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Ester Espinoza-Reyes
El Colegio de la Frontera Norte

Marlene Solís
El Colegio de la Frontera Norte

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Decolonizing the Womb: Agency against Obstetric Violence in Tijuana, Mexico

By Ester Espinoza-Reyes¹ and Marlene Solís²

Abstract

Obstetric violence is a human rights violation that consists of actions or omissions of healthcare personnel that harms people during pregnancy, childbirth or puerperium. Some practices through which it is expressed are the mistreatment, unnecessary procedures, denying of medical attention or provoking damage either physically or mentally. In particular, we understand obstetric violence as the result of a colonization of the womb, that is, of the occupation of the concept of motherhood by the dictates of patriarchal ideology (Fineman, 1991; Ehrenreich, 1993) and of the Colonial/Modern Gender System, proposed by Lugones (2007). The objective of this paper is to analyze the experiences of obstetric violence and the different agency forms of women who have experienced it in hospitals in Tijuana, Mexico. To achieve this, we follow Galtung (1969, 1990, 1998) who states that direct violence is just the tip of the iceberg of cultural and structural forms of violence that are more difficult to see. Based on Bourdieu (2001) and De Certeau (1998), agency is classified in four categories: 1) unawareness, 2) passive awareness, 3) tactics and 4) strategies. The intersectional analysis of the narrative stories of 20 women leads us to conclude that both those who have privileged positions and those who experience different oppressions based on their identity characteristics perform their agency in various ways. Including modern and non-modern knowledges, relations, values and practices, Decolonial Feminism (Lugones, 2010) contributes to an understanding of the decolonization of the womb at the collective level while simultaneously influencing individual learning and promoting social justice and the formation of a culture of rights.

Keywords: Obstetric Violence, Women Agency, Narrative Stories, Intersectionality, Decolonization, Mexico.

¹ Ester Espinoza-Reyes holds a PhD in Cultural Studies from El Colegio de la Frontera Norte (El Colef), where she defended her thesis “Descolonizar el útero: Experiencias y agencia frente a la violencia obstétrica en Tijuana” (2019). She has taught graduate and undergraduate courses at Universidad Pedagógica Nacional Tijuana. Her main research interests include: obstetric violence and women’s agency, gender and religion studies. She published the paper “Entre el discurso religioso y las prácticas de sexualidad femenina en una iglesia pentecostal en Tijuana, México” at the journal *Culturales* (UABC, 2015).

² Marlene Solís Pérez holds a Phd in Social Sciences from El Colegio de la Frontera Norte. She belongs to the Mexican National System of Researchers, level I. She is a professor-researcher at the Department of Social Studies, El Colef, also she has been coordinator of the Phd in Cultural Studies. Her research topics include: labor and gender, gender violence, border and social change. Among her recent publications is the edition of the book *Gender Transitions Along Borders: The Northern Borderlands of Mexico and Morocco* (Routledge, 2016).

Introduction

To talk about the colonization of the womb means to think about motherhood as a colonized concept, an event that although experienced by women is defined by concepts of patriarchal ideology (Fineman, 1991; Ehrenreich, 1993). This colonization is also the result of the asymmetric relationships established between men and women, as well as colonized and colonizers, described in Lugones' theory of the Colonial/Modern Gender System (2007). Currently, with the emergence of new ways of motherhood that question the classic models of being a mother, it would be an overstatement to affirm that all forms of motherhood are colonized³, however it is also impossible to deny that forms of this "colonization" are still present in the lack of access to sex education, contraception and legal and safe abortion.

In this sense, to consider a decolonization of the womb means to imagine, analyze and make visible the forms of agency employed by those who have suffered this occupation, to resist it and reappropriate their bodies and their sexuality, either responding through modern or non-modern shared knowledges, relations, values and practices, that is, a Decolonial Feminism (Lugones, 2010). One of the modalities that has taken the colonization of the womb is obstetric violence,

a specific form of violence against women that constitutes a violation of human rights. It is generated in the field of obstetric care both in public and private health services and consists of any action or omission by the personnel of the National Health System that causes physical and/or psychological damage to women during pregnancy, childbirth and puerperium, which is expressed in the lack of access to reproductive health services, cruel, inhuman or degrading treatment, or an abuse of medicalization, undermining the ability to freely and informedly decide on such reproductive processes (Grupo de Información en Reproducción Elegida, GIRE, 2015, p. 124).

In Mexico, the inclusion of the concept of obstetric violence in its laws is recent—the first state to include it was Veracruz in 2012—, however, it was a long journey for this to happen. In Latin America, obstetric violence gains visibility with the creation of the Organic Law on the Right of Women to a Life Free of Violence, by Venezuela in 2007; while in 2009, Argentina issued the Act 26.485 Comprehensive Protection to Prevent, Punish and Eradicate Violence against Women in the Areas where they develop their Interpersonal Relations. The year 2019 marks a milestone at the international level regarding the institutional acceptance of the concept, as the United Nations (UN) uses it for the first time extensively in a report of the Special Rapporteur on violence against women, its causes and consequences (United Nations General Assembly, 2019) and also at the national level, since the term obstetric violence is added to the Mexican General Law on Women's Access to a Life Free of Violence, after a series of initiatives that had been presented throughout this decade without reaching its approval in the Congress of the Union (Cámara de Diputados, 2019).

