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Ambiguous subjects: Obstetric violence, assemblage and South African birth narratives

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Abstract

Obstetric violence is gaining recognition as a worldwide problem manifesting in a range of geopolitical contexts. While global public health attention is turning to this issue, there has been a lack of theoretical engagement by feminist psychologists with the phenomenon of obstetric violence. This paper contributes to the literature on obstetric violence via a feminist social constructionist analysis of "marginalized" and low-income South African women's narratives of giving birth in public sector obstetric contexts. Drawing on interviews conducted in 2012 with 35 black, low-income women living in Cape Town, South Africa, the analysis focuses on obstetric violence as a relational, disciplinary, and productive process that has implications for the construction of women's subjectivities and agency during childbirth. The findings focus on relational constructions of violence and agency in women's narratives, including (1) the performance of docility as an act of ambiguous agency and (2) resistant bodies and modes of discipline. Framed within a Foucauldian approach to power and using the concept of assemblage, I argue that obstetric violence needs to be conceptualized as more than isolated acts involving individual perpetrators and victims. Instead, the analysis shows that obstetric violence functions as a mode of discipline embedded in normative relations of class, gender, race, and medical power.

Keywords

childbirth, obstetric violence, assemblage, intersectionality, agency, South Africa, narrative

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The abuse of women and girls during childbirth is gaining recognition as a significant worldwide problem (Freedman & Kruk, 2014; Jewkes & Penn-Kekana, 2015) manifesting across a range of diverse geopolitical contexts, including Britain, Scandinavia, Latin America, and Africa (Baker, Choi, & Henshaw, 2005; Dixon, 2015; Mselle, Kohi, Mvungi, Evjen-Olsen, & Moland, 2011; Schroll, Kjaergaard, & Mitgaard, 2013). In Venezuela, ''obstetric violence'' has been legally recognised as a form of criminal violence since 2007 (Pérez D'Gregorio, 2010). The current movement against obstetric violence, most prevalent in Latin America and Spain, argues that obstetric violence is a form of gender violence (Dixon, 2015; Smith-Oka, 2015). While global public health attention is turning toward this issue, there has been little engagement by feminist psychologists and/or social scientists with the concept of obstetric violence. As a result, obstetric violence remains ill-defined (Jewkes & Penn-Kekana, 2015), under-theorized and missing from debates about gender violence. Furthermore, there is a troubling tendency in public health literature for women to be represented as passive victims of obstetric violence and a lack of engagement with questions of resistance and agency. At the same time, the rise of the term obstetric violence is politically significant, particularly for feminist researchers, because it names *as violence* (Vacaflor, 2016) phenomena that are often hidden or invisible (as forms of violence) in obstetric contexts (i.e., dehumanized treatment and unnecessary use of medical interventions).

My aim in this paper is to contribute to the literature on obstetric violence via a feminist social constructionist analysis of ''marginalized'' South African women's birth narratives. I unpack the concept of obstetric violence and explore the ways in which violence operates as a dynamic relational process that produces docile bodies *and* complex intersectional subjectivities during birth in South African public sector settings. I try and move beyond a descriptive analysis of individual acts of obstetric violence, which tend to produce static perpetrator and victim positions, and am particularly interested in the productive effects of obstetric violence for women's subjectivities and agency.

Proceeding from the position that childbirth is a sociocultural, discursive, and political event in which multiple forms of power coalesce, I explore the subjectivities and forms of agency that are produced in women's narratives of obstetric violence. The concept of assemblage is used to extend the framework of intersectionality beyond conceptions of race, class, age, and other identity positions as stable, discrete, or static categories which ''intersect'' (Geerts & van der Tuin, 2013). Underpinned by new materialist theory (see Barad, 2007; DeLanda, 2006), assemblages are conceptualized as flows and patterns of affective, material, discursive and embodied relations which, ''develop in unpredictable ways around actions and events'' (Fox & Alldred, 2015, p. 401). Fusing the concept of assemblage with a Foucauldian concept of power as multisided, capillary, and more than overt domination (Foucault, 1975), I explore the productive and relational aspects of obstetric violence – namely: what kind of ''ambiguous agency'' (Geerts & van der Tuin, 2013) is produced in the spaces around violent and coercive obstetric relations? What modes of agency are performed and reproduced in marginalized women's birth narratives?

Conceptualizations of obstetric violence

A variety of terms have been used to describe the poor treatment of women during childbirth, including mistreatment, childbirth abuse, birth rape, and most recently, obstetric violence. The concept of obstetric violence emerged in Latin America and Spain in the 2000s from activist movements to humanize childbirth. Feminists have long critiqued medicalized modes of childbirth (Martin, 1987) and led the way for reforms in many high-income Euro-American contexts. It is therefore surprising that there has been a lack of theoretical engagement by feminist researchers and psychologists with violence and abuse in obstetric settings. It is possible that reforms in childbirth practices in high-income contexts and the rise of a neoliberal consumer rhetoric of individual "choice" in the feminist politics of childbirth (Beckett, 2005; Crossley, 2007) are implicated in this silence.

At the same time, evidence of the abuse of women during birth in the Global South intensified in the 2000s (Chadwick, Cooper, & Harries, 2014; Dixon, 2015; Mselle et al., 2011; Smith-Oka, 2015). There have also been reports of abuse in high-income contexts (Baker et al., 2005; Schroll et al., 2013). As a result of the lack of engagement from feminist scholars, discussions of childbirth mistreatment have been dominated by medical and public health professionals and framed predominantly in relation to quality of care issues and the failure of evidence-based medicine (Vogel, Bohren, Tuncalp, & Gülmesoglu, 2016).

