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Reproductive (In)justice in Coahuila, Mexico: An Ethnography of Obfuscation, Violence, and Feminist Care

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ABSTRACT

While global health efforts emphasize clinical factors and technical solutions to address maternal mortality, obstetric violence and other forms of reproductive injustice remain crucial contributors to preventable deaths worldwide. Bringing together critical and phenomenological medical anthropology with decolonial and feminist political-economic approaches, this thesis argues that reproductive injustice in Coahuila, Mexico cannot be understood solely through the lens of legal rights, health coverage, or biomedical access. Rather, this thesis proposes the concept of *care obfuscation* as the political, structural and embodied practice of claiming access, coverage, and humanization while simultaneously obscuring the lived realities of neglect, abandonment, and violence in care settings. In responding to this obfuscation and to address broader forms of reproductive injustice, including obstetric violence, feminist *colectivas* and community birth workers in Coahuila enact alternative infrastructures of care rooted in *apapacho*: a relational, generative, and socially situated practice that foregrounds care as a collective healing experience. Chapter 1 traces how the State allows for the infra-structural conditions that produce, perpetuate, and normalize violence in care settings, particularly by obscuring the gap between policy and lived experience. Chapter 2 delves into the *apapacho*-woven alternative infrastructures of care enacted by *colectivas* and birth workers, articulating how these practices restore connection, dignity, and autonomy for those giving and receiving care. Finally, Chapter 3 examines the constructions around different kinds of reproductive bodies to show how these biosocial distinctions serve to obfuscate reproductive labor, normalizing reproductive and gendered violence against women and girls.

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Acknowledgements

The *apapacho* of *colectivas* and birth workers is the very heart and soul of this project. This is for them and those they walk with. During those long days and nights where the grief part of this work (the injustice, the death, the violence…) were too much to bear, they carried me on. Their *apapacho* has saved and sustained thousands of lives across the years, including mine. Their work gives me hope; the same hope embroidered within these pages.

I am forever grateful for the support of my supervisor, Lys, in thinking with me: thank you for, beyond offering scholarly insight, walking with me throughout this project. I also want to thank my boss, César, for inviting me to step into the realm of reproductive justice and for being an ally, a colleague, and a friend: gracias.

This project also wouldn't have been possible without the *apapacho* from my family. To my dad, my unofficial research assistant, for taking me places; for instilling in me the passion to think and learn; for teaching me how to lead with strength and kindness. To my mom, the embodiment of both resilience and grace: I can only hope to become half the woman you are. To my little sister, who is everything that I am not, in the best kind of way; whose uncontainable sunshine breaks through the cloudiest of days. To my partner, my best friend, my love: thank you for walking through life with me. To my friends, human and otherwise, for showing me soulmates can take different forms.

This work is dedicated to those whose lives are lost due to violence–in birth and beyond.

Notes on Language

All translations from Spanish, my mother tongue, are my own. The data I engaged with (e.g., fieldnotes, interviews, policy documents…) are in Spanish; I have done my best to translate them as accurately as possible into English for this thesis while also leaving the 'untouched' version of certain phrases or words in their original language when it holds significant theoretical and/or cultural value and when these are, like *apapacho*, simply untranslatable. In terms of Mexican institutions and policies, I used a combination of either translating them for simplicity or using either the full or abbreviated original forms, depending on the context in which they are used and pertinent. Either way, phrases or words in Spanish or in their original language if these are not in English are italicized.

Introduction

Maternal and reproductive health remain central sites through which social inequality, gendered power, colonial legacies, and state responsibility are rendered visible. Despite sustained international attention, maternal mortality continues to be unevenly distributed, with most deaths concentrated in low- and middle-income countries (LMIC) along the lines of race, class, Indigeneity, migration status, and geography (Lawrence *et al.* 2022). Global health frameworks, particularly global governance agendas such as the Sustainable Development Goals (SDGs), investigate maternal and reproductive health while increasingly framing maternal mortality as preventable by emphasizing technical solutions, clinical protocols, and access to skilled care (Ekinci 2025). However, these approaches often obscure how reproductive outcomes are shaped not only by biomedical capacity but by political economies of health, histories of colonial rule, and enduring forms of gendered and racialized control. Obstetric violence, for instance, is a concept arising from the Latin American socio-political context that refers to a human rights violation encompassing physical abuse, nonconsensual and non-dignified care, discrimination, abandonment, coercion, among other violent practices (Pickles 2014, Chadwick 2021). While it remains overlooked in global health settings, obstetric violence significantly contributes to maternal deaths worldwide (Wallace *et al.* 2020). At the same time, restrictions on reproductive rights, particularly through access to safe and timely abortion care, continue contributing to preventable maternal deaths (Halder *et al.* 2024, Willis *et al.* 2023). In this way, maternal mortality cannot be meaningfully addressed without attending to broader forms of reproductive injustice, including obstetric violence and restrictions on reproductive rights, that shape the structural conditions that enable or foreclose reproductive autonomy in birth and beyond.

This thesis argues that reproductive injustice in Coahuila, Mexico cannot be understood solely through the lens of legal rights, health coverage, or biomedical access. Instead, this thesis articulates how maternal and reproductive harm emerge and become reproduced within institutional settings through a process one might call *care obfuscation*: a political, structural, and embodied practice through which the State, across federal and state-levels, invokes compliance with normative policies, legal reforms, and discourses of care to obscure the lived realities of

violence, neglect, and abandonment within reproductive and obstetric settings. Through ethnographic engagement with feminist *colectivas*, birth workers, public health institutions, and women navigating care, this thesis demonstrates that obstetric violence is not reducible to isolated, individual or interpersonal acts but that it is instead produced and reproduced through broader infra-structural conditions shaped by misogyny, colonial histories, and uneven forms of governance. While this thesis heavily engages with violence and obfuscation, this work does not constitute a catalogue of fear or suffering. Rather, this thesis develops *apapacho* as both an ethnographic concept and a feminist-decolonial analytic for rethinking reproductive and maternal care beyond technocratic and biomedical models. In this way, this work also argues that *colectivas* and birth workers enact alternative infrastructures of care rooted in *apapacho* to directly respond to intertwined forms of violence and address broader forms of reproductive injustice.

In 2025, before starting this project, I worked as an academic collaborator with GIRE ('Group of Information on Chosen Reproduction')—Mexico's leading reproductive rights organization—and the Uehiro Oxford Institute of Practical Ethics. During that project, I analyzed over 60 testimonies, clinical charts, and human rights complaints made by women (and two nonbinary individuals with the capacity to gestate) who had lived through obstetric violence and sought GIRE's *acompañamiento*: while literally meaning 'accompanying,' it refers to the process that feminist *colectivas* like GIRE engage in with women and people with the capacity to gestate to address different forms of reproductive injustice. With GIRE specifically, this process entailed *accompanying* those who had survived violence in obstetric spaces, offering psychological and legal counseling free of cost. Because these *colectivas* made the explicit, political choice to not call themselves *colectivos*, which is the heteronormative term for the word 'collective,' I so make this choice throughout these pages.

It was GIRE who initially filed the complaint, originating from the state of Coahuila, that ultimately led to the decriminalization of abortion by the Federal Supreme Court of Justice (SCJN) in 2021. While it wasn't a single case that tipped the scale, the accumulation of widely visible national and state reproductive injustices circulating across the media ultimately culminated in the 2021 decision. These events included news of girls as young as ten being forced to continue gestating and to mother; stories of maternal and neonatal deaths during childbirth linked to obstetric violence; women and girls giving birth in emergency room bathrooms, on streets outside

of hospital entrances, or on stairwells in search for privacy due to overcrowding or direct refusal by clinical staff. Even during my work with GIRE, it became evident that, despite these cases of violence, the institutional responses followed a strikingly similar pattern, one that further compelled me to do this work: instead of meaningfully addressing harm through structural reform or any sort of binding measures, the institutions persistently refused to acknowledge fault or accountability. Quite the opposite, the institutions repeatedly insisted that care had been timely, adequate, safe, and delivered according to the highest standards and existing normative policies even when victims' testimonies entirely contradicted their claims. In this way, I came to this research project because I wanted to engage with what it might mean to make reproductive care dignified in places where bureaucratic procedures, moral judgements, structural inequities, obstetric violence, and obfuscation have long shaped the intimate experiences of reproductive bodies in public health institutions.

THEORETICAL FRAMEWORKS

Maternal and reproductive care are critical analytical sites for medical anthropology and postcolonial feminist political-economic scholarship to investigate how care, violence, and biopolitical governance converge in clinical encounters. These frameworks articulate how harm is reproduced from macro-level structures (e.g., political-economic, colonialism, state or global-health projects) to micro-level encounters of care. This work approaches these scales not as neatly nested or smoothly aligned but as sites of awkward engagement where their universalizing ambitions encounter local histories, practices, and bodies that unsettle their coherence (Tsing 2011). Therefore, this thesis brings together critical and phenomenological medical anthropology with postcolonial and decolonial feminist scholarship to trace reproductive harm across these scales.