Although so far only four of Mexico states have not included obstetric violence in their specific Law on Women's Access to a Life Free of Violence, the country has an important regulatory framework on the subject—for instance article 4 of the Mexican Constitution, the General Health Law and Official Norms—, supported by international instruments such as article

³ Regarding the issue of new maternities, feminist maternities and non-maternities in Mexico, see Sánchez, Espinosa, Ezcurdia and Torres (2004); Távira, García, Ronzón and Román (2018) and Gómez and Tena (2018).

12 of the Convention on the Elimination of All Forms of Discrimination against Women or the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (Meza, Mancinas, Meneses and Meléndez, 2015). However, these laws have failed to effectively guarantee that the right of access to obstetric healthcare from a human rights perspective is fully respected, as shown by the National Survey on the Dynamics of Household Relationships (ENDIREH) 2016, which states that more than one third (33.4%) of women aged 15-49 years who had their last childbirth between 2011 and 2016, experienced incidents of abuse that can be described as obstetric violence⁴ (Instituto Nacional de Estadística y Geografía, INEGI, 2017).

Regarding the difficulties and limitations faced by pregnant and birthing people who experienced violations and the organizations that defend them, Sesia (2017) has analyzed one particular case that received international attention recently: Irma López, an indigenous woman who gave birth in the lawn of a public hospital in Oaxaca due to healthcare staff refusing to admit her, and the role of GIRE, an organization that disseminates information on reproductive rights and providing legal support, aids in securing remedies and compensation and campaigns to prevent future occurrences.

Existing legislation and regulations result from women's long struggle, exemplifying successful agency in politicizing gestation and maternity experiences. However, the construction of citizenship is a constant task requiring awareness-raising, but also the staging of political and organizational resources through which laws are prevented from becoming a dead letter. This is why it is of capital importance to inquire in the capacity of action of those who speak out about experiences of obstetric violence.

We aim to contribute to the understanding of the roles, logic and agency of women and pregnant or birthing people⁵, because there are still unanswered questions concerning the distinction between cases in which agency can be exercised in a strong and strategic manner, and cases of more defensive, immediate tactics. Likewise, it is necessary to reach an understanding as to how the individual and collective agency are linked in the struggle for the defense of women's and pregnant or birthing people rights.

This paper presents research findings of an empirical study carried out in Tijuana, Mexico⁶ during 2017 and 2018. Interviews were conducted with women who reported experience of abuse during their pregnancies, childbirth or puerperium. Based on the concept of colonization of the womb (Fineman, 1991; Ehrenreich, 1993), Lugones' idea of a colonial system (2010), Galtung's notion of violence (1969, 1990, 1998), and a classification of different forms of agency based on Bourdieu's (2001) and De Certeau's (1998) theories, we analyze the scope for resisting violence present in these cases, and the implications for collective action and the decolonization of the womb.

⁴ ENDIREH 2016 does not explicitly mention the term "obstetric violence", referring to it as "mistreatment in obstetric care", however, the situations included in this section of the survey coincide with the various ways in which this type of violence is expressed according to the definitions and texts we reviewed.

⁵ Chadwick (2017) uses the term ambiguous agency to describe passivity, obedience and acting the role of the docile patient as forms of action; Castro and Savage (2018), who explain through the concept of adaptive preference why women accept the poor quality of care they receive, and Bellon (2014) and Gonzalez-Flores (2015) who examine activism against obstetric violence.

⁶ This paper is based on the research carried out as part of the Doctoral Thesis "Descolonizar el útero: Experiencias y agencia frente a la violencia obstétrica en Tijuana, México" (Espinoza, 2019), to obtain a Phd in Cultural Studies at El Colegio de la Frontera Norte.

