the obstetric violence continuum involves the naming of interconnected structural harms that stretch across different areas of reproductive healthcare delivery – with the commonality that this violence is one specifically perpetuated against reproductive subjects. This is not an attempt to re-centre abortion and contraception in the conversation, but rather, by identifying these commonalities, better enables us to work towards all three tenets of reproductive justice.

Finally, the language of obstetric violence represents a call to action, and a call for care, that has been absent from mainstream conversations on abortion and contraception. Reproductive justice scholars have critiqued the 'pro-choice' framing for ignoring the social, cultural, economic, and relational aspects of abortion (and contraceptive) decisions (Price 2010; Chrisler 2012; Luna and Luker 2013). Similarly, theorists have moved away from identifying issues of autonomy in obstetric violence towards those of relationality, care, and embodied agency (Chadwick 2018; Cohen Shabot 2021; van der Waal and van Nistelrooij 2022). Though the reproductive justice movement retains a commitment to bodily autonomy, it also prioritises concepts of social justice, care, and community. Recognising the ways in which obstetric violence occurs in the abortion and contraceptive contexts enables a framing of access to abortion and contraception as relational and of decisions to use those services as

embodied, rather than as an individual, disembodied choice. Ensuring comprehensive abortion and contraception care requires much more than formal or legal access, and requires a radical rethinking of how this care is delivered.

4. Obstetric Violence in the Abortion and Contraceptive Contexts

a. Conscientious Objection

In many countries, healthcare providers can opt out of providing reproductive healthcare services. Conscientious objection provisions afford healthcare providers the legal right to refuse to provide abortion and contraceptive services on the basis of their personal moral opposition. In some countries – particularly Catholic-majority countries – conscientious objection is so widespread as to significantly obstruct access to these services. In Italy, for example, an estimated 67% of gynaecologists conscientiously object to abortion (Ministero della Salute 2019, 56). In Poland, which has a very restrictive abortion regime permitting abortion only in cases of a risk to the life or health of the pregnant person or in cases of rape, abortion is very difficult to access even on these grounds due to conscientious objection (Tongue 2022). Healthcare providers in Brazil often conscientiously object to providing abortion on the grounds of rape where they do not believe the pregnant person has provided enough evidence (Diniz et al 2014). In these contexts, emergency contraception is sometimes viewed as an abortifacient, so healthcare providers including pharmacists also conscientiously object to administering the morning-after-pill. Scholars have identified how the use of emergency contraception in Italy is particularly low in comparison to other European countries (Montanari Vergallo et al 2017), which is likely due to conscientious objection as well as the general stigma around contraception and reproductive healthcare. The

effect of conscientious objection may be to entirely prevent a person from accessing abortion and contraceptive services, particularly for those living in regions with no or very few non-objecting providers. Delays in obtaining abortion and emergency contraception are also an issue, given the timely nature of both. These consequences are clearly harmful to pregnant people and people with the capacity to become pregnant, amounting to obstetric violence – particularly where the person is ultimately forced through an unwanted pregnancy.

Fink et al (2016, 74-75) identify a spectrum of conscientious objection: some healthcare providers fall into the 'extreme' conscientious objection camp, where they not only refuse to provide services themselves but additionally make efforts to obstruct or dissuade their patient from accessing them elsewhere. This may take the form of healthcare providers giving inaccurate legal information to their patients, for example lying or being deliberately vague about the legality of an abortion in their case (Tongue 2022) Some healthcare providers instigate their own gestational time limits for abortion which are not prescribed by law, suggesting to pregnant people that they are too late for a legal abortion (Küng et al 2021). Others may give inaccurate medical information concerning the development of the foetus and the risks involved in abortion procedures (Bryant and Levi 2012; DePiñeres 2017). Here, healthcare providers gaslight pregnant people in order to prevent them from accessing abortion services.