The concept of obstetric violence emerged as a legal term in Venezuela in 2007, followed by Argentina in 2009 and Mexico in 2014. Perpetrators of obstetric violence are subject to criminal liability in these countries. In Venezuelan law, obstetric violence is included as one of 19 forms of punishable 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 a loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting the quality of life of women. (Pérez D'Gregorio, 2010, p. 201)

Importantly, this definition names abuse in obstetric practice as a form of gendered violence. At the same time, the definition is not without problems; birthing women are positioned as victims and obstetric violence is assumed to be limited to clear acts of abuse, dehumanization and appropriation by identifiable perpetrators. More complex feminist engagements with obstetric violence are needed which are able to theorize violence beyond static victim/perpetrator positions and which offer space to explore women's responses/acts of resistance in the face of power and coercion.

While feminist conceptualizations are lacking, researchers in public health have begun to grapple with the complexities of defining obstetric violence (Bohren et al., 2016; Jewkes & Penn-Kekana, 2015; Sadler et al., 2016). At the moment, the definition remains broad and includes a wide range of categories, including physical violence, verbal and emotional violence (including non-dignified and

disrespectful care), violence in the form of unnecessary medical technologies (such as caesarean section and episiotomy), and structural violence embedded in system inadequacies (Freedman et al., 2014; Sadler et al., 2016). There is thus consensus that obstetric violence includes both direct violence (physical, verbal, and sexual abuse), subtler forms of emotional violence (dehumanization, disrespect, non-dignified care), and structural violence (stigma, discrimination, and system deficiencies). Importantly, recent conceptualizations seek to name phenomena which are often not easily or normatively recognized as forms of violence (humiliation, shaming, dehumanized treatment) *as violence*. It is this very insistence that gives the concept of obstetric violence its disruptive and radical edge. According to Dixon (2015, p. 450) the term obstetric violence is "unexpected, jarring and provocative" and is deliberately used by activists as a means of challenging problematic practices that have often been hidden and unacknowledged as forms of violence. I resist normative tendencies to regard direct and extreme forms of physical violence as more authentic, urgent or problematic than subtler (often hidden) forms of violence (Žižek, 2008). Furthermore, I reject attempts to classify obstetric violence into a hierarchy or even a continuum of severity. As explicated more fully in the following section, obstetric violence is conceptualized here as an assemblage (Fox & Alldred, 2015) or emergent dynamic involving multiple relations of power, affective flows, bodily energies, structural and material configurations, and discursive repertoires.

While feminist engagement with obstetric violence remains sparse, the work of feminist philosophers Shabot (2016) and Wolf (2013) has begun to open up conceptual debates in this area. Both argue that obstetric violence is gender violence, "directed at women because they are women" (Shabot, 2016, p. 231). Shabot (2016) analyzes obstetric violence as a form of gendered bodily oppression that domesticates noisy and unruly laboring/birthing bodies which are, in her argument, "antithetical to the myth of femininity" (p. 231). According to Shabot (2016), obstetric violence is different from other forms of medical violence because laboring and birthing bodies are not ill, diseased, or dysfunctional. Instead the laboring body is usually "a healthy and powerful body" (p. 232). The abuse of women during labor functions as a mode of gender discipline which constrains and punishes the threatening bodily force of women/girls' birthing bodies. For Shabot (2016), obstetric violence is "embodied oppression" defined as a diminishment of self and embodied worth and agency.

The conceptual work on obstetric violence by Shabot (2016) and Wolf (2013) is important but limited by a conceptualization of power as solely oppressive. It is also limited by an overemphasis on gender as a primary mode of bodily discipline. Feminist empirical investigations exploring the discursive, embodied, and relational operations of violence, coercion, and power in obstetric contexts are sparse (as exception, see Kruger & Schoombie, 2010). There is also a lack of studies which explore power and violence as multisided and intersectional. It is not enough to conceptualize obstetric violence as gender violence; the operation of multiple forms of oppression and power need to be recognized. In studies of obstetric violence in

Mexico, Smith-Oka (2015) and Dixon (2015) found that violence was often aimed at women defined as ''problematic others'' (Smith-Oka, 2015, p. 9) and regarded as defying middle-class norms of ''good mothering'' or normative femininity. Racialized and class-based stereotypes of poor, black, and/or adolescent mothers are implicated in acts of micro-aggression (Smith-Oka, 2015) and violent encounters in obstetric wards. Obstetric violence thus acts as a mode of discipline that is inextricably intertangled with multiple axes of social marginalization.

Following Žižek (2008), I conceptualize obstetric violence as comprised of both subjective and objective violence. According to Žižek, subjective violence is physical violence perpetrated by identifiable agents against individual victims and is what immediately comes to mind when the word ''violence'' is mentioned. Objective violence is often invisible as violence per se, and is woven into everyday life and ''normalcy'' where it is embedded in language and discursive frameworks, moral and social categories, and social institutions. Invisible forms of objective violence create the conditions of possibility for outbreaks of physical violence. In this paper, I will focus predominantly on forms of objective (subtle, hidden, normalized) violence. This is part of a deliberate move to avoid prioritizing dramatic acts of subjective violence as more important or urgent than covert forms of violence. The concept of assemblage is explored below as a useful way of extending intersectionality and rethinking obstetric violence.

Childbirth, intersectionality, and assemblage

The experiences of middle-class, white women in Euro-American settings have dominated social science and feminist research on childbirth (Dillaway & Brubaker, 2006). The feminist politics of childbirth is thus premised on perspectives of medicalization, agency, choice, and ''natural birth'' derived from the Global North (Johnson, 2014; Kumar, 2013). Often the perspectives of women from other geopolitical spaces appear only in the literature on maternal mortality, childbirth abuse, and public health literature on maternal health, with their experiences homogenized and ''Othered'' (Kumar, 2013).