Structural Violence, Power and Governance

Critical medical anthropologists have long examined how health and illness cannot be understood solely through biomedical frameworks but through broader political-economic, historical, and structural conditions that unevenly distribute suffering across populations over time. Central to

these debates is the question of how macro-level forces such as colonialism, capitalism, governance, and institutional inequality materially organize the conditions upon which care is delivered or withheld (Fanon 1965, Anderson 2006, Liboiron 2021, Rouse 2021, Gamlin *et al.* 2020). Working in the context of HIV/AIDS and racialized health disparities, Paul Farmer's (2004) theorization of *structural violence* has been foundational in demonstrating how social suffering emerges through historically produced and politically maintained inequalities that constrain people's life chances, particularly in the afterlife of colonialism, exposing them to disproportionate harm. Scholars working with environmental injustice further extend this concept by showing how structural violence can mutate into *slow violence,* accumulating over time and becoming materially registered in the body through prolonged exposure to neglect and institutional abandonment (Nixon 2013, Davies 2022). This connection between structural and slow violence is crucial for understanding how reproductive violence emerges not only through acute moments of crisis but through *infrastructural violence* as the harm that is reproduced through chronic shortages, bureaucratic disarray, institutional neglect, uneven resource distributions, and the temporalities of waiting for care themselves (Dixon 2020, Morales 2025).

In examining reproductive care specifically, critical medical anthropologists have contributed to these analyses by articulating how these forms of violence shape maternal mortality, obstetric care, and reproductive governance, especially in LMIC (Chertow 2008, Dahdah 2017, Deomampo 2013, Fiks 2024, Castro and Savage 2018, Gómez-Duarte *et al*. 2025). These analyses underscore that reproductive suffering emerges through political-economic constraints, racialized inequalities, and colonial structures that structure healthcare delivery (Grace 1997, Davis 2018, de Kok *et al*. 2019, Asfaha 2024, Bello-Urrego 2025, Boyd 2024, Gamlin *et al.* 2020). Crucially, this scholarship critiques biological determinist narratives that naturalize maternal death while obscuring the roles of poverty, gendered oppression, and inequality (Stone 2016, Johnson 2013, Das *et al.* 2022, Oni-Orisan 2023). Foucauldian scholarship further extends these analyses to examine how state and institutions exert biopower in regulating reproductive bodies, populations and their labor through health (Foucault 1978, Packard 1989, Povinelli 1993, Holmes 2013, Vora 2015, Jereza 2021). Specifically, these analyses allow scholars to investigate how maternal health becomes entangled with broader projects of citizenship, governance, and population management (Hegde 1999, Unnithan 2019, Sarelin 2014). A significant contribution to this literature is the concept of *reproductive governance* in examining how states regulate behavior through medical,

legal, and moral frameworks (Suh 2018, Suh and McReynolds-Pérez 2023, Hallowell 2014, Singer 2017), but also through *reproductive and gestational labor* as the unpaid work of maintaining both social reproduction and biological procreation through gestation (Isard 2025).

Postcolonial and Decolonial Feminism

Applying a feminist lens allows critical medical anthropologists to situate the role of reproductive labor in broader systems of political-economic and social reproduction while, importantly, foregrounding the feminized, exploited, and largely invisibilized nature of such labor (Harcourt 2023). Specifically, postcolonial and decolonial feminist scholarship have become central theoretical orientations through which scholars investigate how colonial histories continue shaping maternal and reproductive healthcare in LMIC. Across this literature, scholars show that reproductive care cannot be disentangled from longer genealogies of colonial governance, gendered racialization, development, and biomedical authority (Lugones 2007, Arukwe *et al*. 2024, Bello-Urrego 2025, Heller and Hannig 2017, Johnson 2013).

Postcolonial feminist approaches trace these genealogies to show how colonial systems normalize racialized and gendered inequalities in the present (Owens and Benia 2018, Falu 2023, Laako 2021). In this realm, *reproductive justice,* emerging from the United States-based Black feminist activism, becomes a crucial intervention (Hall *et al*. 2023, Davis 2019), particularly in moving beyond legal or rights-based understandings of reproductive autonomy and insisting that reproductive justice cannot be separated from the broader social, racial, economic, and political conditions shaping people's lives. Scholars working in LMICs have adapted and expanded these frameworks to account for coloniality, local epistemologies, and structural inequality (Bailey 2011, Chiweshe *et al.* 2017, Suh and McReynolds-Pérez 2023, Zavella 2016, Williamson 2021). Across these debates, intersectionality operates as a connective analytic through which race, gender, class, caste, age, and coloniality become mutually constitutive rather than separate systems of oppression (Rajat and McLaren 2023, Gamlin 2020, Sehrawat 2021, Rudrum 2017, Pande 2015).

At the same time, African and Latin American scholars move beyond postcolonial debates toward decolonial feminist approaches that seek not only to critique colonial power but to delink from dominant epistemological frameworks altogether. This thesis approaches 'decoloniality' with

caution, recognizing the contested nature of the term and the ways in which decoloniality itself can become performative, extractive, institutionalized, depoliticized, and mobilized within academic and global health spaces without unsettling colonial relations of power (Shah 2024, Doyle 2025, Venkatesan *et al.* 2024). For this reason, I engage with feminist decolonial scholarship foregrounding how dominant reproductive rights frameworks often fail to fully capture how reproductive suffering is lived and understood in local contexts (Chaparro Buitrago 2022, Rangel-Flores *et al.* 2022, Wentworth and Blalock 2025, Rajat and McLaren 2023, Espinoza-Reyes and Solis 2020). These decolonial feminist approaches complicate postcolonial portrayals of women as passive recipients of patriarchal systems, conceptualizing analytics like *negofeminism* or *afro-feminism* to understand African women's strategic navigation of reproductive environments through negotiation, compromise and relational autonomy rather than through dominant liberal ideals of individualized choice alone (Udenigwe *et al*. 2023, Werunga *et al.* 2016, Tamale 2020).

From Structures to Intimate Moments of Care

Both critical medical anthropology and feminist political-economic approaches to care situate bodily and social harm not merely as interpersonal but as embodied effects of everyday clinical encounters that are deeply entangled with longer histories of inequality and broader structural conditions. In this view, obstetric violence and broader forms of reproductive injustice emerge as every day, embodied harms that coproduce how reproductive bodies encounter and experience care. Paying attention, then, to micro-level encounters renders visible how intimate moments of care are tethered to broader state logics, institutional arrangements, and societal hierarchies (Tsing 2011, Mills 2017, Lidola 2024). In the Mexican context, for instance, harm materializes through routine obstetric practices (e.g., episiotomies, unnecessary or nonconsensual procedures, invasive vaginal examinations or *tactos*) and through microaggressions, practices that become more than interpersonal slights but constitutive of class, racial, and gender hierarchies (El Kotni 2018a, Smith-Oka 2015).

In order to trace how reproductive health and illness are coproduced at the intersection of socio-political conditions and intimate moments of care, this work pays particular attention to the body. This phenomenological attention to the body acknowledges it as the primary site through which the world is perceived, lived, and experienced (Merleau-Ponty 1962). It also insists on the multiplicity of the body(ies) as they are enacted through and from practice (Mol 2002). Crucially,

I follow Thomas Csordas's (1994) framing of *embodiment* as an analytic paradigm rather than a mere object of study, approaching care as a practice that is not simply administered or governed from above but deeply felt and made meaningful through the body itself. I am also thinking with scholars that critique, contest, and politicize the body as a site both of existence but also of erasure. In tending to Black reproductive bodies, Dána-Ain Davis (2025: 631) articulates how the sovereignty of the medical-obstetric complex reconfigures them into 'anti-bodies' that are 'consistently intruded upon and interrogated'. Still, as Falu (2025) argues, in responding to these pathogenic or violent systems, 'anti-bodies' can mirror antibodies' immunological response within the body itself. In this way, anti-bodies can also become sites of resistance, particularly through the work of community-based networks of care that operate as 'resistive antibodies' in weaving and enacting feminist infrastructures of care (Jolly 2025), effectively providing protection against harmful systems.

Feminism as Object of Study

Beyond drawing on feminist theory to interpret and investigate reproductive (in)justice, this research also traces how feminism itself is named, disavowed, embodied, and contested in contemporary northern Mexico. In doing so, this work considers feminism not as a stable category but as a socially and politically situated formation with multiple, and sometimes conflicting, configurations (hooks 1994, Butler 2004, Lorde 2019, Butler 2004, Butler 2015, Ahmed 2012, Amadiume 2024, Badrī and Tripp 2017, McCann and Kim 2017, McClaurin 2001).

Early in my fieldwork, I visited a local CJEW, or Center for Justice and Empowerment of Women. The center, nominally a feminist institution that seeks 'justice' and 'empowerment' for women, is made up of only women employees who have relatively similar profiles: trained in law or psychology with postgraduate specializations in family therapy, gender, or criminal law. While Chapter 3 delves deeper into the CJEW, the employees in the center work to support women navigating violent conditions and pursuing legal remedies. Yet, more than once, in almost whispers, as if confessing something improper, the women employees clarified, without my asking, that they were not feminists. Confused by these declarations, I remained silent in the moment. Now, I wish I had instead declared myself a feminist and inquired why they rejected an identity that seemingly aligned with their work. Nevertheless, their whispered statements made me wonder: why did women who were engaged in the defense and 'empowerment' of other women

distance themselves from feminism? What did the label of 'feminist' signify in this context that made it so disavowable? On some level, did I perhaps feel ashamed of pushing back against these statements and declare myself a feminist? And if I did, does it make me less of a feminist? Does it make me a *bad* one?