Some efforts to prevent a pregnant person for accessing abortion are more overt, amounting to abuse and coercion. Mavuso (2021) highlights coercive anti-abortion practices in South Africa, in which healthcare providers discuss abortion as being wrong and harmful to the foetus, present abortion as a traumatising option, and suggest adoption as a preferable alternative. These practices induced shame, doubt, and conflict in pregnant people seeking to access abortion services (Mavuso 2021). In the European Court of Human Rights case of *P and S v. Poland* (2012), doctors conscientiously objected to providing an abortion to a 14-

year-old girl who had become pregnant from rape. They brought in a priest while her mother was not in the room to convince her to continue the pregnancy to term. In addition to this, doctors had informed the press about the girl's situation and as a result both her and her mother were subjected to anti-abortion harassment. In other contexts, pregnant people may also be subjected to disrespect, verbal abuse, and bullying during their attempts to access abortion services (Leite et al 2022; Tobasía-Hege et al 2019). In addition to the denial of care, conscientious objection is often coupled with the active undermining of the pregnant person's agency – the gaslighting, abuse, and coercion present here mirrors that in other obstetric violence contexts.

In addition, I also want to consider the harm caused by conscientious objection where the person goes on to access abortion or contraceptive services from another provider without a significant delay and without these additional layers of mistreatment. I have previously argued elsewhere that conscientious objection to abortion amounts to a dignitary harm as it perpetuates harmful stereotypes which prioritise the foetus over the wellbeing of the pregnant person, reinforcing patriarchal ideals around motherhood (Tongue 2022, 361-363). McLeod (2010) similarly argues in relation to emergency contraception that conscientious objection is to make a statement about the patient's sexuality, moral responsibility, and maternal instincts regardless of whether that is what the healthcare provider intends, because of how reproductive healthcare is inextricably linked to gendered norms. Conscientious objection disproportionately impacts people belonging to marginalised groups, for example people of colour and poor people (Yang 2020), and so must also be recognised as a racializing and class-based violence. Healthcare providers conscientiously object out of the belief that abortion or emergency contraception is morally wrong, a belief that is rooted in these gendered (as well as race and class-based) norms. I have already highlighted above how obstetric violence in other contexts is premised upon the same norms. In the birth context,

healthcare providers act to protect foetal interests and uphold norms around motherhood; the same occurs with conscientious objection. Thus, even where the patient is subsequently able to access reproductive healthcare services, conscientious objection remains harmful as a form of violence enacted on the gendered body.

Healthcare Providers and Criminalisation

Obstetric violence has been identified by some scholars in the context of aftercare following an unsafe abortion, where healthcare providers disrespect and abuse patients presenting with complications (Fernández Anderson 2020; Lima et al 2021) and collude with law enforcement in collecting evidence of illegal abortion, threaten to report them, or actually report them (Larrea, Assis, and Mendoza 2021). In some countries, healthcare providers may report people presenting with complications from a suspected illegal abortion out of fear that they may otherwise be prosecuted for compliance. Texas recently passed a Bill which criminalises anyone who 'aids or abets the performance or inducement of' an illegal abortion (S.B. No. 8, section 171.208(a)(2)). However, some anti-abortion healthcare providers may opt to report patients of their own accord, and Larrea et al (2021, 62) note that in many countries in Latin America, most prosecutions for illegal abortion are initiated by healthcare providers' reports. Here, healthcare providers are unable to act as foetal protectors, but uphold gendered norms around reproduction by punishing those who deviate from socio-cultural standards by terminating their own pregnancies.