An intersectional approach in which gender is conceptualized as entangled with multiple axes of power, marginalization, and privilege, has not been widely adopted in feminist studies on childbirth. Some exceptions include the work of Brubaker (2007), Dillaway and Brubaker (2006), and Johnson (2014). When they do appear in public health and social science studies, marginalized women are often represented as passive (e.g., Bowes & Domokos, 1996; Zadoroznyj, 1999) and as victims of Third World conditions, infrastructure, and violence (Kumar, 2013). The potential agency and complex intersectional subjectivities of marginalized women have not been widely explored in relation to childbirth. According to Kumar (2013), research in the Global South also tends to focus on gender and overlook women's social and economic positions in analyses of childbirth.

In this paper, I explore the complexity of South African women's intersectional subjectivities in the context of multiple modes of oppression while giving birth.

Doing empirical research within an "intersectionality" framework is difficult (May, 2015). Derived from the work of black feminists such as Audre Lorde, Kimberlé Crenshaw, and Patricia Hill Collins, intersectional approaches resist single-axis thinking and argue for the complex interaction of multiple axes of difference. Problematically however, the intersectionality framework makes it difficult to break free of categorical thinking in which race, class, gender, age, ethnicity, and sexuality are separate entities which somehow get added together or "intersect." Some theorists have argued that intersectionality needs to be extended by the concept of assemblage (Geerts & van der Tuin, 2013; Puar, 2007, 2012). According to Geerts and van der Tuin (2013, p. 175), intersectionality theorists "lack a profound analysis of power and its affected subjects," because they work with a limited conception of power as only oppressive. As a result, "the ambiguity of intersectional subjects' agency" (p. 175) has been absent from intersectional analyses. Further, Puar (2012, p. 56) argues that intersectional approaches "fail to account for the mutual constitution and indeterminancy of embodied configurations of gender, sexuality, race, class, and nation." Instead of conceptualizing race, gender, class, and other axes of difference as stable components or coherent aspects of identity, the concept of assemblage shifts the focus to process and becoming (Puar, 2007). Originally drawn from the work of Deleuze and Guattari, the concept of assemblage has been developed and extended in the "new materialism" (DeLanda, 2006). In new materialist frameworks, agency, subjectivity, and materiality are regarded not as ontological essences but as emergent and relational processes of becoming (rather than being; Fox & Alldred, 2015). Assemblage is thus defined, for the purposes of this paper, as emergent processes of becoming (Puar, 2012), or networks of affective, material, discursive, and embodied relations, which "develop in unpredictable ways around actions and events" (Fox & Alldred, 2015, p. 401).

Within this framework, obstetric violence becomes reconstituted as a relational process comprised of flows, connections, affects, and practices (Kennedy, Zapasnik, McCrann, & Bruce, 2013). Furthermore, the focus shifts from describing acts of violence to asking: what does obstetric violence *do* (Puar, 2007)? Assemblages are relational networks which, "do something, produce something" (Fox & Alldred, 2015, p. 401). New questions thus arise, such as: what consequences does obstetric violence have? What kinds of performances, subjectivities, and strategies does it engender? Moreover, the birthing woman becomes visible as a fluid and ambiguous intersectional subject situated within and against relations of power. The term "ambiguous agency" is drawn from Geerts and van der Tuin (2013) and is used in this paper to refer to a decentred view of agency (following Foucault) in which power is seen as a force which produces agency, subjectivity, and resistance. As a result, agency can only ever be "ambiguous" and is never total or separate from wider relations of power.

After discussing methodological issues, an analysis drawing on narrative data from interviews with 35 low-income South African women is presented. This analysis explores the ways in which women negotiate obstetric violence as relational process (assemblage) and the possible forms of "ambiguous agency" produced in their narratives.

Methods

In South Africa, the maternal mortality rate (MMR) has not decreased sufficiently since 1990. In fact, MMRs increased between 2005 and 2010, before beginning to decline from 2010 (Moodley et al., 2014). While the most recent national confidential report on maternal deaths cited a figure of 176 deaths per 100,000 live births (Saving Mothers 2008–2012, 2013), the mortality survey by Bradshaw, Dorrington, and Laubscher (2012) reported a higher rate of 333 deaths per 100,000 births. Despite uncertainty regarding the "actual" MMR in South Africa, there is agreement that it has not declined sufficiently since 1990 (Bradshaw & Dorrington, 2012). While HIV/AIDS is a significant indirect cause of maternal deaths, approximately 59% of deaths are due to direct causes that are avoidable given appropriate care (Saving Mothers 2008–2012, 2013). Quality of maternal health care (including dignified and supportive treatment) remains an important and often neglected factor shaping maternal health outcomes. I have explored the implications of poor quality of care for maternal health outcomes in South Africa elsewhere (see Chadwick et al., 2014).

In South Africa, 83% of women give birth in the government-funded public sector and only 6% enjoy highly resourced, private sector care (South African Demographic and Health Survey, 2007). Obstetric services in South Africa are bifurcated by race/class inequalities stemming from historical legacies of apartheid, colonialism, and racial discrimination. As a result, public sector services are under-resourced and rife with infrastructural problems. Nurses thus often work in difficult conditions in which they experience substantial stress, are overworked, and lack resources to do their job effectively.

The findings presented in this paper are based on interviews conducted in 2012 with 35 black, low-income South African women who gave birth in the public health sector. Women were recruited with the help of a nongovernmental organization (NGO) that offers preventative services, support, and counselling for new parents and works with mothers living in impoverished areas of the Western Cape. For this study, women participating in a home-visiting programme, run by this NGO, who had given birth in the preceding four weeks, were approached by community counsellors and asked whether they were interested in participating in the study. If a woman indicated willingness to participate, her name was forwarded to the researcher and an interview was organized.