These interactions stood in sharp contrast with statements from *colectivas* and birth workers, who explicitly framed feminism as both their political compass and ethical stance. But what does 'feminist' signify? Who gets to call themselves, or others, a 'feminist' and for what reasons? Across Mexico, the media plays a significant role in shaping public perception of who or what a 'feminist' is, and for the most part, the spotlight lands on feminist *colectivas* themselves who are deeply vilified to the point where being considered a 'feminist' is akin to insult. Each March 8th, for instance, while International Women's Day elsewhere may be a commemorative day of celebration, in Mexico it unfolds as a day of protest, grief, and even collective rage in a country where, on average, ten women are murdered daily at the hands of violent partners, relatives, friends, and even strangers (REDIM 2025). These March 8th (8M) marches are tense but resolute: bodies draped in purple, green, black; voices chanting in unison; signs held high. Yet, public discourse, across news outlets, social media, and everyday conversation, casts participants as destructive, dangerous… as irrational, violent, man-hating *feminazis*. The vilification of feminism in public discourse circulates against a backdrop of normalized 'masculine' violence, where domestic violence reports spike after rival soccer matches or where tragic events like the March 5th 2022 soccer game between Querétaro and Atlas that descended into mass violence among men spectators, resulting in 26 injured, are quickly dismissed as isolated failure instead of something far more sinister.

In this context, feminism becomes both a political practice and a stigmatized identity; it becomes a label to disavow or hide because claiming it might entail risking social sanctions, threats, and humiliations. At the same time, the distinction between 'feminist' and 'non-feminist' is not enough, since feminism in this context is not a unified or universal category that is internally coherent. In fact, multiple forms of feminism emerge. Take for instance the 8M 2026 march in Saltillo: the feminist march was organized into contingents, including victims of violence and their families, maternities and infancies, disabled women, *batucada*, survivors of vicarious violence, abortion rights activists, and notably, both a Trans-Exclusionary Radical Feminist (or 'TERF')

contingent and an explicitly intersectional, trans-inclusive one. In the weeks leading up to 8M 2026, tensions between the TERF and the trans-inclusive contingents intensified, particularly due to the former's attempts at demarcating the march as a 'female-only' event. The trans-inclusive contingent, by contrast, framed feminism as intersectional and expansive, claiming that struggles against gendered violence must include trans women, and even men themselves, as targets of patriarchal harm.

What these differing configurations of feminism point to is not simply disagreement but to competing ontologies of womanhood, protection, solidarity, belonging, and care that cast some women as either 'good' or 'bad' feminists. Still, this casting risks falling into an authoritarian, even paternalistic, moralism that would reproduce the very hierarchical logics that this project interrogates. I am wary of substituting one form of feminism for another and adjudicating from above which claims count as emancipatory, and which do not. Instead, thinking with Saba Mahmood's (2006) critique of liberal feminism, especially in relation to questions of subjectivity and agency, I dwell in the work that this boundary-making performs in tracing these negotiations to understand what they reveal about the social worlds they inhabit.

Violent Pathologies, Violent Ecosystems: Naming Misogyny

Across this Introduction, I have named different forms of violence as they relate to obstetric and reproductive care, as well as the violence directed toward feminists in both public and digital spaces. In doing this, however, I risk foreclosing these forms of violence as isolated events rather than as manifestations of a broader ecosystem of gendered and sexual violence that exceeds any single institutional setting. Indeed, I would not be the first scholar to examine how obstetric violence does not emerge in a vacuum but that it bleeds through the cracks of everyday violence in Mexico. Lydia Z. Dixon (2015), for instance, traces how Mexican midwives in the south situate obstetric violence within wider landscapes of gendered, sexual, and social violence. Her work ultimately links medical abuse and mistreatment to the forms of violence that lead to femicide, domestic abuse, and even the ambient violence associated with organized crime and armed conflict. Considering reproductive and obstetric violence, then, as isolated pathologies would 'hotspot' them, effectively drawing attention to this kind of violence in institutional settings while

leaving uninterrogated the broader, underlying structures that render such violence intelligible and ordinary, but somehow exceptional all the same.

Medical anthropologists have engaged with 'hotspots' to elucidate the ways in which global health efforts selectively concentrate scientific attention and intervention in particular places for specific reasons. For example, Alex Nading's (2023, 2025) work on chronic kidney disease of non-traditional cause (CKDnt) in Nicaraguan sugar cane plantations or Kierans and Padilla-Altamira's (2021) work on CKDnt in agricultural communities in Mexico. What emerges in these cases is disease that either becomes hypervisible through 'hotspots' or invisibilized through 'blind spots' shaped by material proximities, surveillance infrastructures, geopolitical urgency, and institutional neglect. Like Kierans and Padilla-Altamira (2021), scholars like Hannah Brown (2026) also engage with the idea of 'blindspots' to articulate how other diseases like Lassa fever in Sierra Leone remain neglected despite ongoing harm, revealing how global health regimes produce uneven visibility, a differential valuation of lives, and a patterned neglect instead of a 'neutral' epidemiological attention. These concepts offer insightful ways to think with reproductive and obstetric violence not as diseases themselves but as *pathologies of violence*: biopolitical manifestations of broader social suffering. In this sense, drawing political and academic attention to these kinds of violence would therefore leave them partially incomplete, unresolved, and (mis)understood. After all, as my interlocutors repeatedly emphasized: violence is everywhere—so much so that it is nearly impossible to pin down. This was echoed during fieldwork, where I encountered a landscape marked by daily femicides; forced disappearances and mass graves; anti-LGBTQ+ hate crimes; persistent sexual and domestic violence against women and girls; and concerning remarks made by women stating they would much rather bear 'violent sons' than 'feminist daughters.'

A common etiology for these violent pathologies can be traced back in misogyny itself, not merely as a personal ideology of hatred of women and girls but as a cultural and structural-ideological system that polices, disciplines, and punishes those who transgress against patriarchal norms—regardless of gender. In Mexico, for instance, everyday *machismo* drives sexist humor, domestic hierarchies, and the overall devaluation of women's autonomy, creating an ideological environment where violence escalates along a continuum: from everyday humor, verbal harassment and control to physical assault, abuse, and at its most extreme, femicide (Rodriguez

2010). Even larger societal formations, including organized crime groups and their hypermasculine hierarchies (Figueroa 2023), *maquiladora* industries that spatially and economically exploit feminized labor (Mehan and Dominguez 2024), and neoliberal economic regimes that commodify both land and bodies (Vargas 2021), further concentrate and intensify gendered violence. Across these domains, state impunity normalizes misogynistic harm (Miranda Mora 2022). Therefore, to make sense of violence in obstetric and reproductive settings, it is crucial to situate its origin in misogyny as a self-sustaining ecosystem that engenders violence beyond birth.

MEXICO: A CHANGING REPRODUCTIVE/HEALTH LANDSCAPE

While Mexico sits in the mid-range of global maternal mortality (World Bank Group 2026), the country offers a particularly important site through which to investigate reproductive and obstetric care because of the intersection of expanding reproductive rights and care frameworks, persistent gendered violence, and deep structural inequalities. To understand maternal and reproductive health in Mexico, it is crucial to first understand the Mexican health system, which is organized around employment status and combines multiple subsystems alongside a private sector. Formal private-sector workers, or *derechohabientes*, and their families are covered by the federal social security system through *Instituto Mexicano del Seguro Social* (IMSS). Between 2023 and 2024, around 42.5% to 47.8% of the Mexican population relied on IMSS for healthcare, while around 8% of workers received care at other public health institutions and 0.7% of the population counted with private medical care (INEGI 2024). The remaining population is not affiliated to any public health institution due to unemployment, and thus, receives care through the Ministry of Health subsystem, which has undergone repeated reforms, transitioning from *Seguro Popular* to Institute for Health and Wellbeing (INSABI) in 2020 and in 2023 toward *IMSS-Bienestar*—a model aimed at federalizing state health services and providing free care at the point of use. Some states, including Coahuila, the primary site of this research, have opted not to participate in this federalization process to retain administrative and political control over their state-run health systems. As a result, hospitals and clinics operated by state health ministries in these states remain under state jurisdiction while IMSS facilities, whether in its employment-based modality or through *IMSS-Bienestar,* remain federally administered in all states. These questions of

state/federal responsibility are crucial for making sense of reproductive harm, accountability, and obfuscation.

The Mexican maternal and child health landscape reflects a pattern of uneven progress accompanied by persistent structural challenges. Mexico's 2003 health reform, which created *Seguro Popular* under the *Partido Accion Nacional (PAN)* administration, dramatically expanded insurance coverage from approximately 48% to 75% of the population by 2012 (Urquieta-Salomón and Villarreal 2016), virtually eliminated socioeconomic inequality in financial protection (Gutiérrez *et al.* 2016), and reduced infant mortality by 10% in poor municipalities (Conti and Ginja 2017). This improvement parallels a decline in low birth weights, suggesting advances in prenatal care, nutrition, and early-life health interventions (ibid). Maternal health outcomes, particularly Mexico's maternal mortality ratio (MMR), which measures the number of pregnancy-related deaths while pregnant or within the 42 days of pregnancy termination per 100,000 live births (World Health Organization 2025), have not followed the same downward trajectory. According to data from the World Bank Group (2023), Mexico's MMR declined between 2000 and 2018 (from 56 to 43 deaths per 100,000 live births), spanning *PAN* and *PRI (Partido Revolucionario Institucional)* administrations. During this period, maternal deaths were concentrated among uninsured women—particularly young, unmarried, rural, and socially marginalized women (Serván-Mori *et al.* 2025). After 2019, however, the MMR flipped, becoming higher among IMSS federally insured women instead.