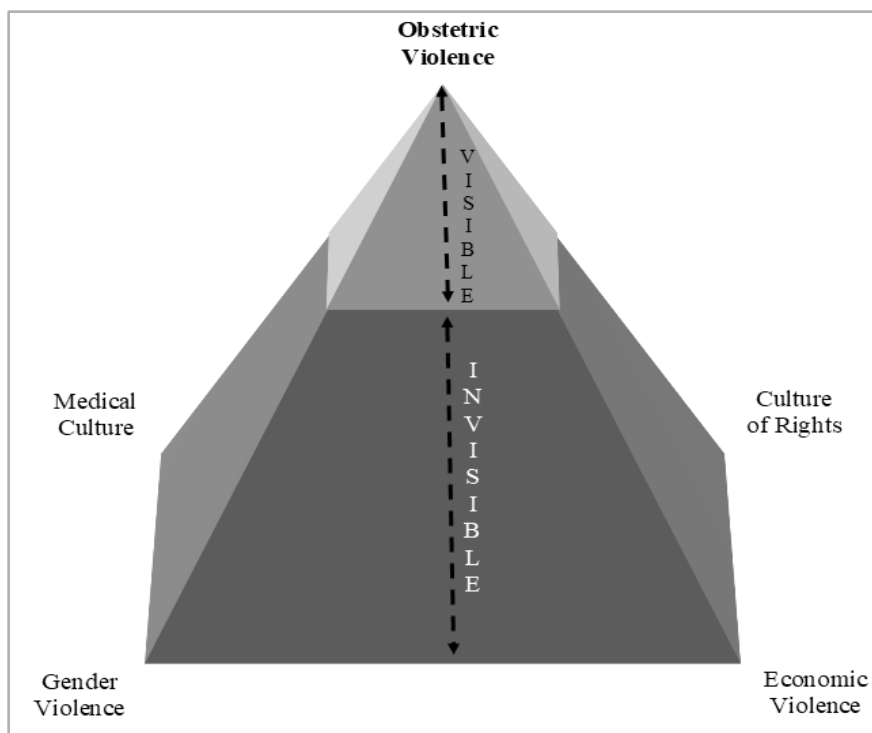
Our analysis is based on the idea that women, pregnant and birthing people can appropriate their own bodies and sexuality as a way of dismantling the persistent coloniality in thinking and behaving around the processes of human gestation, at individual and collective levels of action. Resistance requires the use of different resources and the creation of learning trajectories as well as a shared and recognized way of understanding the world and living in it. It is important to specify that the recognition of the experiences of abuse implies a form of subjectivation that comes with an awareness about female subjection to hegemonic knowledge.

This text is organized into five sections. First, our theoretical framework presents the notion of obstetric violence as a pyramid made up of four structural and cultural elements resulting from the colonial imposition of gender. We define agency and call attention to the idea of non-modern practices. Then we describe the methodology and the data analysis, which is organized in two sections: the individual agency of women against obstetric violence, and the relationship between individual and collective action. Finally, in the conclusions we discuss Decolonial Feminism in relation to the hegemonic medical culture and ways of reappropriating the body and the sexuality through modern and non-modern knowledges, relations, values and practices shared by women, pregnant and birthing people.

The Pyramid of Obstetric Violence

Violence is comprehended as a polysemic phenomenon that is difficult to delimit and is full of tensions. We follow Galtung's proposal (1969, 1990, 1998) that violence is a vicious cycle that can be described as a triangle formed by three types of violence: direct, cultural and structural. Direct and visible violence is only the tip of the iceberg that sits on top of cultural and structural forms of violence that are more difficult to see and are key elements for the legitimation or justification of direct violence.

Obstetric violence is a multifactorial phenomenon in which intertwine problems such as i) gender violence and the attempt of institutions to discipline bodies; ii) State economic violence, through the implementation of neoliberal policies that affect a large part of the population, albeit unequally; iii) the violence of the healthcare field -which arises from the authoritarian habitus that distinguishes medical professionals (Castro, 2014) and the power asymmetry that characterizes the doctor-patient relationships- and, finally, iv) the absence of a solid culture of rights in Mexico. From this, we describe obstetric violence as the tip of a pyramid, at whose base are these four factors holding it and justifying it, as can be seen in Figure 1.

Figure 1. Pyramid of Obstetric Violence

Source: Espinoza, 2019

To think about obstetric violence as a result of various elements leads to conceive it as a product of an apparatus/dispositif⁷ of obstetric power, which is exerted on bodies that can get pregnant and give birth, in order to make them docile and useful to the economy of reproduction (Arguedas, 2014). Violence is also understood as a continuum (Scheper-Hughes and Bourgois, 2004), since it is produced in the form of chains, spirals or mirrors in which those identified as perpetrators can also be subjected to it, because it is rooted in the common sense of everyday life, in social feelings and in institutions. This implies avoiding the opposition victim=passive/victimizer=active and considering that those who suffer from violence have the agency to conform, resist or negotiate.

This root of violence in the everyday life is explained by Lugones through the idea of a colonial imposition of gender that “cuts across questions of ecology, economics, government, relations with the spirit world, and knowledge, as well as across everyday practices that either habituate us to take care of the world or to destroy it” (Lugones, 2010, p. 743). Her approach proposes that this coloniality is grounded in a dehumanization of people that fits them for classification and turns them into less than human beings. We propose that this occurs precisely from the conjugation of the aforementioned cultural and structural components of the pyramid of obstetric violence.

Agency is the socially determined ability to act and make a difference conditioned by the social structures of language, the routine nature of modern life and the narratives that we cannot

⁷ We understand the apparatus/dispositif as a heterogeneous set of discursive or non-discursive elements with a specific strategic function and inscribed in a power relationship, which results from the crossing of power and knowledge relationships (Agamben, 2011).

bring to consciousness completely (Barker, 2004). We agree with Sewell Jr. (1998), for whom being an agent means being able to exercise a certain degree of control and transformation within the social relationships in which we are involved. Agency arises from actors' knowledge regarding cultural schemes and their ability to apply them creatively in new contexts – this differs in scope within and between societies, according to the subject's social positioning.