People belonging to already marginalised groups are disproportionately targeted by punitive abortion laws, and it is important to recognise the extent to which this is due to who and in which contexts healthcare providers choose to report suspected illegal abortions. Scholars have identified in the Latin America and US context that a person is more likely to

be reported after seeking post-abortion care in a public hospital than a private one (Oberman 2018; Fernández Anderson 2020). Poor pregnant people are more likely to resort to unsafe methods of abortion due to a lack of resources, and upon requiring emergency care, will have no choice but to attend a public hospital, putting them at risk of being reported. Some people may therefore avoid seeking necessary post-abortion care to avoid criminalisation, putting their own health at risk instead (Fernández Anderson 2020). In El Salvador, where abortion is completely prohibited, healthcare providers routinely report stillbirths and miscarriages as suspected illegal abortions, and since 2000, at least 181 people experiencing obstetric emergencies have been prosecuted for abortion or aggravated homicide (Center for Reproductive Rights 2021). Young, poor people from rural areas, with limited access to healthcare, are disproportionately prosecuted under the El Salvadorean law (Lakhani 2022). Black and Indigenous people are more likely to be socio-economically disadvantaged, more likely to live far from urban centres with limited access to healthcare facilities (Wurtz 2012; Baird 2019; Johnson and Butler 2022) and are therefore more at risk of being prosecuted for illegal abortion. Racialised and class-based stereotypes of poor people of colour as 'bad mothers' also influence healthcare providers reports of suspected illegal abortion (Goodwin 2020).

Assis and Larrea (2022, 245, 253) have argued that 'abortion-related obstetric violence is an instance when modern medicine and law operate simultaneously to reproduce heteropatriarchal values' and 'exercise control over women and pregnant people who dare challenge prevailing social norms on reproduction'. The criminalisation of abortion relies on healthcare providers to be effective; healthcare providers therefore contribute to the structural violence enacted by criminal abortion laws. Recognising healthcare providers' role in the criminalisation of abortion as a form of obstetric violence is therefore integral to combatting

the injustice of legal prohibitions on abortion, and the way criminalisation is levied against some groups more than others.

b. Contraceptive Coercion

In contrast with the resistance of some healthcare providers to offer reproductive healthcare services, others engage in coercive practices around contraception. The non-consensual or forced sterilisation of marginalised groups is an obvious example. Poor and lower caste women in India have been targeted for mass coerced sterilisation and unsafe injectable contraceptives (Wilson 2018). Government-sponsored population policies and sterilisation programmes in countries such as Australia, Canada, Mexico, the US, and Peru have historically targeted Indigenous peoples (Pereira 2015; Pegoraro 2015; Sanchez-Rivera 2022; Vasquez Del Aguila 2022). While it is typically people capable of becoming pregnant that have been the targets of forced sterilisation policies, millions of lower caste and Muslim men were also sterilised during India's Emergency period between 1975 and 1977 (Prakesh 2019). Scholars have also identified the coercive sterilisation of trans people in countries where they are forced to undergo genital surgeries that render them infertile, in order for their gender to be legally recognised (Lowik 2018; Radi 2020). Ethnic minorities, such as the Roma in Europe, and people with disabilities are also targeted by coercive sterilisation practices (Zampas and Lamačová 2011; Tilley et al 2012). This is a form of reproductive violence that reinforces gendered, racialised, and class-based inequalities around which reproductive subjects ought to be allowed to reproduce.

However, the control of the reproductive capacities of marginalised groups may take more subtle forms than forced sterilisation. Senderowicz (2019) highlights that contraceptive coercion need not result from overt force or violence but can also result from limits on free

and informed choice, including where healthcare providers encourage fertility reduction and contraceptive uptake. Family planning programmes operating in lower-income states have resulted in coercive practices such as people being denied their preferred contraception or coerced into an alternative method, and people who do not want to use contraception being compelled to do so (Senderowicz 2019). This includes people being encouraged to use long-acting reversible contraception (LARC) such as the subdermal contraceptive implant or intra-uterine device (IUD). These methods cannot be easily discontinued, unlike methods such as the contraceptive pill, and require healthcare providers to remove them. A study on IUD uptake in Tanzania highlighted biased counselling in favour of the IUD, with either no other methods offered or the implication that other methods would be unsuitable (Senderowicz et al 2021). In another African setting, a study noted healthcare providers' refusals to remove contraceptive implants upon request, with user desire deemed an insufficient reason to discontinue contraceptive use (Senderowicz and Kolenda 2022). Healthcare providers act as gatekeepers of abortion and contraceptive care in the context of conscientious objection, and similarly act as gatekeepers to fertility in other contexts.