The temporal alignment between federal political transitions and maternal health outcomes provides contextual evidence for potential causal relationships. In 2019, the historic transition from *PAN*/*PRI* administrations to the *Movimiento de Regeneración Nacional (Morena*) administration was accompanied by the dismantling of *Seguro Popular*, which was then replaced by INSABI. This policy discontinuity, embodying the Morena's ethos of 'austerity policies' and 'transformation,' was associated with a sharp drop in insurance coverage, a doubling in the number of uninsured households, and an increase in catastrophic health spending, especially among rural and low-income populations (Cabrero-Castro *et al.* 2025). While the COVID-19 pandemic certainly contributed to the 2020-2022 spike in MMR (ibid), the upward shift appears to begin in 2019, aligning with the policy transition. Several studies have argued that the concentration of maternal mortality among women covered by IMSS suggests that insurance coverage alone

became insufficient in protecting women from obstetric complications and death, reflecting a broader systematic strain and fragmentation in care modalities (Serván-Mori *et al.* 2025, Velasco Espinal *et al.* 2025). Differently put, if access to care through insurance coverage no longer protects women from obstetric death, then, what is happening within these institutions that may elucidate the institutional factors and structural dynamics contributing to this disproportionate mortality?

Reproductive (In)justice: Obfuscation and Care

One of the most significant shifts in Mexico's reproductive health landscape occurred in 2021, when the Supreme Court of Justice of the Nation (SCJN) issued a landmark ruling (NOM-046) declaring the criminalization of consensual abortion unconstitutional (Bonifaz Alfonzo and Mora Sierra 2024). The decision established that penal sanctions against people who obtain abortions and against health personnel who provide or assist in abortion care violate fundamental rights, and it rejected overly restrictive provisions such as rigid gestational limits in cases of rape (ibid). Prior to this ruling, abortion regulation was largely determined at the state level. Outside of a few jurisdictions—most notably Mexico City[1], which decriminalized abortion up to 12 weeks in 2007—most states criminalized abortion except under narrow 'causal' exceptions such as rape or life endangerment. While the 2021 ruling did not automatically harmonize all state penal codes, it created binding constitutional precedent that states are required to follow, however, many have lagged or resisted, producing an uneven and politically contested landscape of implementation across the country.

Overall, across both public and private sectors, the ruling shifts abortion governance from the penal system to the health system. This implies that public health institutions cannot lawfully deny abortion care on criminal grounds and must integrate abortion into reproductive health services, develop clinical protocols, and ensure access without fear of prosecution. Despite this shift in abortion, and even expanding legislation against obstetric violence including normative frameworks aimed at 'humanizing birth,' these policy efforts do not necessarily, nor consistently, materialize in practice—reality that was echoed during my work with GIRE and throughout this project. This is why *care obfuscation*, as the structural, political and embodied practice of

[1] Mexico City is neither a state or merely a city but an autonomous federal entity that is equivalent to the state, having its own constitution and local government.

obscuring the lived realities of neglect, abandonment, and violence by invoking compliance with policy, is a central mechanism of reproductive injustice in Mexico.

This realization crystallized during an encounter early in my fieldwork when I visited Dra. Salma[2], Chief of Education overseeing all research done within a federal public hospital and its clinics[3]. While I had been hoping for a longer conversation to discuss the possibility of collaborating with the institution in tracing the materialities and experiences of care delivery, it became clear that was not going to happen when she left my hand waiting in the air for hers as I introduced myself.

'So, you are doing a qualitative study on reproductive health?' Dra Salma asked, her piercing eyes fixed on mine as I tried explaining the project. She turned her gaze to her monitor, her fingers quickly typing away, and said:

> 'If you wish to know how reproductive care works, you should simply look at our normative policies online. There is no reason for you to be standing here observing how care works,' bringing our encounter to an abrupt end.

Both before this meeting and afterwards, news media circulated stories of women and their babies dying during childbirth because of obstetric violence; patients giving birth in emergency room bathrooms or out in parking lots; critical, life-saving surgeries being postponed due to infrastructural shortcomings; and a lack of care due to inadequate staffing and medication outages. Still, even though this information is public knowledge and inevitably tied to institutional shortcomings, the public statements shared by the administration follow the same pattern of pointing back to existing policy frameworks, 'ensuring' that care *is* there and was provided. Like Dra. Salma said, surely, there was no reason for me to 'stand there and observe' the gap between what the institution claims to do and what happens in practice. Dra. Salma embodies this political and structural obfuscation of care, articulating how the State—across state and federal scales—through its institutions, relies on pointing to existing normative policies of access, care, and humanization while these fail to materialize in care settings. Instead of meaningfully addressing

[2]All names are pseudonyms except for publicly available figures and news stories.
[3]This multi-sited research was conducted in several municipalities in the state of Coahuila. However, due to the highly sensitive and politicized nature of abortion, the specific sites will remain anonymous to maintain my interlocutors' privacy.

the infrastructural and structural shortcomings tied to obstetric violence, the State obfuscates the realities but also the possibilities of care, enabling and perpetuating violence and other forms of reproductive injustice within institutions and bodies.

The work of feminist *colectivas* and birth workers, nevertheless, directly emerges in response to this obfuscation. Take GIRE as an example. They accompany women, girls, and people with the capacity to gestate through their cases of obstetric violence precisely because of a lack of institutional accountability or acknowledgement to their embodied harm. They provide psychological and legal counseling while also driving societal and legal change, exemplified by the decriminalization of abortion. They were also among the first to raise awareness about obstetric violence and inform the public about their reproductive rights beyond birth. For this research, then, it was imperative to engage with *colectivas* and birth workers because of their instrumental role in advancing reproductive justice in Mexico. After being welcomed and embraced by them, my question increasingly became: if the State relies on obfuscating care to deflect accountability for violence, what forms of care do *colectivas* and birth workers enact?

METHODOLOGY

Between June 2025 and May 2026, I conducted ethnographic fieldwork, encompassing both in-person and digital settings, in different municipalities within the northern Mexican state of Coahuila. In the summer of 2025, I spent three consecutive months in the field, carrying out participant observation, semi-structured and unstructured interviews within public health settings and with feminist sexual and reproductive care *colectivas* and birth workers, including midwives and doulas. I returned to the United Kingdom for coursework in the autumn, during which time I continued the project through sustained digital ethnographic engagement which started with 'immersive cohabitation' while in the field (Bluteau 2021). This expansion of the physical fieldsite onto the virtual allowed me to remain in close relation with interlocutors and field-based dynamics as they unfolded online. In the winter, I returned to the field for six weeks, resuming in-person research.

During fieldwork, I joined *colectivas* in their activities, including post-abortion discussion groups, workshops in training and certification to provide medical abortion, group meetings, and

during reproductive and sexual health drives and brigades in different community settings. These networks allowed me to connect with women who had received abortion *acompañamiento*, with *acompañantes* themselves (those who provide *acompañamiento*), and with women involved in reproductive care, rights, and advocacy, including birth workers. I also relied on purposive sampling, particularly through digital settings, to find individuals associated with this landscape. In addition to working with *colectivas* and birth workers, I also engaged with different kinds of state/health workers. Three main sites for these endeavors include a state-run Center for Justice and Empowerment of Women (CJEW), a state-run public health hospital (Hospital A), and its associated public community health centers (*Centros de Salud*). Through these spaces, I joined medical brigades on sexual and reproductive health as well as workshops on gendered violence.

I decided to enter public/health institutions in large part because a large portion of the Mexican population receives care in these settings, as I mentioned earlier, but also because of my own experience as a researcher. Several years prior to engaging with this project, or even before my work with GIRE, I held a brief research internship at a private hospital in Coahuila during the summer of 2022, where I examined how the physical infrastructure shaped workflows and patient care. That experience unfolded in a setting defined by abundant resources, streamlined bureaucratic processes, and state-of-the-art equipment that prioritized patient satisfaction, which falls in line with arguments about the increasing commodification of healthcare (Manelin 2020). But when I later worked with GIRE analyzing cases from public health institutions, I found myself deeply unsettled.

These cases were marked by multifaceted forms of violence, from verbal abuse to institutional coercion and infrastructural breakdowns, and even embodied harms that, in the worst of cases, led to the death of both patient and newborn (Alton Martelet 2025). These stories haunted me, urging me to engage with their lived realities beyond legal case files and large datasets. At the same time, these cases elucidated the harrowing reality that those often at the margins of care—especially women, girls, and people with the capacity to gestate marked by race, class, ethnicity, educational attainment and even geography—were being predominantly vulnerabilized by a violent system. This reality crystallizes in the unspoken but widespread rule that to enter public care entails accepting violent care, and that racial and class privilege provides a protective coat against this violence, especially if it grants access to private care. This is the reality of those

insulated with racial, class, and educational privilege, including myself, as someone born and raised in Coahuila but trained in the United States and now in the United Kingdom. These layers of relation inadvertently shape how someone moves through care. Some of my interlocutors, in fact, shared with me that they saved up for years to get private health insurance because they were terrified of giving birth in a public maternity ward. As this thesis demonstrates, these testimonies of fear are not isolated events. Rather, these fears are grounded on the realities that many Mexican women, girls, and people with the capacity to gestate face today—especially those who can't fall back on private medical care, or perhaps even then. For this reason, I engaged with public/health institutions to trace how reproductive (in)justice is produced, negotiated, and embodied in everyday encounters. This ethnographic attention captures nuances that are often flattened in legal case files and large-scale testimonial datasets while situating these experiences within broader reproductive/health politics.