We propose a classification of four positions in the spectrum of agency, the first two following Bourdieu (2001) and the other two from De Certeau (1998): 1) unawareness, which represents a lack of knowledge about experiencing violence; 2) passive awareness, in which one notices being subject of violence, but this does not lead to action; 3) tactics, carried out with mainly defensive and immediate purposes and using, manipulating and diverting the circumstances, and 4) strategies, namely, forms of strong and overwhelming agency, which go on the offensive and confront, having the time and space to carry out calculations of force relations. We highlight the concept of non-modern practices (Lugones, 2010), since, along with other modern practices, they are important mechanisms used by informants to confront the dichotomous, hierarchical and “categorical” logics on which the violence they are subject to is based. These categories are proposed as tools for thinking about how women face violence and analyze from an intersectional perspective, how the actions they carry out are related to their privileges and oppressions.

Narrative Stories as a Knowledge Tool

We used a qualitative methodology that privileges the perspective of the actors, to describe and analyze obstetric violence as perceived by the people who have experienced it. In this research, gender stands out as a category of analysis, however, we also explore its intersection with other categories such as class, education, age and ethnicity (see table 1). The case selection was guided by a purposive varied sample, for the intention of carrying out an intersectional analysis.

The general inclusion criteria were that the participants had received obstetric healthcare in a Tijuana hospital during their pregnancy, childbirth or puerperium and considered having experienced obstetric violence. We included participants who had been treated in both public and private institutions, as this served as a proxy for socio-economic differences. Since we pursue an intersectional analysis in which the diversity of experiences of obstetric violence was highlighted, age, education attainment and ethnicity were also taken into account.

Table 1. Characteristics of Interviewed Women

	Pseudonym	Age	Education Attainment	Occupation	Ethnicity	Number of Children	Type of Healthcare Received
1	Abigail	32	Postsecondary	Housewife	Non-indigenous	1	Seguro Social
2	Mariana	32	Secondary	Housewife	Non-indigenous	2	Seguro Social
3	Tita	38	Postsecondary	Formal employment	Non-indigenous	1	Private services
4	Brisa	33	Secondary	Housewife	Non-indigenous	3	Seguro Popular
5	Amelia	30	Postsecondary	Formal employment	Non-indigenous	1	Private services
6	Jimena	25	Postsecondary	Formal employment	Non-indigenous	2	Seguro Social
7	Tula	42	Secondary	Informal employment	Non-indigenous	3	Private services/ Seguro Social
8	Lizeth	31	Postsecondary	Housewife	Non-indigenous	1	Seguro Popular
9	Lucia	30	Elementary	Housewife	Non-indigenous	3	Seguro Popular
10	Julia	31	Elementary	Informal employment	Non-indigenous	3	Seguro Popular
11	Rosario	30	Secondary	Informal employment	Non-indigenous	1	Home birth
12	Miranda	32	Postsecondary	Formal employment	Non-indigenous	1	Private services
13	Karla	26	Secondary	Housewife	Non-indigenous	1	Seguro Social
14	Nancy	31	Postsecondary	Formal employment	Non-indigenous	2	Seguro Social
15	Sandra	32	Secondary	Housewife	Non-indigenous	3	Seguro Popular
16	Citlali	39	Secondary	Informal employment	Indigenous	5	Seguro Popular
17	Sabina	39	Secondary	Informal employment	Indigenous	3	Seguro Popular
18	Daisy	23	Secondary	Formal employment	Indigenous	1	Private services/ Seguro Social
19	Felipa	43	Elementary	Informal employment	Indigenous	2	Seguro Popular
20	Ágata	28	Postsecondary	Formal employment	Non-indigenous	1	Seguro Social

Source: Authors' elaboration

We worked through narrative stories using a biographical approach, carrying out a total of 20 interviews. The informants were contacted using different means, some through personal contacts, others through the Facebook group called “Parto humanizado/respetado en Baja California” and the rest via the “Casa de la Mujer Indígena” in Tijuana (CAMI). The interviews were conducted in person, both in public spaces and in the homes of some women. Two sessions were held with each of the interviewees, which were recorded after receiving their consent. The first session focused on exploring their experiences of pregnancy, childbirth and puerperium, while the second focused on learning about their biographies in order to understand their backgrounds in greater depth. Interviews were transcribed and the data was analyzed using coding In-Vivo and by list in Atlas.Ti.

The sample is theoretical or intentional, so the results are not statistically generalizable. What interests us is the detailed qualitative and interpretive examination of agency. In the following section we present and interpret a selection of the most relevant cases in terms of resistance, struggle against oppression and relevance to colonially structured knowledge and power from which obstetric violence arises.