Contraceptive coercion can also be linked to the stigma around abortion. Studies from the US have demonstrated that pregnant people seeking abortions are pressured into using some form of contraception in order to prevent future unwanted pregnancies and thus repeat abortions (Brandi et al 2018; Cannon et al 2021). One of the studies considered the perspectives of healthcare providers, finding that healthcare providers felt they had a responsibility to prevent unintended pregnancies and repeat abortions, and many expressed a preference for LARC when counselling their patients on contraceptive methods (Cannon et al 2021). Many pregnant people may not wish to discuss contraception use at the time of their abortion (Iyer et al 2022), so healthcare providers' insistence on contraceptive counselling at this point could be interpreted by the patient as shaming them for failing to use contraception

in the context of their abortion, and as coercion around future contraceptive use. Adolescents are particularly vulnerable to being coerced by healthcare providers into accepting contraception following an abortion (Chiweshe, Fetters, and Coast 2021, 18; Buckingham et al 2021).

The coercive contraceptive practices of healthcare providers again reflect gendered, racialised, and class-based assumptions around sexuality and reproduction. This is tied to norms around the ideal mother (read as a white, cisgender, socio-economically stable adult), abortion, and acceptable fertility rates. Teenage pregnancy is often met with shame and rejection (Chadwick 2019), and scholars have pointed out how welfare concerns are levied against Black, Indigenous, and poor parents (Roberts 2017; Goodwin 2020). Fertility rates are instrumentalised in the service of economic and development goals, with a focus on fertility reduction in lower-income regions (Nandagiri 2021). Acknowledgement of the eugenicist history of contraception is also important here. Early feminist movements for birth control, for example, were steeped in racialised and gendered ideas of motherhood; notable birth control campaigners Marie Stopes and Margaret Sanger advocated for birth control on the basis that it would allow for selective breeding and thus white racial progress (Carey 2012). These racialised and gendered assumptions around motherhood continue to influence how healthcare providers encourage contraceptive use. Black women living Britain and the US in the 1970's were involuntarily sterilised and persuaded by healthcare providers to use contraception they had not requested (Roberts 2017; Bryan et al 2018) and low-income minority women continue to experience coercive or discriminatory contraceptive counselling (Yee and Simon 2011). Contraceptive coercion thus perpetuates intersectional and global inequalities. I argue that the ways in which healthcare providers curtail reproductive agency by influencing contraceptive decisions must therefore be recognised as a form of obstetric violence.

c. Embodied Decision-Making and Medical Gatekeepers

As I have already argued above, the denial of embodied agency in reproductive healthcare is a key issue in obstetric violence. The dismissal of embodied knowledge can be identified in the contraceptive and abortion contexts as well as in relation to antenatal healthcare and birth. The desire to avoid or end a pregnancy is an embodied one. For some people, this is a visceral and unshakeable feeling. For example, Shane (2022) describes her abortion decisions as living within her 'at a different depth':

> 'It constituted me like my lungs and my limbs and my mind. No, I do not want to be pregnant, I do not want to give birth, I do not want to have children. I wasn't choosing because there was no choice. I didn't want to be pregnant. No.'

For people capable of becoming pregnant who do not want to experience pregnancy, birth, or have children – either at a specific moment in time, or at all – the decision to use contraception or have an abortion is deeply tied to one's body and sense of self. Feminist scholars (Moi 1999; Young 2005) have emphasised the importance of agency over one's lived body, experiences, and relationships – which being forced to continue an unwanted pregnancy undermines.