Although I did not gain access to federally run IMSS institutions, these facilities not only provide care to a large proportion of the population but they also emerged most frequently in complaints raised by my interlocutors and in GIRE's case files—a pattern echoed in national statistics, news reporting, and digital discourse. While the state-run hospital and community health centers were by no means without shortcomings, they nonetheless permitted me to conduct research within their spaces to, in their own words, 'improve care practices and revise policies in ways that might better serve the population.'

In thinking through these different dynamics of accountability, I am also reminded to hold myself accountable to my interlocutors, their stories, and to the critique I present in these pages. In presenting this work through a postcolonial/decolonial feminist lens I contend with questions of what kind of 'possibilities might be opened up when academic critique is guided by and responsive to quotidian, localized form of critique' through the multiple engagements with my interlocutors (Morales 2025: xiv). At the same time, academic critique and knowledge production are often entangled in the very systems that we, as scholars, seek to critique, and like Morales (p. xv), I also see this as a 'step toward co-theorization' and 'toward engaging critique as generative, rather than a foreclosing, practice', especially in reimagining accountable political futures and modes of engagement. Therefore, to hold myself accountable, I first distinguish critique from criticism by approaching critique as a practice grounded in care and respect toward the people

whom institutions and *colectivas* serve, toward my interlocutors, and toward the labor of those working within these systems. Still, my positionality is not external to the webs of meaning-making I describe. Rather, my relationships and conversations with interlocutors, acquaintances, and points of contact continually revealed the multiple ways in which I am already entangled in this work. For example, my father has been engaged in Coahuila's political landscape since his youth. His familiarity with local political structures and networks facilitated my access to key institutional figures, including the director of Hospital A and the CJEW. Nevertheless, this proximity placed me in the uneasy position of critiquing the institutions to which my own family history is, in part, tied. These encounters compelled me to attend carefully to the layered relations that shape how I move through the field, prompting ongoing reflection on how I am positioned, what forms of access are made available to me, and what responsibilities I carry as I interpret, write, and ultimately return to the communities whose stories sustain this project.

Given my positionality, then, how might I move through the field ethically? How might I use these forms of access that my different layers of relation grant me with, not to speak over others, but to hold myself accountable to them? To engage with these interrelated concerns, I engage with *apapacho* as a central orientation and guiding methodology. In responding to TallBear's (2014) call to move beyond extractive models of research framed around 'giving back' to building reciprocal relationships of collective 'flourishing,' *apapacho* enables *studying with* rather than *studying about* by centering a relational ethics and embodied presence as the research conditions through which knowledge is co-produced (Paris and Winn 2014). Therefore, I orient myself closely with Garzón Martínez (2024), who posits *apapacho* as an epistemic practice of creating relational spaces where trust, mutual recognition, and affect enable knowledge-making. In this sense, *apapacho* becomes not just an analytic but an affective theorization and methodology that legitimizes subjectivity, ties research to collective care, and makes 'no way back' from a decolonial, feminist stance that fuses intimacy and critique.

APAPACHO AS FEMINIST CARE

Coming from the Indigenous Nahuatl verbs *pahpatzoa* and *pachoa*, *apapacho* means 'to squeeze,' 'to caress,' 'to pet' (Gómez De Silva 2001), or even to soften or to knead gently with the hands to bring something closer to the self (Montemayor 2007). But *apapacho* also exceeds the physical

act of touch by evoking a spiritual register, as it also entails 'caressing with the soul' (Tepichín 2025). In this way, *apapacho* brings together both the mundane and the transcendent, capturing both tactile and spiritual or 'intangible' dimensions that are nonetheless felt and materialized in the body. As I have explored in the context of pediatric cardiac care (Alton Martelet 2026), *apapacho* is an affective, interembodied practice of *being with* that emerges as decolonial feminist theory and praxis, resisting commodification and reclaiming pediatric cardiac care as a collective healing practice. After spending time with *colectivas*, their allied birth workers, and the women they accompanied, it became evident that their practice is grounded in *apapacho* as a form of feminist and embodied care: *Apapacho* was there in the way they accompanied women during their abortions; it was there during childbirth; and it was there in the way they collectively embraced each other in interconnected webs of emotional catharsis and care, as Chapter 2 will show

Because both research (Smith 2022) and reproductive/medicine (Fanon 1965, Owens and Benia 2018) are entangled in colonial pasts with postcolonial presents, *apapacho* serves as decolonial praxis within a reproductive justice framework that centers the voices and embodied knowledges of women, particularly Women of Color, as epistemically authoritative (Davis 2019). Rather than treating lived experience as anecdotal or supplementary, this approach recognizes it as a critical site of theory-making. Therefore, I also situate myself and this piece of work within a tradition of critical feminist and decolonial scholarship that conceptualizes *apapacho* as both theory and praxis, understanding theorizing itself as a living embodied act that is 'fundamentally linked to processes of self-recovery, of collective liberation,' where 'no gap exists between theory and practice' (hooks 1994: 61). As a non-Indigenous scholar myself, I also have the responsibility and obligation of 'getting the story right, [and] telling the story well' (Smith 2021), and I try to do so through *apapacho* as a decolonial research methodology that 'demands exposing those foundations, refusing commodification, and re-centering Indigenous agency, histories, and knowledge' in this research endeavor (ibid). Thus, in approaching *apapacho* as theory and praxis, not as ethnographic curiosity, this work stands as a political refusal of epistemic violence (Spivak 1988).

In practicing *apapacho* in theorizing, analyzing, and writing about this project, while also acknowledging that these processes co-constitute each other, I follow Elizabeth Hordge-Freeman

(2018) in bringing my body and its affective and emotional potentials as analytic sites themselves. In other words, how my body and my emotions become affected by those of others–immersing myself in and practicing *apapacho*–is part of how knowledge is co-produced with my interlocutors. In doing so, I ground my methodological commitment in feminist ethnography by refusing the false neutrality demanded by neoliberal logics while tending to the 'particularity of women's experience' against attempts to erase or commodify them (Davis and Craven 2011). *Apapacho*, thus, becomes both an ethical orientation and an epistemic practice–an embodied, affective, feminist-decolonial method that allows me to co-theorize with my interlocutors while remaining critically attentive to the uneven relations of power that shape our exchanges. Throughout this research, I have been guided by these feminist and decolonial commitments, understanding feminism not as abstract theory but as a lived, embodied practice emerging from everyday encounters with injustice (Ahmed 2017). Because of this orientation, I take seriously the labor of naming harm but also of sustaining solidarity and the possibility of fairer worlds.

CHAPTER OVERVIEW

This thesis argues that reproductive injustice in Coahuila cannot be understood solely through the lens of legal rights, health coverage, or biomedical access. Instead, it foregrounds *care obfuscation* as the political, structural and embodied practice of invoking access, coverage, and humanization while obscuring the lived realities of neglect, abandonment, and violence in care settings. In responding to this obfuscation and to address broader forms of reproductive injustice, including obstetric violence, feminist *colectivas* and community birth workers enact alternative infrastructures of care rooted in *apapacho*: a relational, generative, and socially situated practice of care that transforms care into a collective healing experience. Chapter 1 traces how the State allows for the infra-structural conditions that produce, perpetuate, and normalize violence in care settings, particularly by obscuring the gap between policy and lived experience. Chapter 2 delves into the *apapacho*-woven alternative infrastructures of care enacted by *colectivas* and birth workers, articulating how their *apapacho* restores connection, dignity, and autonomy for those giving and receiving care. Finally, Chapter 3 examines the constructions around different kinds of reproductive bodies to show how the biosocial distinctions between girl/teen/woman serve to obfuscate reproductive labor, normalizing reproductive and gendered violence against women and girls.

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Chapter 1

Obfuscation and Violence in Reproductive Care

On September 24th of 2024, a woman from El Salvador gave birth on the sidewalk next to the General Hospital in Saltillo, Coahuila's capital. The video of the event, shared by the woman's family looking for accountability, circulated in the news and in social media networks. The unnamed woman had gone to the hospital in the morning when her labor started. However, the clinical staff sent her home, insisting she didn't have the 'appropriate' centimeters of dilation yet. Later in the evening, she returned to the hospital where she was told to go home again. As she made her way back out of the hospital, she felt the baby coming out of her womb. She laid down with her back on the pavement, used a blanket she and her sister had brought with them, and gave birth on the sidewalk. Only after the baby was born did hospital personnel emerge, alerted by security guards, to cut the umbilical cord and wheel the mother and newborn inside on a gurney. The woman was twenty-five years old, an immigrant, and uninsured. She and her sister had lived in Saltillo for two years, but fear of deportation kept them from revealing their names. The baby was born alive and healthy, the mother recovered, but the hospital maintained silence, insisting that care was delivered to the highest of standards and in accordance with existing normative policies.