The Individual Forms of Decolonization of the Womb: From Unawareness to Strategies

Tijuana is a border town located in northwestern Mexico, highly populated and urbanized, in which around 30,000 births take place annually (INEGI, 2016). Of these, approximately half are concentrated in three public hospitals that are part of the Mexican Social Security Institute (IMSS) and the Baja California State Institute of Public Health Services (ISESALUD), institutions that have been characterized by high need and deficiencies (Maya, 2018; Miranda, 2019), which compromise access to a dignified and timely obstetric healthcare⁸.

On the other hand, private sector users have the possibility of receiving individualized healthcare, however, this does not necessarily imply that the treatment is in accordance with their requirements. Women receiving private treatment are three times more likely to have an unnecessary C-section, compared to those treated in hospitals of the Ministry of Health (SSA) (Suárez-López, *et al.*, 2013).

On top of these conditions, a culture exists in which physicians develop an authoritarian habitus and are seen as figures of power/knowledge. Women are placed in an unequal position, where they are conceived only as work objects and their status as individuals entitled to their rights with autonomy over their own bodies is denied. This leads to the practice of medical routines that, when unnecessary, can cause damage to patients, such as multiple vaginal examinations, restriction

⁸ In Mexico, health services are classified as public and private. Most public services are accessed by being affiliated by your employer, so there are some hospitals dedicated to specifically serving those who are part of the Secretary of Defense, the workers of Petróleos Mexicanos -the state-owned company- and the government employees. However, the institution that serves the population formally employed in private companies is the Mexican Social Security Institute (Instituto Mexicano del Seguro Social, IMSS), which is why an important part of the health needs of the Mexican population depends on it. There is also the Seguro Popular (Popular Security), available to anyone who does not have other forms of access to health and is responsible for responding to the needs of the most vulnerable population in the country, including those who work informally or are not part of the economically active population. regarding obstetric care, there are midwives in different areas of the country, including Tijuana, and although the cost of their services can be high, some of them provide free care to vulnerable populations or reach financial agreements with their potential clients, which include practices such as credit or bartering.

of mobility, food deprivation, use of oxytocin⁹, Kristeller maneuver¹⁰ or episiotomy¹¹. The violence exercised in the delivery rooms is not only physical, but also psychological, through sexist language that describes the female body as weak or reinforces the idea of the physical pain of childbirth as a penalty for sexual pleasure. Furthermore, some women may experience discrimination based on characteristics such as their class, ethnicity, age, weight or appearance (Espinoza, 2019).

Being a victim does not mean staying passive, accepting and reproducing the hegemonic obstetric practices, but that it is also possible to resist and subvert them through various lines of action. To understand the individual agency towards decolonizing the womb, that is, the agency used by women in the face of obstetric violence, we developed an analysis based on the four-category analytical framework of: unawareness, passive awareness, tactics and strategy.

Unawareness

Since the sample consisted of informants who at the time of the interviews were aware of having experienced obstetric violence, there were few cases in which they reported having been subjected to violence without identifying it. One of those few was Julia, a low-income woman who had been employed in a factory and as a domestic worker. During her first delivery, at Tijuana General Hospital (ISESALUD), the physician performed a Kristeller maneuver which left her with two broken ribs, and also made an episiotomy that caused an anal fissure. She did not find out until later, during an examination with an ob/gyn doctor in a private clinic:

Suddenly [the physician in the public hospital] passed by and told me “Let’s see, I will pass you to the delivery table and if you don’t push well, I’m sending you back”, but no matter how hard I pushed, my baby didn’t come out. I don’t remember when he laid me down on the table, I just looked at his feet, and then he put his hand on my belly and lifted his foot and dropped himself on top of me, then I felt like a hot flash and I heard something crack, but when I felt the hot flash, my baby’s head came out (Interview, Julia, Tijuana, March 14th, 2018)¹².

Although Julia noticed that something unusual was happening, at that time she was not aware of the reason this happened. The fact that the maneuver resulted in the birth of her son eased her concerns and prevented her from inquiring about it. Unawareness of the inadequate practice of which she was subjected to and lack of informed consent for the procedures were combined. She decided not to file a complaint because she lacked confidence that her claim would be given attention. This suggests that unawareness is a mechanism that allows institutional reproduction of obstetrically violent practices without being questioned.

⁹ Synthetic oxytocin stimulates uterine smooth muscle contractility and is used for labor induction, augmentation, and management.

¹⁰ Kristeller maneuver consists of pressure of the uterus fundus to aid with expulsion, currently not recommended by organisms like the World Health Organization (WHO, 2018).

¹¹ An episiotomy is a surgical incision of the perineum and the posterior vaginal wall generally done by a midwife or obstetrician during labor to quickly enlarge the opening for the baby to pass through.

¹² Names of informants were modified to protect their anonymity. Testimonies were edited and translated from Spanish.

Passive awareness

Almost all informants were involved in some situation in which they realized that the way they were being treated was not right, yet they decided to remain passive. One of them was Tita, a middle-class woman with postgraduate-level education, who felt intimidated by a private practice ob/gyn doctor who treated her during her first pregnancy and insisted that she should have a C-section, which until today she considers was unnecessary: *I had already read and at a point he told me “You read too much”, I feel that it was very subtle, but finally he achieved the goal of inducing me fear and I consciously made the decision to continue with that doctor; I know I was not trapped* (Interview, Tita, Tijuana, February 20th, 2018).