Further, there are many physical bodily changes resulting from pregnancy: from vitamin deficiencies, nausea, and pain to more serious issues such as gestational diabetes, urinary tract infections, and damage to the pelvic floor. Neff (1990) argued that the physical effects of an unwanted pregnancy as similar to the effects of bodily violation that would be considered battery in other contexts. Pregnant people are encouraged to change their lifestyle and habits, and Young (2005) discussed the changes in moving through the world while pregnant; no longer being able to move around objects or bend down to tie her shoes as she could before her body began gestating and growing. These bodily changes, though

experienced subjectively by each pregnant person, can represent estrangement from and a loss of control over one's body where the person is forced to remain pregnant.

For others, the decision to avoid or end a pregnancy may not be so visceral. There may be uncertainty, or the decision may be due to broader (for example, socio-economic) circumstances, but this is nonetheless an embodied and relational decision, a negotiation between the body and the external context of reproduction. In *In A Different Voice*, Gilligan (1993) observed how pregnant people are likely to consider their relationship to the foetus in making abortion decisions, including projections as to whether they would be able to care for the potential future child. The normative separation of pregnant person and foetus which is present in pregnancy and birth contexts is emphasised even more so with abortion, which is presented as a conflict between the two separate entities rather than this more complex relational negotiation.

The decision not to use contraception is similarly an embodied one. The instrumental emphasis on fertility reduction ignores the subjective desires of individual people to have more children, or at least leave open the possibility of having more children. Again, for some people this is also a visceral bodily feeling while for others it represents a negotiation between the self and their broader circumstances. In addition, hormonal contraception can have physical side-effects, and mental health conditions such as anxiety and depression are relatively common (Wessel Skovlund et al 2016). These side-effects can be significant enough for people who want to avoid pregnancy to decide against hormonal contraception. Further, forms of LARC such as the contraceptive implant and the IUD require their placement inside the body – the implant in the upper arm, and the IUD attached to the uterine wall. Where LARC cannot be easily removed, the combination of physical side-effects, and inability to control one's fertility, and this physical intrusion can result in a sense of bodily violation.

Thus, the embodied and relational harms involved in obstructing access to abortion and emergency contraception and in coercing contraceptive use are not merely about reproductive outcomes. The embodied violation of being forced to continue an unwanted pregnancy is not solely about the potentially resultant child, but also about the process of gestation. Thus, the forced continuation (or beginning) of pregnancy is a violence even this is only for a short period of time due to delays in accessing an abortion or emergency contraception. Likewise, the loss of embodied agency involved in contraceptive coercion is not merely about the desire to have a child, but the estrangement from one's own body and fertility.

The provision of abortion and contraception within the medico-legal system situates healthcare providers as gatekeepers to access. Healthcare providers can obstruct access to abortion and emergency contraception, create risks to health and of prosecution in the provision of post-abortion aftercare, and pressure people into using any or specific forms of contraception. Even if abortion is legalised on relatively broad grounds, this is often an 'abortion-permissive' framework rather than an abortion-supportive one (Romanis 2023) in which healthcare providers remain the arbiters of access. Thus, pregnant people and people capable of becoming pregnant are unable to make embodied decisions around abortion and contraception. This undermines two of the central tenets of reproductive justice – the rights to have children and to not have children, which encompasses the broader right to bodily autonomy. In the final section below, I will offer an alternative to the current medico-legal framing by adopting Martha Fineman's vulnerability theory, which would seek to move the provision of reproductive healthcare in line with reproductive justice through a focus on care and support.

5. Addressing Obstetric Violence

The term 'obstetric violence' emerged as a legal term in Latin America in the early 2000s, with several Latin American countries passing laws aiming to combat dehumanising treatment and abuse during childbirth (Favre 2020). However, while some scholars have called for the recognition of specific criminal offences for obstetric violence (see Pickles 2015; Brennan 2019), this would only go so far in addressing obstetric violence. Criminalisation would not address the issues around severed relationality, dismissing pregnant people's embodied knowledge, and the complex gendered, racialised, and class-based dimensions of obstetric violence. Criminalisation would not be an appropriate response to conscientious objection and contraceptive coercion as these forms of violence are, in many cases, much more subtle. Further, criminalisation is an individualised response, focusing on sole perpetrators rather than recognising and tackling structural patterns of violence across different forms of reproductive healthcare.