Before interviews proceeded, the research project was explained and informed consent was obtained. Women were assured that they could elect not to participate or withdraw at any stage without negative repercussions, that the interview would remain confidential, that their names and identities would be protected throughout the research project and that pseudonyms would be used in all reports, articles, or presentations based on the research. A consent form was read to each woman and her signature was obtained to indicate consent to participate. Women who were proficient in English or Afrikaans could be elected to be interviewed in the language of their choice. As the researcher was not proficient in isiXhosa, interviews with first-language isiXhosa speakers were conducted in English if women agreed to this. Interviews conducted in Afrikaans were translated by the author.

Ethical approval for the study was obtained from the University of Cape Town's Health Sciences Faculty Human Research Ethics Committee.

Following consent, participants participated in an unstructured interview which began with the question, "Can you tell me what happened with your most recent birth experience?" The interviews unfolded as conversations in which follow-up questions were asked based on participants' stories. This was appropriate given that the study was interested in women's childbirth stories and narratives are more likely to be elicited via an unstructured and open-ended style of interviewing (Riessman, 2008). Interviews lasted between 30 minutes and 1 hour and were digitally recorded, transcribed, and where necessary, translated by the researcher (see Table 1 for details about transcription notation).

Participants resided in 10 different informal settlements in the wider Cape Town metropole. They lived in shacks, backyard sheds, council flats, and small freestanding houses. One woman was homeless. All of the interviews (except one) took place in the homes of participants. Interviewing conditions were difficult and at times dangerous for the researcher, particularly in areas characterized by gang violence. Participants' ranged in age between 18 and 42 years. Most of the women had given birth to their first ($n = 19$) or second child ($n = 10$). The remaining six women had given birth to a third ($n = 3$) or fourth child ($n = 3$). Sixteen of the women were married or in a cohabiting relationship. Eight women reported a boyfriend and 11 women had no partner. The majority of women ($n = 28$) were Afrikaans speaking. Most of the births were vaginal deliveries ($n = 27$) with eight women reporting a caesarean section.

Table 1. Transcription notation.

*	Undecipherable words
(*)	Short pause
(**)	Long pause
(***)	Very long pause
(. . .)	Words omitted
You(r)	Completion of word in bracket
Massive (in bold font)	Words spoken loudly
. . .	Speech trails off
#	One person talks over the other
Good thing (italicized)	Words that are spoken slowly for effect
Tiny (bolded, italicized and underlined)	Words that are spoken slowly, loudly, and with emphasis
↑Oh my word↑	High-pitched words
Definitely (bolded and underlined)	Words spoken loudly and with emphasis
No (underlined)	Words that are emphasized
^^ Oh yes ^^	Words spoken with laughter in the voice
[doctor] (in square brackets)	Explanatory material
OH NO (capitalized)	Words shouted out

Sixteen of the women gave birth in a Maternal Obstetric Unit (MOU), 17 births took place in a public hospital, and two women gave birth outside of a health care facility.

The interview transcripts were analyzed via a functional approach to narrative analysis (Mishler, 1995) which is interested not only in the content of narratives but also in the broader social and ideological effects of narrative – i.e. what are the functions of particular story lines for storytellers, institutions, and societies? This type of narrative analysis is rooted within a social constructionist meta-theory (Parker, 1992) in which individual stories are seen as intertwined with broader sociocultural discourses. As a result, a key aim of the analysis was to interrogate the ways in which individual story lines constructed realities, selves, and identities and reproduced or subverted normative relations of power. Individual narratives were read through repeatedly and were subject to multiple layers of analysis. First, transcripts were summarized for narrative content, plot lines, key characters, and temporal structuring. Second, the narratives were analyzed in terms of the ways in which they were told – i.e. how were the stories "put together?" Finally, the narratives were analyzed in relation to broader sociocultural discourses. In particular, the analysis involved reading individual narratives for the ways in which medical, gender, and socioeconomic power relations, and different forms of violence and coercion, were constructed. The analysis also paid attention to the shifting construction of agency in women's narratives.

Obstetric violence: Relations of power and ambiguous agency

The following analysis explores women's narratives of obstetric violence in public sector settings in South Africa and thus explores obstetric violence from the perspectives of laboring/birthing women only. The analysis focuses predominantly on the forms of agency and subjectivity produced in women's narratives of obstetric violence, focusing on: (a) performing docility as an act of ambiguous agency and (b) resistant bodies.

Performing docility

A key finding of this study was that obstetric violence, and the threat thereof, functioned as modes of discipline which shaped women's actions and subjectivities during labor. The threat of violence and abuse was found to be a productive force which resulted in certain kinds of embodied performances from birthing women. In their narratives, women were aware of the importance of performing the role of the "good patient" in order to receive adequate care and avoid violence. According to broader public health literature in South Africa, "good patients" are compliant, docile, clean, and obedient (Khahil, 2009). Even when in the midst of severe labor pains, women were concerned with the successful performance of a "good patient" script in order to avoid trouble or hostility. For example:

> **Asanda**: The problem is at the [Maternal Obstetric Unit] um (*) the nurses get (**) I dunno how to say it – pissed off very easily and the(y), they get like annoyed, that's the

problem there, if you are nagging too much or asking too much they get like pissed off – I dunno why?
Interviewer: And did that happen to you?
Asanda: This time yes but I was trying to avoid that cause I was also in pain
Interviewer: So how do you try and avoid them getting angry?
Asanda: *Byyyy* doing what they say I must do, ja
Interviewer: So being, just kind of listening and being a kind of #
Asanda: A good patient, ja [yes].