This case shows how, despite having doubts, some women finally decided to accept their treatment by physicians, thereby participating in symbolic violence (Bourdieu, 2001), granting the physicians recognition over their own reservations and reproducing asymmetric power/knowledge relationships. This also happens through affective as well as medical agency, for example a process of fear induction.

Tactics

Tactics are the “arts of the weak”. Unlike strategies, they are carried out when one must act defensively. An immediate result is sought in a situation in which the balance of forces is not in the subject’s favor, but they take opportunities in the absence of a proper place for action. An example of them was given to us by Abigail, a female professional, who during her first pregnancy received attention at an IMSS hospital, originally requested the subdermal implant, but after much pressure from the health staff she gave up and signed the consent form to have an intrauterine device (IUD) inserted. However, when she began to feel a strong pain because of the C-section and after the suggestion of one of her hospital roommates, she decided to remove the document:

When my lower stomach started to hurt, the woman in the bed next to me told me “So are you going to let them put the IUD on you feeling like this? If I were you, I wouldn’t allow them”, “But how? -I told her-, I already signed the form, there is the record”, “Remove the form”, and I said “Nooo! How am I going to do that? I mean, I can remove it, but obviously they have another record, a copy”. Well, guess what! I armed myself with courage and removed the document (Interview, Abigail, Tijuana, February 19th, 2018).

Tactics may be seen as “morally reprehensible” by the subjects themselves. Abigail was initially hesitant to report this part of her experience to the researchers. She subsequently shared that after removing the document and been discharged from the hospital, she was extremely nervous that the staff would notice and make her go back. Employing tactics requires enormous cleverness and creativity with limited resources, which makes it difficult for them to enact during the hospital stay, when people are highly vulnerable.

Strategies

Strategies are the true foundations to achieve the decolonization of the womb because they make visible that there are disputes over how the processes of pregnancy and birth should be constructed, whose body is at stake and who has autonomy. Our research suggests that although most of the strategies occur outside the institutions, they can also be exercised within them. From

our analysis we identified a significant amount of strategies put into play by the informants, which we classified into four groups:

a) Verbalization of needs, doubts and discontent related to procedures applied to patients or treatment received. An example of this is the experience of Jimena, a young college student attending an IMSS clinic for her first pregnancy. Jimena reported one of the most intense cases of violence among our interviewees, which included constant scolding during labor, psychological harassment, food deprivation, prohibition of mobility and a poorly sutured episiotomy that left physical consequences:

It was when I began to feel very bad because apart from the pain, the nurses began to make some comments and everything that had already happened, so I thought “I’m getting really mad”. Then they started talking about the soap opera and I said “Nurse, can’t you do something? I feel very bad, it hurts a lot, I want to get up”, “No, you can’t get up”, “But I want to go to the bathroom”, “No, you can’t!”, “But I want to go to the bathroom”, “I’ll bring you a urinal”. I used the urinal and then I sat down and she said “No, lie down” and I told her “But I want to sit down, I can’t lie down, it hurts,” so she said “If you don’t lie down, we’ll tie you up”. And then the other one said, “What if we put a sedative on her?” And I told them “I’m fine, I’m calm, the sedative isn’t necessary, I just want to move” and she said again “No, you have to lie down”, “But if I lie down my back hurts a lot, these beds are hard, cold, I need to move”, “We already told you that we are going to tie you up”. And at like 8:00 p.m. I got up and said, “I have to move”, so they began to get aggressive, “I said to lie down!”. I grabbed the IV and left the room, and then one of them said “Oh! where are you going?” and I answered, “I feel bad”. Then I went to see the social worker, I was already upset and I said “I want to leave” and the doctor in charge of the area came out and asked me “Ma’am, can you afford to go to a private service?” and I said “No, I don’t have money for that”, “Then we can’t let you out”, “But I don’t want to be here, nobody treats me well, the nurses are very rude, they don’t listen to me”. Then he told me “Ok, what we can do is that right now I’m going to talk to the other nurses and doctors so they treat you well” and I answered “Please, I would really appreciate that because I feel very bad”. And that’s it, he had a meeting with all the staff (Interview, Jimena, Tijuana, February 25th, 2018).

Almost all interviewees attempted to dialogue with the health personnel in charge at some point, however, our results suggest that this strategy is rarely successful. One exception is Brisa, a communication student who arrived prepared with a strategy. The IMSS hospital staff attempted to detain her until she allowed them to apply a contraceptive. Brisa replied that if she was not discharged, she would go to the media to tell them what happened, so they let her go. In other cases, such as that of Jimena, we surmise that the effect of her tactic may be less lasting, because although the personnel were forced to attend a meeting, the mistreatment soon resumed.

b) Change of type of healthcare. Changing providers was a constant strategy among the informants, in both the short and long term. One of the most important reasons why women make the decision to change the type of service they use is because they do not think they will receive a dignified and timely healthcare in the busiest and most overcrowded hospitals. Some health personnel do not

trust women's knowledge about their bodies when they indicate that they are ready to give birth, as happened to Fidelia, a migrant indigenous person, who had attended ISESALUD for her second pregnancy: "I went to the General Hospital, they didn't take care of me, it hurt me so much that I wanted to die and I said to my husband [the physician] said no, that I had two weeks left, that they were only contractions, that I had to wait" (Interview, Fidelia, Tijuana, July 17th, 2018).