REPRODUCTIVE AND MATERNAL HEALTH IN COAHUILA

Reproductive and maternal health in Coahuila is formally governed by national clinical and legal frameworks, most notably the federal normative policy NOM-007, which establishes standards for perinatal care. In line with NOM-007, practices categorized as obstetric violence, including verbal

abuse, non-consensual procedures, neglect, and coercion, directly contravene these federally mandated guidelines. Despite this federal regulatory architecture, alongside emerging proposals of state law reforms to codify obstetric violence as a criminal offense in the state's penal code, empirical data reveal inconsistencies. Data published by the *Gobierno del Estado de Coahuila* (2019), for instance, place the state within the highest national bracket of obstetric violence, with between 36.0% and 39.5% of women reporting abuse during childbirth. According to the National Survey on the Dynamics of Household Relationships (ENDIREH) conducted by the National Institute of Statistics, Geography, and Informatics (INEGI 2023), an estimated 230,971 women and girls aged 15-49 in Coahuila gave birth between 2016 and 2021, with approximately 3 in 10 reporting experiences of obstetric violence during their most recent birth. This occurs in a context where Coahuila paradoxically has one of the highest coverages of medically attended births in the country (99.73%, ranking 4th out of 32 states), yet simultaneously exhibits one of the highest MMRs nationwide, at 42.4 deaths per 100 000 live births in 2023 with a 50% increase in 2025 (Gobierno del Estado de Coahuila 2023, Pérez Paz 2026). Further compounding these outcomes, and despite being the birthplace of the federal decriminalization of abortion and consistently ranking high on health coverage and education indicators, Coahuila also ranks among the states with the highest proportion of pregnant children, including girls as young as ten years old (González 2026). While I return to questions surrounding women and girls' reproductive bodies in Chapter 3, these contradictory dynamics illustrate that normative frameworks that formally guarantee reproductive autonomy, along with favorable health/education indicators, frequently fail to capture the lived realities of reproductive care. This sticky terrain, where legality or access does not ensure dignified care, calls for a closer examination into what forms of care are enacted when reproductive bodies enter these spaces.

Obfuscating Care

Care obfuscation is particularly evident in medical/obstetric settings. Despite policies such as NOM-007, violent obstetric practices persist across public health institutions. During fieldwork, I encountered numerous cases in which women were denied timely care and forced to give birth in emergency room bathrooms, on sidewalks outside hospitals, or in stairwells in search of privacy. Other cases involved invasive and non-consensual procedures, routine episiotomies, and verbal

abuse by clinical staff. When cases of medical negligence or obstetric violence escalate to the 'National Commission of Human Rights' (CNDH), the outcome is typically limited to the issuance of non-binding 'recommendations' urging institutions to avoid future violations—without sanctions, accountability mechanisms, or structural reform. Hospital administrations, in turn, release public statements expunging themselves from responsibility, asserting that care was timely and adequate, even when such claims directly contradict victims' testimonies and clinical documentation reviewed by the CNDH.

Similarly, despite NOM-046 declaring the criminalization of abortion unconstitutional, women, girls, and people with the capacity to gestate continue to require individual legal protections in practice. While the ruling established that punitive abortion laws violate constitutional rights, it did not automatically repeal state-level penal codes or fully transform local legal and institutional practices. As a result, although Coahuila's abortion-related criminal provisions should no longer be enforced, they remain formally embedded in legal texts and are often operationalized by police, prosecutors, and health authorities. Consequently, women who are investigated or detained for abortion must still seek *amparos*, individual constitutional injunctions to halt criminal proceedings and secure their release. This reliance on *amparos* effectively shifts the burden of constitutional enforcement onto reproductive bodies themselves, exposing them to prolonged legal uncertainty, emotional distress, and economic costs, revealing a persistent gap between constitutional jurisprudence and the lived realities of reproductive governance at the local level. Differently put, lawful access to abortion co-exists alongside the persistent threat of criminalization.

Even prior to entering judicial spaces, reproductive bodies encounter barriers and re-victimization within clinical settings when seeking abortion care. These include demands for unnecessary documentation; coercive counseling aimed at dissuading abortion; the moral personification of the embryo; and discursive framings of motherhood as a 'blessing.' My interlocutors, alongside online discourse, repeatedly described abortion care as oscillating between bureaucratic indifference and outright violence. Some accounts included forced and non-consensual sterilization procedures, such as salpingectomies, imposed as punishment, while others described denial of care rooted explicitly in clinicians' personal ideology or religious beliefs. These conditions raise a critical question: if personal ideology and religion have no legitimate place in

state or medical decision-making, particularly where autonomy is concerned, why does abortion remain an exception? In other clinical contexts, such as when a patient who is a Jehovah's Witness refuses a blood transfusion, clinicians are expected to respect patient autonomy even when they personally or medically disagree. Why, then, can clinicians refuse abortion care, impose additional barriers, or victimize patients based on personal or religious opposition, thereby undermining reproductive autonomy guaranteed under NOM-046? If abortion care *is* obstetric care, are these practices not also forms of obstetric violence?

In this way, the obfuscation of care, as the assertion that care is accessible, adequate, and free of violence when it is not, emerges as a central mechanism of reproductive injustice in Coahuila. At its core, this is what this chapter is about: the gulf between what the State claims to do, across federal and state scales, and what it enacts in practice. By articulating the tensions, frictions, and contradictions between the care projects of the State, feminist *colectivas* and birth workers, this chapter argues that reproductive governance operates as a biopolitical project through which the State enables, obfuscates, and reproduces the infra-structural conditions that make violence possible.

Waiting for Care

Olivia has been patiently waiting for months for a surgery to remove a large cyst that is lodged uneasily in her womb—one that has been growing, slowly, menacingly, for nearly a decade. Each time a surgery date is marked red on the calendar, it eventually gets postponed by the IMSS administration. First, she is told, because the elevators at the IMSS clinic are not working and going ahead with scheduled procedures would be 'unsafe,' as if, living with a life-threatening cyst that could rupture at any time is not. Then, because the specialist is on vacation and there are not enough specialists on site to perform the procedure. The most recent cancellation comes down to a lack of hospital beds—claim that stands in contradiction with the 100-million pesos refurbishing of the hospital unveiled at the time of the call. In the days leading up to the scheduled procedure, Olivia had dipped into her savings to travel back and forth across the city, entering public and private laboratories and clinics to gather the required laboratory tests, imaging, and paperwork. Still, the call comes early in the morning of the scheduled surgery, and while it is devastating, it is not entirely unexpected.

Olivia is in her late forties, thin lines of age contouring her tired yet nurturing eyes. She is a domestic worker who has labored for a living since she was sixteen—the same age at which she became pregnant for the first time. While I return to her story in Chapter 3, her experience receiving care, or rather, of *waiting* to receive care, speaks to a broader infra-structural condition that shapes how reproductive bodies encounter State-led reproductive care projects. Online discourse echoes Olivia's frustration. Comment threads circulate beneath news of hospital remodels, questioning what renovation really means when elevators still do not function (and have not for months); when medications are unavailable; when securing a consultation appointment takes a year—and receiving care takes another year after that. And then, when receiving treatment entails tolerating paternalistic, condescending attitudes and *regaños* or reprimands from clinicians. Both Olivia's experience and these online complaints converge around a shared critique that 'improved' infrastructure alone is insufficient if it is not accompanied by supplies, staffing, *atención* and *buen trato.* While *atención* literally means 'attention,' in this context, it refers to both the clinical and dispositional or affective aspects of receiving care. *Buen trato*, similarly, while literally meaning 'good treatment,' deviates from the clinical aspects of treatment itself, focusing, rather, on the affective quality of receiving care.

What Olivia and online discourse repeatedly call for is not only a physical remodel, but a transformation of *atención* that centers on *buen trato* and humane treatment, urging clinicians to treat patients with *calidez* or warmth and as though they were members of their own families. Interweaving with these complaints under comment threads, IMSS workers often respond defensively, shifting responsibility onto *derechohabientes* themselves. These comments often describe patients and their families as ignorant of how 'the system' works, or as arriving already angry, already rude. These critiques speak to broader questions of accountability, responsibility, and of care, challenging an institution that claims 'coverage' and 'improvement' of infrastructures while producing unequal care within its walls—an institution that promises care while repeatedly deferring it, offering the language of 'protection' while normalizing waiting. Here, waiting for care emerges as both a temporal and political condition (Morales 2025), becoming a form of slow violence that becomes embodied over time. Like in Olivia's case, her restricted gait and movements echo the pain that continues to grow, without postponement, inside her womb. In this way, Olivia's condition constitutes both a biomedical disorder and an embodied expression of social suffering (Smith-Oka 2014), intimately linked to her cumulative experiences of neglect,

physical labor, and limited access to health resources. What emerges in cases like Olivia's is the accumulation of unkept promises; of institutions hiding behind normative frameworks while simultaneously washing their hands from responsibility when these frameworks fail to materialize as care.

Additionally, recall the disjuncture between legal 'progress' and lived experience, and how this gap crystallizes in the state's uneasy metrics of reproductive health. In Coahuila, the reduction of maternal mortality and child pregnancy has been articulated as a state priority for years (Gobierno del Estado de Coahuila 2025). And yet, as shown earlier, recent figures suggest not only a failure to reduce such numbers but a reversal, where MMR and rates of child and teen pregnancy remain among the highest in the country. Official state policy briefs respond to these outcomes with prescriptions of expanding access to prenatal care, increasing clinician training in obstetric and surgical techniques, and further consolidating birth coverage in medical institutions (Gobierno del Estado de Coahuila 2019). These objectives have, in turn, been codified into policies aimed at preventing obstetric violence and 'humanizing' birth. On paper, this appears as a 'progressive' and robust architecture of care. How come, then, that a nearly 'universal' hospital birth coverage coexists with one of the highest MMRs in the country? Why does Coahuila's 'progressive' abortion legislature sit alongside persistently high MMRs and rates of child and teen pregnancy? How can a multimillion-peso investment in 'improved' hospital infrastructure unfold in tandem with the absence of timely, humane care, and a lack of *atención* and *buen trato* within?