Prochaska (2019) argues that the recognition of obstetric violence as a human rights violation would compel steps to be taken to improve maternity care at both the individual and systemic level. The concept of obstetric violence has been largely absent from human rights standards. The Committee on the Elimination of Discrimination against Women (CEDAW) is the only UN human rights body to have explicitly adopted the language of obstetric violence, albeit in a small number of documents (Costa Rica 2017, para. 31(d); Mexico 2018, para. 42(d); Bulgaria 2020, para. 34(a)). In 2022, CEDAW heard a case concerning the obstetric violence a woman in Spain experienced during childbirth, in which a caesarean section was performed without her consent and found violations of several rights (*N.A.E. v. Spain*). Significantly, CEDAW responded to the structural dimension of obstetric violence,

recommending that the state conduct research into obstetric violence and provide training to healthcare personnel on reproductive rights as well as ensuring access to effective remedies in cases of violation (*N.A.E. v. Spain* 2022, para. 16). There may be scope for the development of human rights standards on obstetric violence by CEDAW following this judgment.

However, there are limitations to approaching obstetric violence from a human rights perspective; in the context of human rights and intersex, Garland, Lalor, and Travis (2022) have argued that the international human rights framework is limited by scale as treaty bodies are unable to directly challenge medical power. Just as the state can deflect responsibility onto the medical profession, the medical institution can deflect responsibility onto individual healthcare personnel, thus preserving existing power hierarchies within the medico-legal regime (Garland, Lalor, and Travis 2022). The development of human rights standards on obstetric violence may be symbolically significant, but it would be insufficient at tackling the structural embeddedness of obstetric violence within reproductive healthcare because of these scalar limitations.

As an alternative approach, Fineman (2008, 2) developed the concept of the 'vulnerable subject' in place of the 'autonomous and independent subject' asserted in the liberal human rights tradition. Recognising that vulnerability is inherent to the human condition enables us to see how societal institutions – by alleviating and exacerbating vulnerabilities – play a significant role in maintaining and extending inequalities (Fineman 2008). Fineman seeks to reclaim the term 'vulnerability' from its negative associations, applied to marginalised groups such as disabled and socio-economically disadvantaged people, and recognise that vulnerability is universal (Fineman 2008). Instead of emphasising self-sufficiency and autonomy, vulnerability theory posits that what is required is a responsive state – one more sensitive to the nuances of vulnerability and existing inequalities

(Fineman 2008). While vulnerability theory emerged within the legal context, Fineman (2019) has also addressed its importance within bioethics, acknowledging that the recognition of the ontological body is central to vulnerability theory. Vulnerability is a 'post-identity' concept which can instead by adopted to 'consider the implications of another form of difference, one that is inherent within each body understood ontologically' (Fineman 2019, 56). Taking a 'life course perspective on difference', Fineman (2019, 56) identifies that a person's need for care varies at different stages – which healthcare providers must be responsive to.

Applying this concept of bodily vulnerability to abortion and contraceptive contexts (and other forms of reproductive healthcare) requires a responsiveness to the specific needs and vulnerabilities of reproductive subjects. As already argued above, decisions around abortion and contraception are embodied and relational, but this is ignored in a medico-legal system which situates healthcare providers as gatekeepers to access. This power imbalance between provider and patient perpetuates gendered, racialised, and class-based inequalities. In relation to pregnancy prevention and abortion, reproductive subjects are situationally vulnerable as they are dependent on healthcare providers; in relation to contraceptive coercion, this power imbalance is levied to exacerbate vulnerability. In the context of birth-related obstetric violence, Berzon and Cohen Shabot (2023, 65) have explored how the labelling of pregnant people (as a homogenous group) as 'vulnerable' by the medical establishment casts them as 'less autonomous, less independent, and less capable.' Yet, Pickles and Herring (2019, 8) have argued that 'there is nothing about being in labour which in and of itself renders a woman more vulnerable than everyone else; rather it is the social power structures that render a woman in labour open to abuse'. Thus, Berzon and Cohen Shabot (2023, 68) emphasise the importance of recognising vulnerability as part of the human condition, rather than as a status placed on certain groups to legitimise medical control.