Being obedient and performing docility thus emerged as a mode of action women took up in order to avoid angry nurses, hostility, and mistreatment. Acting the role of the docile patient was thus a form of ambiguous agency as medical power (via the norm of "the good patient") both constrained and made possible spaces for the emergence of agency. Hierarchical power relations embedded in Western medicine often require the enactment of the prescribed roles of expert/patient in which the patient becomes a passive and obedient patient body. For example:

Abigail: If you just listen to them they [nurses] are quite fine.
Interviewer: Can you give me an example of what you mean by listen?
Abigail: Maybe they told you 'go pee quickly *in that thing*' and then (*) they test now – with a straw and then they say go and throw that quickly away for us, sit quickly on the bed, lie quickly that way, lie this way, *sooo*... (This extract has been translated from Afrikaans. See the online supplementary material for the Afrikaans version.)

According to Abigail, as long as laboring women obeyed orders and did not "speak back," the nurses were "fine" – i.e. there was no abuse. The threat of hostility and violence for noncompliance in relation to medical ideals of the good, docile patient engenders a situation in which some women adopt a "hesitant, docile, silent body" (Shabot, 2016, p. 246) during labor as a way of avoiding obstetric violence. The threat of violence is thus often enough to produce docile bodies and compressed selves in obstetric contexts. As argued by Shabot (2016), the diminishment of self during labor/birth is in itself a form of obstetric violence or "embodied oppression." In public sector settings, wider norms and expectations about the behavior of "good patients" function as modes of disciplinary power which shape women's actions and structure interpersonal dynamics (between nurses/patients) according to the threat/possibility of violence for noncompliance.

As a result of the possible violent consequences of misbehavior, performing the good patient script was important to many women. Compliance, obedience, and docility were strategies in which low-income women actively engaged in order to enact the "good patient" script and avoid violence. According to Tanassi (2004), compliance is not synonymous with passivity and should be recognized as a "material strategy" (p. 2053) and form of agency. Performing embodied docility thus emerged as a form of "ambiguous agency" (Geerts & van der Tuin, 2013) formed in response to hierarchical obstetric power relations, norms, and ideals.

Performing passivity and docility was a response to threats of violence and thus a form of constrained or "ambiguous agency."

Performing the "good patient" script required obedience, passivity, and not making "demands" or asking questions. Women were expected to accept their situation and suffer in silence, which often included laboring alone without a companion or caregiver and being denied regular monitoring and information. This was anxiety-provoking and stressful. For example, Wendy, pregnant with her first baby, became desperate for information and made an appeal to nurses for assistance:

> **Wendy**: ^^Nobody came^^, the pains got stronger and stronger and um (*) then I went to one sister and *asked* her like (*) won't she check me to see how *far* I am, how many centimetres I am and then she said '*no*, um, does she, do I want one, one of them to get ***angry*** with me?' they are going to get **angry** and scold me if I now ask how many centimetres and that they must check on me (both laugh incredulously) ↑and then↑ um (*) ^^then I left it and then went back to the room^^ because I didn't want big trouble, then I left it and nobody checked me. (see online supplementary material for the original Afrikaans)

Being assertive and asking for care is punished in the scene above. The nurse responds to Wendy's request by threatening her and insinuating that she is "asking for trouble" (i.e., violence) if she insists on requesting information. Wendy is disciplined, silenced, and forced to, "become docile" Obstetric violence becomes visible here as a relational, disciplinary, and productive process, involving a flow of unspoken norms, affects, and regulations embedded in class, race, and gender dynamics and with implications for the subjectivities of women during labor. As a low-income, black, public sector patient, Wendy needs to be undemanding and passive in order to fulfil normative expectations and qualify as "good." When she defies accepted norms, there is a violent encounter resulting in subjective diminishment and loss of agency. As a result, Wendy's ability to enjoy a dignified and satisfying birth experience is reduced. According to Shabot (2016, p. 232), obstetric violence is experienced by women as "a diminishment of their embodied selves: a reduction, repression, and objectification." As we have seen, the threat of violence is often enough to constrain, reduce, and diminish women during birth; this points to deeper and entrenched forms of objective violence, which include "subtle forms of coercion that sustain relations of domination and exploitation, including the threat of violence" (Žižek, 2008, p. 9).

Ideals of the good patient were not the only regulatory norms operative in public sector contexts. Moral imperatives tied to gendered norms were also present. Notions of "good femininity" and "good mothering" functioned as normalizing judgments and justified modes of discipline and punishment. Obstetric violence thus involves multiple arrangements and flows of power, normalization, and subjectification, including medicalization, gendering, racialization, and class marginalization. For example, in women's stories, being impoverished and teenage marked women not only as "bad mothers" and potentially "bad patients," but also as "bad women/girls." Women and girls were thus sometimes positioned as

"bad," out of order, and worthy of punishment because they were poor, young, HIV+, or black. Punishment often took the form of degrading comments about women/girls' sex lives and petty humiliations, which were sanctioned and justified as a form of moral correction. For example:

> **Jasmine**: They're [nurses] RUDE, they will tell you, they will say, 'No you did that (sex) *lekker* [lustfully] – that kind of stuff.
> **Constance**: I screamed because it was burning and she said, the one sister [nurse] 'No shut your mouth, why are you screaming? You people keep on screaming because you want to... wait now – ^^'Yes, you people keep screaming ^^ because you want to do such things' (have sex). (see online supplementary material for the original Afrikaans)
> **Sanele**: They keep on shouting...you must not assist *her*, is her fault, you, you were not there when she was *having sex* so now she's pregnant, she wants your assistance, she must try for herself – they say so.