These questions do not point simply to a lack of policy or a problem that legislation alone can fix, but to something happening within institutions themselves—within everyday practices, hierarchies, and temporalities through which care is enacted (or withheld). What is at stake, then, is not the State's stated intentions, which appear to be 'good' or 'benign' on paper, but to the forms of care that State projects ultimately produce and perpetuate by largely going unchecked.

Embodied Violence and Violent Care

Before owning his private obstetrician-gynecological (OBGYN) clinic, Dr. Homero worked and trained at IMSS facilities in several municipalities within Coahuila for most of his professional career. I stumbled upon his practice's webpage as I was trying to find OBGYNs providing abortion

services in a municipality. His was the first and only webpage that publicly advertised providing abortion care alongside broader OBGYN services. When I reached out to him about my project, he did not hesitate to participate.

It is a hot summer day. I drive to his clinic and park just outside. Inside, I am met by the cool rush of air conditioning, providing relief from the piercing 45C° degree weather outside. The receptionist checks me in, and I sit down to wait. The lobby holds six chairs and is painted oyster white. As I look around, becoming acquainted with the framed diplomas and academic accolades that line the walls, I can't help but notice what *isn't* there. Unlike other OBGYN practices and clinics I have been to, I don't see framed pictures of fetuses or birthing mothers holding their babies. Five minutes pass before the door to my right opens. From inside the office, Dr. Homero calls my name, his voice echoing hints of warmth. I follow it into the brightly lit room and take a seat in one of the chairs across from a wooden desk; its surface cradling several binders and a 3D model of a uterus. He settles into the chair opposite mine. Dr. Homero wears indigo scrubs beneath a neat, white lab coat. When he smiles wrinkles contour his almond-shaped eyes, softening them behind a pair of rectangular glasses that are framed by his thick, bushy eyebrows.

When I ask Homero to walk me through his journey, especially as it relates to abortion care and reproductive rights, he starts at the end:

> 'Even though I did all of my training upon finishing medical school at IMSS facilities, I had to quit because of issues of violence,' he says, his voice carrying a vulnerable strength.
>
> 'What do you mean by "issues of violence"?' I feel my body edge closer to the desk in anticipation.

Before delving into his response, it is necessary to situate medical training in Mexico—a system that is highly unique for many different reasons. Unlike in some countries, medical education in Mexico begins immediately after high school and lasts six years, after which graduates must complete an *internado* (or intern) year and a year of *servicio social* or social service. Placement for these is usually merit-based, depending on the institution, allowing students to rank their preferred sites. Still, most available *plazas* or spots are within the public sector. Some students, usually through connections, merit, or a combination of both, pursue placements in private hospitals, which are often more desirable due to a higher remuneration of around 20,000 pesos per

month on average. Yet, most trainees pass through public institutions, where monthly stipends often range between 2,000-4,000 pesos, with *guardias* or shifts stretching into 36 or even 48 hours[4]. As several of my interlocutors pointed out, this compensation, despite covering the average monthly cost of living in Mexico, which is 1,000 pesos, it doesn't *really* consider rent, utilities, transportation, among other expenses—nor does it seem fair or dignified at times.

For this and other reasons, training under these conditions is widely contested. Interns often work with minimal supervision while being responsible for dozens of patients at a time. For instance, one of my interlocutors recounted beginning his intern year at an IMSS hospital on December 15th, a date chosen precisely because many attending physicians leave for their 15-day holiday break, leaving interns to manage wards largely on their own during the holidays. Another one of my interlocutors described completing both his intern year and social service in a rural IMSS site, where he was effectively the sole provider for an entire community, with little oversight and limited resources. Despite learning a lot by doing most, if not all, of the procedures entirely by himself—and, for the most part, for the first time—my interlocutor admitted that such exposure might have not been the safest for his patients. Even when I worked with GIRE analyzing human rights violations in obstetric violence cases, many of these cases involved medical trainees inadvertently causing iatrogenic harm due to a lack of adequate medical supervision.

Beyond exhaustion and precarity, many interlocutors described a deeply toxic training culture. Several spoke of gendered violence embedded within medical hierarchies, where female medical trainees are expected to tolerate, if not acquiesce to, sexual advances from male attending physicians to access fair treatment or meaningful learning opportunities. Those who refused, they told me, were often sidelined, denied mentorship, or ostracized. The nationwide social movement spearheaded by the *Ley Abraham* proposal speaks to these debates surrounding dignity, social justice, and human rights in medical training. The proposed law and its movement began in response to recent (and accumulating) suicides committed by those laboring within the system, particularly medical residents and interns, including Luis Abraham Reyes, the 30-year-old medical resident at IMSS in Monterrey whose suicide inspired the movement. At its core, the *Ley Abraham* movement calls for a structural transformation of an abusive, dehumanizing public health system

[4]This was true at the time of writing, however, in February 2026 *IMSS* officially eliminated shifts exceeding 24 hours in response to the *Ley Abraham* movement.

that has become normalized. It especially calls for the restoration of 'human dignity' in medical training against a culture that normalizes and exploits those who labor within it, demanding them to *aguantar* or tolerate humiliations, threats, academic punishments, and a lack of psychological *acompañamiento* in the name of education. Even after completing both the intern year and social service, the latter of which is sometimes unpaid or inconsistently compensated unless *becas* or scholarships are available, specialization remains financially inaccessible for many. Residency training often requires out-of-pocket expenses, reinforcing a system that privileges those with economic means, even as the medical labor market increasingly favors specialization (Segura 2023).

What kinds of care, then, emerge from such conditions? Forged within training systems structured by scarcity, hierarchy, abuse, and unfair remuneration—conditions that are far from being dignified—how can clinicians provide dignified care? How can *buen trato* and *atención* as forms of care that are warm, humane, and enacted as if to one's own family, be sustained when the very process of becoming a clinician is shaped by neglect, exhaustion, and abuse?

> 'I knew it was going to be a question of time until I was responsible for a death,' Dr. Homero turns his eyes away from mine, 'it was last year. Before I arrived for my shift, one of my pregnant patients was in a debilitating labor. And even though pain alone is not reason enough to perform a C-section, at IMSS, C-sections become the norm, even when there just aren't enough resources to provide analgesics to alleviate women's pain. So, before I was able to get there to help my patient through her delivery, another physician rushed her to perform an inopportune and excruciating C-section to supposedly save her life by removing her uterus. I feel responsible for her death, not because of my direct action exactly, but because she was under my care and there just weren't enough resources to provide the care she needed.'

His eyes cloud with pain and his initially strong voice begins to falter.

We sit in silence for a few moments, absorbing the depth of the story.

After acknowledging his pain and strength in sharing this with me, I ask:

> 'Why do you think these "issues of violence" arise or where do you think they come from?'

In what feels like almost a reflex, he replies:

> ‘On paper, you know, IMSS has good normative policies to prevent obstetric violence, and they talk to us about ‘humanized’ births, and I think that these are idealized by those who are not there, on the ground.’ He pauses; his eyes now fixed on mine. ‘But if you have five or six patients and not enough staff or resources, or if you don’t even know the patients names, or if you have these women lined up next to each other in a room filled with beds, and they have nothing on but a small robe to cover them up, and you have the interns, the staff, the residents, or even the maintenance crew there gawking at them uncovered and exposed, then, how can you *really* humanize birth? How can you personalize their care?’

His chest inflates with frustration.

> ‘When I was working there, I wasn’t doing my work with pride,’ he continues, ‘I was often in a bad mood, I wasn’t as warm as I should have been. But honestly, that is how you learn and how you are taught at IMSS, so you just go with the flow. And all of these issues of privacy, of opportune C-sections, of analgesics, of respecting birth, and not making procedures painful and giving *tactos* with care, it all just gets lost; you lose that sensibility because everything becomes a machine. It happened to me, which is why I decided to quit; I started to become violent. And the institution will always defend and expunge itself, claiming it is the clinician’s fault. But that’s not true. It’s due to a system that was created this way and evolved this way.’

What Homero’s story renders visible is how violence operates not only through individual, isolated acts, but in that it permeates the very conditions of training and working within the public health system. Dr. Homero and clinicians in training are socialized into trespassing boundaries—transgressions that are not incidental but central to the reproduction of professional authority and biomedical power (Smith-Oka and Marshalla 2019). It is through these transgressions, prolonged exposure to scarcity, toxic hierarchies, and moral injury that the system dehumanizes those who labor within these institutions, co-producing how care is practiced and felt. In this sense, clinicians do not merely enact violence, but absorb, embody, and reproduce it, internalizing the same colonial logics of control and domination behind the medical-obstetric enterprise (Fanon 2008). In other words, the system grows the same conditions that reconfigure clinicians into *becoming* violent. This *embodied violence*, when layered onto institutional infrastructures and demoralizing

architectures that already dehumanize patients, becomes enmeshed in a cycle of violence that births further violence.

Homero's story also articulates that access or coverage alone do not constitute nor guarantee dignified care. Across his story and those of others, it matters little how many people are brought into hospitals to give birth, or even whether abortion is formally free and legal, if upon arrival reproductive bodies enter systems that are already violent. Seen this way, it starts to make sense why near-universal birth coverage fails to translate into reduced MMRs, or even why 'progressive' abortion frameworks and normative policies fail to materialize as dignified care on the ground. From this perspective, fears of giving birth in public wards also begin to make sense, just like the hesitation and eventual refusal of having to rely on public health institutions for abortion care when obstetric violence becomes the norm.