Faced with denial of treatment in the public hospital, Fidelia and her partner decided to return to the private low-cost clinic where she gave birth to her first child some years ago, delivering there just minutes after being admitted. This can be considered an extreme case, due to the urgency of treatment for Fidelia and the fatal consequences that may have arisen. What encouraged her to act immediately was that during prenatal checkups she had experienced discrimination due to her ethnicity and precariousness.

In other cases, the change of service provider comes with a new pregnancy and this is linked to unsatisfactory experiences and the development of learning trajectories, in which women learn about humanized or alternative ways of giving birth, so they decide to move from one type of benefit to another -e. g. from Seguro Popular (ISESALUD) to Seguro Social (IMSS) or vice versa-, or from public to private care. This type of strategy is important because it also allowed us to identify the resurgence or popularization of some non-modern practices such as home births with a midwife, the support of a doula and other traditions related to these, such as Blessingways or birth altars¹³, that some of the interviewees experienced. Finally, it is important to say that in the case of Tijuana, because it is a border city, some pregnant people decide to give birth in the United States.

c) Complaint filing. This was an infrequent strategy among our informants, since only one of them, Sandra, a woman with a low income and education attainment, put it into practice. She had been treated for the pregnancy and birth of her three children at Tijuana General Hospital and, although she felt mistreated by some nurses, she had not had major problems. However, when she found herself in need of a D&C procedure¹⁴ after a miscarriage, this was carried out without anesthesia, while she cried and screamed and the nurses prevented her from moving, which made her feel she was treated like an animal:

I have a friend who works at Seguro Popular, he told me to go find a certain doctor, one of those outside the hospital, who are the promoters. He sent me with another doctor so that she explained to me how the procedure was done and she told me "It's like that, it's painful", "No, it's not, you're not going to tell me how it is, I already had a D&C here". Then I told her how they sedated me, and she answered, "Now that's weird". Then she told me that every fifteen days they go and check the complaint boxes and they send all complaints straight to Mexicali¹⁵. And from Mexicali they come here to the hospital. I said "Well, I already filed my complaint",

¹³ Blessingways are ceremonies originated among the Navajo, that have been taken up today by some women - particularly by home birthing ones- as an alternative to baby showers. The experience is centered on the pregnant woman and it is focused on the spirituality of the celebrated person and her guests as a connection with nature. The creation of birth altars is one of the rituals that shape the Blessingway along with matrilineal introductions, wrist weaving, and bead threading, among a few others (Burns, 2015).

¹⁴ Dilation and curettage surgical procedure in which the cervix is dilated, and a special instrument is used to scrape the uterine lining.

¹⁵ Mexicali is the capital city of Baja California, state in which Tijuana is located.

because she said they won't call me, they just check them and take action (Interview, Sandra, Tijuana, March 31st, 2018).

In this testimony we can see that there is a lack of institutional accountability¹⁶, which reinforces the distrust in their usefulness and as a consequence people who experience violence in health institutions do not report it. On the other hand, some virtual platforms, such as social networks, are functioning as spaces in which users share their experiences, as in the case of Sandra, who also published her complaint on the hospital's *Facebook* page.

d) Therapy or support groups. These function as ways to compensate for the emotional damage caused by the psychological abuse suffered during obstetric care and were put into practice by three of the informants. One of them was Miranda, a woman with significant resources and education:

Interviewer: So, you are a psychologist, haven't you been to therapy?

Miranda: No, I haven't yet. I started doing like these support groups.

Interviewer: Are you still doing it now?

Miranda: Not now, I left it. I was going ... I created a postpartum group. "I need to talk about this!", It was just about venting everything that goes through your head (Interview, Miranda, Tijuana, March 20th, 2018).

One aspect that stands out in this case is that the strategy was very short term and circumstantial, given that at the time when Miranda started the group some of her friends were also living postpartum. As in the case of complaints, support groups have found an important place in social networks, where groups dedicated to sharing experiences on more respectful and humanized forms of birth can now be found.

Collective agency: Communities, organizations and institutions facing obstetric violence

It is important to see obstetric violence as a phenomenon that develops amid tensions and conflict. In Mexico, this problem became visible in 2013, when the picture of Irma giving birth at the lawn of a hospital in Oaxaca went around the world. The same year GIRE published its report *Omission and Indifference. Reproductive Rights in Mexico* (GIRE, 2013). Further comments have been made by the World Health Organization (WHO, 2014) and the National Human Rights Commission (CNDH, 2017).