Punitive encounters between nurses and laboring women were narrated as relational and moralizing exchanges involving "a whole series of subtle procedures...from light physical punishment to minor deprivations and petty humiliations" (Foucault, 1975, p. 178). For example:

> **Sanele**:...What was, and, and, and, there's another thing that I didn't like – the moment I feel the baby's **coming**, the nurses say I must put the baby's stuff on the baby's cot while I feel the pains and I feel **now** the head is near, is also shouting at me "No you must put the clothes of the baby into *the* um (*) the cot" (*) I say to her I didn't feel well because I am weak and then I feel the pains and I feel the baby is coming, she says it's not her fault because (**) she, she is not pregnant and she is, it's not her child.

Within the assemblage of obstetric violence, Sanele, an impoverished and pregnant black African woman, is treated as deserving of punishment and lack of care. According to the logic of obstetric violence in this context, she is a "guilty" body (by virtue of being poor, black, and pregnant) that requires chastisement. As a result, a punitive set of relations is enacted, characterized by humiliation, verbal abuse, and unreasonable demands.

While some women were able to perform docility and enact the role of the "good patient," others had difficulty in doing so because their positionalities as poor, teenage, or HIV + automatically marked them as difficult or out-of-order. For example, Jasmine, a mother of four, gave birth at home without a caregiver largely because she was scared of being punished by staff at the maternity unit for being a "bad mother" due to her poverty and lack of baby goods:

> **Jasmine**: I was shy, I was afraid also of what people were gonna say, I told X [friend] also that was my main reason also that I didn't go book [at Maternal Obstetric Unit]... I didn't have kimbies [nappies], I didn't have baby clothes, what are people gonna say if I uuh (*) gonna *give birth* like that.

In the assemblage of obstetric violence, class, racialized, and gendered imperatives about ''good mothers'' and ''good women'' intertwined with medical norms surrounding the ideal of the ''good patient,'' to create relational networks of discipline, punishment, normalizing judgment (Foucault, 1975) and coercion. Via this disciplinary assemblage, laboring women were (re)produced as ambiguous subjects both performing docility and the (moving) targets of corrective punishment in which their race, class, age, and sexual activity made them automatically morally suspect. Many women narrated a process of actively practicing docility, obedience, and compliance in order to negotiate ''care.'' At the same time, women had to negotiate the embodied process of labor, which created further challenges for modes of agency and docility.

Resistant bodies

> Power, after investing itself in the body, finds itself exposed to a counter-attack in the same body. (Foucault, 1980, p. 56)

Labor and birth evoke powerful forms of embodiment which are often at odds with idealized medical bodies that are passive, mute, and inert (Leder, 1992). This can create tensions in obstetric contexts between patients and health care workers which are potentially implicated in eruptions of violence. In women's stories of obstetric violence, nurses were narrated as agents of control who tried to punish, discipline and ''mute'' their ''loud bodies'' (Shabot, 2016). Efforts to perform docility, passivity, and the good patient script sometimes broke down as women negotiated the fleshy, painful experience of labor and birth. As women/girls' laboring bodies became ''loud'' and agentic, they became particularly vulnerable to punishment and discipline.

Women described the ways in which nurses would reprimand them for adopting certain bodily positions during labor, for being ''loud'' (i.e., screaming) and for asking for water or pain relief. Punishment was effected by threats, shouting, insults and rough, punitive treatment. In the interviews, many women spoke of their attempts to assert bodily agency during labor and to ''listen to'' their bodies. These attempts were sometimes interrupted and punished by caregivers. For example:

> **Kuhle**: So I was sitting there and when I'm sitting there I feel like, if I open my, my legs I feel comfortable, so I open my legs (*) so then the sister came and check and she said 'Why are you doing this?' I said 'I feel like to do this thing' she said 'No it's not a good thing' I said okay, I stand up and then I go to the bed...
> **Interviewer**: What did they want you to do?
> **Kuhle**: They say, they said I must sleep, I must sleep
> **Interviewer**: You must sleep? Flat on back?
> **Kuhle**: Yes, back flat, so I don't feel like it, I just feel like to do that thing I want to do, okay then after that I said 'I want to push' they said, 'No, don't push, you are not

> allowed to push – you must go to that side' I said 'Okay' I go to that side and then when I go to the other side they check me there, blood and then they checked the heartbeat of the baby and they said it's fine so I asked 'Can I push now?' they said 'No wait', I push myself because they said 'No, don't push' but ***I feel like it***, yes, so I push and then they are shouting, 'Why are you pushing? I said don't push!' I said 'I feel like I want to push' they said '**No!** I didn't say *push*!' ok (inaudible) so I rather keep quiet.

Kuhle struggles to follow her bodily sensations and do what *feels* comfortable while her caregivers interrupt her attempts to assert embodied agency. She is not "allowed" to listen to her bodily cues and has to get "permission" from nurses before she is allowed to give birth. Later in the interview, Kuhle makes mention of "the chart" (medical poster) on the wall of the labor ward encouraging women to adopt active birth positions. However, when she tries to follow the advice on the poster, she is reprimanded:

> **Kuhle**: The thing I noticed, there, there was a (*) something like this (points to poster on the wall)
> **Interviewer**: Like a poster?
> **Kuhle**: And they have a (*) pain labour thing there BUT THAT'S THE THING that I was doing, that was THERE but they said 'Mustn't do'
> **Interviewer**: Okay, so what was the poster saying?
> **Kuhle**: They, they put the pictures there, if you are in labour you are supposed to do this and that but when I am doing this, they say 'No, it's not allowed.'