Likewise, accessing abortion and contraception need not be situations of inherent vulnerability. Obstetric violence in these contexts are instances of vulnerability and inequality (re)produced by the medico-legal system.

The concept of obstetric violence, as Pickles (2019) argues, is important for contextualising violence, demystifying how and why it occurs, and works to challenge medical privilege. However, tackling obstetric violence requires more than challenging or punishing healthcare providers for their actions; emphasis must also be on encouraging a responsive, supportive, and caring environment for reproductive healthcare delivery, and working towards reproductive justice. That is to say, structural transformation is required. Van der Waal and van Nistelrooij (2022, 1193) have called for a 'relational form of abortion and midwifery care would consist of long-term individual or communal relation-building, that allows for freedom of choice'. The focus must be on 'developing the structures and policies required to promote a woman's agency' (Berzon and Cohen Shabot 2023, 68). Responding to the embodied vulnerability of reproductive subjects requires support for their agency, with healthcare providers affording care and connection to abortion and contraceptive healthcare seekers.

A formal healthcare system founded on these values would be radically different, and the sites of obstetric violence explored in this article would be reimagined. Conscientious objection would not be viewed through the lens of competing interests or rights, but through the lens of providing an environment where the embodied agency of the patient is valued and respected. Rather than gatekeeping abortion and emergency contraception, healthcare providers would offer non-judgmental and supportive services. Clearly, the reporting of patients suspected of illegal abortions exacerbates vulnerabilities created by the law. Trust is integral to care-centred healthcare provision; people must be able to seek post-abortion care without fear of judgment, abuse, and prosecution. Healthcare providers would receive

training and education on the importance of care and agency in reproductive healthcare. This would include facilitating and respecting the decisions of reproductive subjects to use, or not use, specific or any forms of contraception. The embodied experiences of reproductive subjects across abortion and contraceptive care would be validated rather than dismissed, and healthcare providers would work *in relation* with patients to ensure this. A responsive healthcare system would also support embodied agency in birthing contexts and in other instances of abortion care, such as in the context of foetal impairments where there may be pressure placed on pregnant people to choose an abortion.

The transformation of the medico-legal away from medicalised power is likely to be slow. Marginalisation and violence is an entrenched aspect of the obstetric institution (van der Waal et al 2021). However, a starting point could be to seek cultural change on a localised level: challenging gendered, racialised, and class-based stereotypes around reproduction, training healthcare providers to be responsive to embodied vulnerability, and instilling feminist values of care within healthcare provision. Reproductive justice activism could engage healthcare providers and work to change everyday norms and practices. Feminist models of care can contribute to structural transformation (Assis and Larrea 2022) – and as a long-term project, obstetric violence must be resisted and reproductive healthcare reimagined.

6. Conclusion

Naming obstetric violence is important for acknowledging and challenging the harms perpetuated against reproductive subjects by healthcare providers. While this concept has typically been adopted in the birthing context, in this article I have argued that there is a

continuum of obstetric violence which includes that occurring in the abortion and contraceptive contexts. Obstetric violence is a relational harm, tied to gendered, racialised, and class-based stereotypes around reproduction, in which the embodied agency of the reproductive subject is denied. In recognising the limitations of legal approaches to obstetric violence, I offered an approach to changing the culture of healthcare institutions based on Fineman's vulnerability theory. Reproductive justice requires emotional safety and compassionate reproductive healthcare provision, which centres the care needs of patients and supports their embodied agency. This calls for the provision of abortion and contraception in a way which is responsive to these needs, positioning healthcare providers as caregivers rather than gatekeepers.

Biographical Statement

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