Moreover, in 2014 the Alliance for Dignified Gyneco-Obstetric Care (ALAGODI) emerged in Tijuana, in order to make gyneco-obstetric violence visible, to include it in the state legislation and to spread information about sexual and reproductive rights (Red Iberoamericana Pro-Derechos Humanos, 2016). Collaboration agreements have also been signed between institutions such as the Medical Arbitration Commission of Baja California (CAMEBC) and the Tijuana's Municipal Women's Institute (IMMUJER), which seeks to prevent obstetric violence (Ayala, 2017), and The IMSS Human Rights and Equality Committee has proposed a transversal program to avoid obstetric violence (Agencia Fronteriza de Noticias, AFN, 2018). Another institutional actor has been the Autonomous University of Baja California (UABC), which has

¹⁶ We refer to the lack of protocols and instances that allow the demand of the rights to sexual and reproductive health, specifically in hospitals.

organized, between 2017 and 2019, activities among its medical students in order to promote their awareness not only on the subject of obstetric violence, but also regarding practices such as midwifery. Likewise, it is important to highlight how some social networks such as *Facebook* have allowed some women to gather and share information and experiences around motherhood, an example is the group “Humanized/respected birth in Baja California”. This same medium has allowed some actors, such as midwives, to gain visibility and build community. An example of this are the “Parteras Fronterizas”, who in addition to exercising their private practice have dedicated themselves to help pregnant migrants at the border (Agencia EFE, 2018).

In the face of the movement against obstetric violence, some physicians have not only remained indifferent, but explicitly rejected the term. The Mexican Federation of Colleges of Obstetrics and Gynecology (FEMECOG), 2015, expressed total disagreement with the definition of obstetric violence, insisting that “the medical intervention or realization of operative procedures that have a scientific validation and support and that demonstrate a benefit in the life and health of the mother and her child” (Federación Mexicana de Colegios de Obstetricia y Ginecología, FEMECOG, 2015), pointing to hospital infrastructure as one of the main obstacles to carrying out desirable accompaniment practices and condemning the generation of punitive laws against its guild.

Collective agency against obstetric violence and for more humanized childbirth has several fronts that converge since those who integrate these movements and communities. They connect through mutual interests, although this does not occur in a linear or obstacle-free way, as there are counterparts with opposed interests. In spite of this, changes and struggles occur at meso and macro levels thanks to the visibility that these organizations make regarding the problems around birth; and the information that is shared through them permeates to the population, contributing to women, pregnant and birthing people learning new forms of agency and at the micro level, engage in processed decolonizing the womb.

Conclusions

In conclusion, it can be said that the women in this study have put into practice significant strategies and tactics linked with the awareness they had regarding the abuses they experienced. Potential for resistance was present even in some cases where they remained passive because of their feelings or limitations, as a lack of knowledge concerning the unacceptability of violence was not the main obstacle. The analysis of these four categories of agency suggests that it is not possible to pigeonhole women at a certain point of an agency capacity scale, since their actions may be very different depending on the situation, in some cases they might tend towards inaction, while in others the opposite could happen.

Likewise, our research suggests that it is wrong to think that only those women who have more economic and cultural resources, experience or support networks are those who undertake resistance actions, because the informants come from different strata, have different economic possibilities, have reached different levels of education. Some had prior awareness based on experiences of discrimination for example ethnicity, but many of them have acted according to their possibilities and interests in one way or another. Despite this, it is possible to point out that, based on these experiences of violence, learning trajectories develop and can become resources for future agency. It is evident that the relationship between subject and power is not immanent but inconstant and that the agency depends not only on the most tangible resources of the subjects,

but on the creativity, ability to learn, self-representation and motivations of those who are experiencing obstetric violence or any other situation of domination.

In this research, we were able to explore different logics of resistance at the individual level, some that openly challenge power relations and others that may seem innocuous. However, all these ways of responding to obstetric violence make possible the construction of collective female subjectivities. When considering learning trajectories, we can also recognize that knowledge acquired means the possibility of it being transmitted from one woman, pregnant or birthing person to another, as part of collective resources and eventually of a feminist intersubjectivity. Lugones (2010) points out that forms of resistance are present in everyday life and shared knowledge is key to the practice of Decolonial Feminism. Likewise, we consider that practices classified as non-modern (i.e. midwifery and the support of doulas) play an important role in the fight against the colonization of the womb, not necessarily as a replacement for, but as a complement to conventional practices such as legislative work, improvement of health systems, and education for a culture of rights.

Finally, it is important to note that the actions at both global and local levels, involving different organizations, institutions and communities play an important impact on both the creation of public policies and the implementation of programs in the healthcare system. They also influence the formation of a culture of rights, in which women, pregnant and birthing people know what rights they are entitled to, how they should be treated in healthcare institutions, what represents a violation of their rights, what to do and where to go when this occurs. As a result, the forms of individual agency are nourished by the action at the collective level, but simultaneously individual agency contributes to these, and to a broader movement towards decolonizing the womb.

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