Freedom to engage in a range of labor positions is encouraged as "best practice" on medical posters in the clinic, but disallowed by nurses on duty. Outdated and harmful practices such as giving birth via the supine position on a delivery bed are often still enforced because they regulate laboring bodies, reiterate normative power hierarchies, and are convenient for health care professionals. Violence and abuse are sometimes regarded as legitimate tactics in obstetric contexts to restore order to unruly laboring bodies (Bohren et al., 2016). For example, in the example above, bullying and coercion are used as tactics to discipline Kuhle's wayward and exuberant body.

Rizwana, left to her own devices during labor, engaged in active walking to try and control the pain. This assertion of agency resulted in sexual insinuations and insults:

> **Rizwana**: And then I walked up and down because they took their own time (laughs), walked up and down and then they said, 'No, don't walk, you must lie down' then I said, 'No sister, the pains are sore' – 'No, do you think having babies *is nice* (smacks lips) I said 'No sister I can't say that but I want to walk now' they said, 'No, lie down' (both laugh) they carried on and on about this *having babies* story – *it's not a nice matter*. (see online supplementary material for the original Afrikaans)

For other women, screaming and being "noisy" during labor resulted in insults and sexual innuendos. For example, Kuhle was told, "No man, don't make noises, because the time when you were making the baby you were not screaming – so

why are you screaming now?'' Other women were punished for involuntary bodily movements during delivery. For example, Fadwah described being subject to verbal aggression while pushing out her baby because her birthing body was moving on the plastic sheet covering the delivery bed:

> **Fadwah**: And um like I was pushing, I was moving on the bed because of the plastic that was on the bed and **I didn't notice** I was moving, like she [nurse] told me I must lay straight (*) and I didn't know that I was like moving (*) and then **she shouts** and then she says 'Lay straight! Why are you laying that way?!'

Fadwah's body is considered ''out of order'' and unruly for not laying ''straight'' and moving about during the process of giving birth. Given this so-called disorderly behavior, she is scolded and shouted at. Her active birthing body is disciplined by medical staff in order to conform to normative imperatives and hierarchies of medical, gender, and class power. In obstetric encounters structured by a logic of hierarchical punishment and control, the volatility and unpredictability of the laboring body is potentially regarded as a problem or threat which needs to be contained. According to Shabot (2016), the noisy and powerful birthing body constitutes a threat to feminine norms of passivity and docility. In this study, norms pertaining to ''good femininity'' were however also embedded in class/race dynamics. As a result, the ''loud (laboring) bodies'' of poor and black women were sometimes seen as evidence of broader sexual lasciviousness (i.e., Kuhle and Rizwana). At the same time, the ''loud bodies'' of labor/birth also disrupted medical norms pertaining to the ''good patient''‘ body. As a result of the disruption of multiple gendered, racialized and medicalized norms pertaining to ''good bodies,'' punishing women for embodied agency during labor/birth is often sanctioned and normalized by medical staff and authorities (see Bohren et al., 2016).

While some women were muted by disciplinary efforts to control/punish their embodied agency, others found room for resistance. For example, Shiyaam, a young teenage girl pregnant with her first baby, narrated a process of constantly speaking back, despite rudeness from nurses. For example:

> **Interviewer:** They were rude?
> **Shiyaam**: ^^ Then they were rude – 'You can't have any water' 'But sister I am thirsty, ^^ I feel *like water*', they say 'No, you can't get any water', 'Just a small bit'! They say 'No, you must push', I say 'Give me a bit of ^^ water and then I will push' (laughter) ^^'Don't give us that nonsense'^^ (laughs)
> **Interviewer:** And then did they give you in the end?
> **Shiyaam**: Then they gave me give a tiny bit, ^^just to wet my throat^^ (laughs) (see online supplementary material for the original Afrikaans)

In this relational encounter there is space for resistance. Shiyaam is able to enter into a dialogical banter with nurses in which she voices her own needs and sometimes gets what she wants. Despite punishments and hostilities, the embodied process of birth offers (some) women the possibility of bodily agency, resistance,

and power, depending on contextual, subjective, and relational factors. For example:

> **Rifquah**: I just thought if the baby comes then I will push by myself, I wasn't going to worry about them [nurses] (see online supplementary material for the original Afrikaans)
> **Interviewer**: So did they [nurses] kind of tell you how to push or…?
> **Bronwyn**: *Yes*, but I didn't listen to them (laughs)

Access to haptic knowledge of the birth process offers women the possibility of embodied agency. As a result, the potentially volatile and agentic bodies produced during labor and birth can create tensions in obstetric contexts as normative relations of authority, hierarchy, and power become potentially troubled. Furthermore, as laboring bodies become noisy and powerful, multiple gendered, racialized, and medicalized norms regarding appropriate and "good" bodies are subverted. As a result, obstetric violence and punishment can function as a disciplinary device which attempts to reclaim order, control, and reestablish normative power relations in obstetric contexts. Importantly, violence is thus not situated in "bad" individual nurses but is the outcome of sets of relations, norms, and historical legacies and modes of medicalization.

Conclusion

Over the last decade, the concept of obstetric violence has emerged as a useful framework for problematizing the mistreatment of women/girls during childbirth. While increasing public health studies have explored abuse in obstetric contexts, particularly in the Global South, feminist theoretical engagement with the concept has been limited. This paper contributes to the literature on obstetric violence via a feminist social constructionist analysis of South African women's birth narratives.

The findings showed that obstetric violence is more than a series of decontextualized events that occur between an individual perpetrator and victim. Obstetric violence is 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." Abusive treatment and violence toward laboring women is normalized in some settings, including South Africa (Bohren et al., 2016; Jewkes, Abrahams, & Mvo, 1998). Midwives, doctors, and women themselves have been found to believe that violence is acceptable when a laboring woman is uncooperative or "disobedient" (Bohren et al., 2016). As a result, violence and mistreatment cannot be seen simplistically as the acts of a few "bad" individual nurses. Oppressive and abusive behavior are not simply "the result of a few people's choices" (Young, 1990, p. 39). Instead, unjust actions often occur because of the "often unconscious assumptions and reactions of well-meaning people in ordinary interactions" (p. 39). In South African public sector settings, interpersonal relations in the "birth assemblage" (Fox & Alldred, 2017) are shaped by racialized, classed, gendered, and medicalized norms which

often function and masquerade as moral imperatives. As a result, when women fail to be morally ''good'' (women, patients, bodies) they are vulnerable to punishment. The analysis showed that obstetric violence functions as a mode of discipline which results in women performing ''good patient'' scripts and actively performing docility. Women thus enact forms of passivity or ''ambiguous agency'' (Geerts & van der Tuin, 2013) in which they perform docility as a strategy to avoid violence and obtain care.

Some women had difficulty in conforming to imperatives to be ''good'' because of their locations in particular class, age, race, or other identity markers. The study also found that while obstetric violence resulted in the performance of docility as a strategy, docile bodies sometimes broke down due to the intensity of the bodily process of labor/birth and became loud and resistant. The ''loud bodies'' (Shabot, 2016) of labor were often the targets of discipline and punishment because they challenged normative hierarchies of power. Violence was thus sometimes a means of reasserting normative relations of power and containing modes of embodiment which threatened established gender, race, class, and medical norms.

Conceptualizing obstetric violence as an assemblage enabled the recognition of fluidity, multiplicity, and relational power dynamics. Laboring women became visible as more than inescapable victims and emerged as ambiguous intersectional subjects situated within and against relations of power. Nurses were not simply perpetrators motivated by individual pathology and psychopathy but actors shaped by power relations in the obstetric assemblage. In the South African context, nurses are still affected by colonial legacies in which they were expected to ''moralise and save the sick, not simply nurse them'' (Marks, 1994, p. 208). Nursing has also traditionally been a route to middle-class respectability for black women in South Africa and they have been positioned as medical authority figures responsible for policing moral, gender, and class boundaries (Marks, 1994). Rather than problematic individual perpetrators responsible for ''causing'' violence, nurses are themselves intersectional subjects positioned in multiple ways in the birth assemblage. They are often overworked, stressed, and left to work in difficult and under-resourced conditions. Further research is required which explores the perspectives and narratives of South African nurses in relation to obstetric violence and traces the complexity of their intersectional subjectivities.

In the paper, I showed that obstetric violence operates through multiple modalities of disciplinary power, including the threat of violence, bullying, petty humiliations, indifference, neglect, and verbal abuse. The findings of the study suggest that social and medical norms are implicated in creating the conditions in which obstetric violence is possible (or thrives). Problematic assumptions about how ''good'' laboring and birthing bodies should be behaving, combined with power differentials between (middle-class) medical professionals with ''expertise'' and (poor) ''patients'' who are not credited with any authoritative knowledge, create the backdrop against which individual outbreaks of subjective violence and abuse occur.

This study has several limitations. One-off interviews were conducted with women which focused only on childbirth narratives. The study did not explore broader issues, personal and reproductive histories, and contextual factors which

might have impacted on women's childbirth experiences. The women interviewed were socioeconomically disadvantaged and black, compared to the interviewer/researcher who was middle class and white. This created interviewing challenges and power imbalances. Every effort was made to make women feel comfortable and to underline the importance of their experiences and stories. As an effort to address inevitable power differentials, every effort was made to enable participants to speak in their mother tongue. As a result, most of the interviews were conducted in Afrikaans. The study is also limited by the fact that it includes only the narratives and perspectives of birthing women and does not include the perspectives of nurses or other medical professionals.

The study found that subtle and often invisible forms of objective violence (Žižek, 2008) structure and shape affective relations in public clinic "birth assemblages" in South Africa. These forms of violence, including verbal abuse, petty humiliations, neglect, and threats of violence, *affect* laboring women in significant ways and produce relational encounters filled with anxiety, shame, and feelings of diminishment. These kinds of negative affective relations have potentially significant implications for the way women feel about themselves, their babies, and their birth experiences. Negative interpersonal relations between caregivers and laboring women have been found to be features of traumatic birth experiences (Elmir et al., 2010; Thomson & Downe, 2008) and can have serious implications for women's long-term psychological health. Future feminist psychological research needs to explore the relations between obstetric violence, traumatic birth, and potential long-term sequela.

This study points to the need to develop more sophisticated conceptualizations of obstetric violence in which multiple modalities of power are acknowledged. Furthermore, obstetric violence needs to be rearticulated as more than a series of events involving individual perpetrators and victims. Until the normalizing and disciplinary aspects of obstetric practice in terms of reiterating dominant relations of race, class, gender, and medical power are acknowledged, eruptions of abuse and subjective violence will continue. It is thus imperative that interventions are designed that treat obstetric violence not as simply individual "bad" behavior but as the outcome of multiple layers of social norms and relations of power. Health care workers need to be sensitized to these dynamics and to the negative impact of moralizing, medicalizing, and marginalizing patients. This study suggests that while individual acts of obstetric violence must be condemned and addressed, attention must also be paid to subtle and often unacknowledged forms of violence. Until these subtle relations are acknowledged as *forms of violence*, the unacceptable abuse and dehumanizing treatment of poor and marginalized women will continue during childbirth.

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