If State-led care is experienced as violent on both ends, whether it is giving or receiving care, then what alternatives are there? For women like Olivia, for instance, the options are narrow. She was considering pursuing her cyst-removal surgery through private care, only to learn that it would cost upwards of 120,000 pesos—something she simply cannot afford. Turning to DIF ('System for the Integral Development of the Family'), which is a social assistance organism dedicated to 'vulnerable' individuals with the goal of promoting 'familial' and social wellbeing, Olivia learned that the surgery would cost 16,000 pesos. Yet, this route excluded follow-up and wound care, which would not be covered by IMSS and would instead require additional out-of-pocket payments. For those seeking abortion care, a similar calculus unfolds. Private clinics, such as Dr. Homero's, offer services at a minimum cost of 500 pesos, excluding follow-up care. For childbirth, private options range even higher, often exceeding 20,000 pesos depending on insurance coverage and payment packages. What happens, then, to those who can't afford private care or even refuse to enter spaces that victimize them? It is these constrained systems and exposures to violence that draw women, girls, and people with the capacity to gestate towards birth workers and *colectivas*.

A Few Good Apples in a Rotten Tree

> 'The public health system is rotten to its core,' Sofia tells me without hesitation. 'Clinicians are taught this way, they learn this way, and then they teach the next generation this way.'

For over a decade and a half, Sofia has worked as a certified doula and perinatal educator. Despite the institutional reluctance for change within the public health system, she insists on 'fighting against the current' and educating women about respected births; about knowing their rights and demanding them. And yet, she adds quietly, longingly, as we sit facing each other drinking coffee at a local café:

> 'The system is not ready for that.'

In public health institutions like IMSS, Sofia explains, echoing Dr. Homero's story, a pro-cesarean logic prevails. One of her patients, for instance, wanted a vaginal birth and made this clear repeatedly. Each time, almost reflexively, the clinical staff would inadvertently ask her when she wanted to schedule her C-section, leaving any possibility of a natural birth out of the question. When she reiterated her wish for a natural birth, she was dismissed and pressured again.

> 'They told her C-sections are fast and easy,' Sofia explains. 'Doctors perform C-sections disproportionately,' she adds, 'not because they're all bad people but because they don't want to struggle. And don't get me wrong, I know kind doctors who want to do good. But they're barely a handful compared to the rest.'
>
> She briefly pauses, then adds:
>
> 'If you think about it, you really are looking at a few good apples in a poisoned tree.'

Her words linger in the air between us.

> 'Respected birth exists in theory,' Sofia continues, 'but not in practice.'

The Ministry of Health, she notes, publishes manuals detailing how births should be attended in theory, including freedom of movement, choice of birthing position, permission to drink water, informed consent.

> 'But that's not what happens in the public sector,' she says. 'It's barbaric. Absurd. An offense to women.'

It was Sofia's own experiences of violence in public obstetric spaces during her own birth that led her to train to become a doula and perinatal educator. Even though it was two decades ago, she recalls it vividly. She tells me about not being able to move around or drink water and being forced to birth on her back when her body was telling her to crouch down instead. She remembers the sharpness of the knife as it cut her skin when the physician performed an episiotomy without her consent. And, unlike her first birth, she wasn't allowed that sacred 'golden hour' of nursing and skin-to-skin contact with her baby upon delivery. This excruciating birthing experience left what she describes as a bitter taste in her mouth, especially compared to her first birth. While abroad in the United States, Sofia qualified for a program aimed at pregnant socioeconomic minority patients undergoing low risk pregnancies. For her first pregnancy and birth, she was paired with a midwife and a doula, who actively engaged with her, taking the time to know her, her body, and her expectations for her first birth. When the time came, even though she was in a hospital setting, the midwife and doula orchestrated her delivery. Using a combination of ointments, touch, and presence, they gave Sofia free reign and autonomy to move, drink, and even dance the pain away. Sofia recalls experiencing an 'explosion of love' and happiness as her baby was immediately placed on her chest upon birth for nursing.

It was these contrasting birthing experiences that moved Sofia to ensure all women experienced the kind of birth she lived when she was accompanied by a midwife and doula. Her own story of experiencing obstetric violence and adamantly breaking from such violent settings is fundamentally mirrored by the women she now accompanies during their own pregnancies and births. These women, like Sofia, and contradicting existing frameworks like NOM-007 underlining respected births, encountered violent practices—from being held down while giving birth; being humiliated and dehumanized by the clinical team; undergoing nonconsensual procedures without analgesics; and being subjected to remarks such as *Stop screaming! Were you screaming like this when you made the baby?*

From these overt acts of aggression to the accumulation of microaggressions, which, as Smith-Oka (2015) articulates, are constitutive practices that re-inscribe classed, racial, and gendered hierarchies at the bedside, women come to Sofia because they need something that completely breaks from this violence. Because of her advocacy, Sofia is a 'controversial' figure within medical circles. When she began naming 'obstetric violence' publicly, she was met with

hostility and was harassed and threatened by physicians who felt personally attacked by the term. She did not want to position herself against doctors, she tells me, she wanted to *work with* them. Eventually, she made the strategic shift of abandoning the language of 'obstetric violence' in favor of 'respected birth' as a softer, more palatable framing meant to reduce defensiveness and open dialogue. Her hope is not to dismantle medical institutions, she says, but to transform them by bringing midwifery and doulas closer to them, so that women might have options.

Moved by Sofia's work, I ask her what the ideal situation would be for birth workers like her, to which she replies:

> 'Doulas and midwives fill a gap that medical institutions have placed us in because of the medicalization of birth. In home births, you have a connection there, you are surrounded by women and guided by our emotions. We doulas go to hospitals because they protocolize attention, and doctors or nurses don't hug women, they don't support their hips or rub their feet. Unlike medical professionals, I forge a bond with my patients from the prenatal stage, getting to know them and their expectations and preferences for their birth so I can do everything in my power to make that happen. I think this is important, given the nature of birth, there is a lot of intimacy, closeness… sometimes I hold them for hours or I massage their bodies.'
>
> 'Still,' she continues, 'the system is not ready to change, and it is up to us as women to pressure the system. To know our rights and demand better.'

Through the violence Sofia experienced during her birth, the medical-obstetric complex reconfigured her body into an 'anti-body', or site of erasure, intervention, and pathology (Davis 2025). While her anti-body was formed in response to these violent conditions, at the same time, Sofia resisted against this violence by becoming a doula and accompanying women during their pregnancies and births. In this way, Sofia became a protective antibody for reproductive bodies who, like hers, had been casted as pathological and in need of obstetric intervention. Sofia's vignette also illustrates that, while the medical-obstetric complex is rooted in a patriarchal and colonial logic of control, domination, and separation, birth workers like her restore connection, dignity, and reproductive autonomy during the perinatal journey. In this way, echoing Jallicia Jolly's (2025) work with Black HIV-positive women in Jamaica, birth workers like Sofia navigate and contest state/medical violence, reproductive injustice, and biomedical neglect by weaving

networks of care with others, ultimately acting as resistive antibodies that offer adaptive forms of resistance to overlapping oppression. It was precisely through these weaving of networks with other birth workers and with feminist *colectivas* themselves that I initially connected with Sofia. It is this shared ethos of both care and resistance that also drives *acompañantes* to join *colectivas* to not only fight for reproductive rights but to restore dignity in abortion care through *acompañamiento*.

Resisting from Within

Through my engagement with feminist *colectivas* and birth workers, a persistent tension emerges—one I have traced throughout this chapter between *colectivas* and birth workers with the State. This tension drags everywhere: during protests, in meetings, in whispered frustrations, and in news coverage. Members of *colectivas* often locate this strain in their explicit commitment to dismantling patriarchal, colonial, and capitalist structures through protest, dialogue, and presence alone. Such commitments, they argue, unsettle and threaten 'State order.' In this sense, *colectivas* and birth workers occupy a double position where they are sites of 'otherness' and erasure while simultaneously resisting such erasure by enacting an 'otherwise' through the re-imagining and enacting of a world that does not yet exist, as will become clearer in Chapter 2. When Lupe, a friend from a *colectiva*, suggested that I met with Alma, a fellow *colectiva* member who not only provides abortion care but someone whose day-to-day labor entails working for the state of Coahuila's Congress, I couldn't help but wonder: how could someone so embedded within the system also work to fiercely critique it to the point of deconstruction? That question alone was precisely why I knew I had to meet Alma.

Alma is a lawyer who was two master's degrees focused on gender equity, and on her free time, she wins regional competitions on horse-riding. She is as fierce and strong as she is kind and gentle. One day, I was waiting for her at her house when she finally came home from her job in Congress. She switched her dark blue suit and donned a comfortable light pink shirt and jeans. We gently groomed her favorite racehorse as Alma tells me that, one day, she was leading a public workshop on gender equity as part of her job. As she opened the floor for questions, a woman in the audience raised her hand:

'If the Federal Supreme Court ruled to decriminalize abortion, that is, effectively removing it from the penal code, why does it still appear in our state's penal code?' The woman asked. 'Is abortion not legal in Coahuila up to twelve weeks?'

Despite the 2021 decision, Alma continues to witness bureaucratic and legal barriers, alongside the persistent re-victimization of women, girls, and people with the capacity to gestate in both clinical and legal settings. With tears welling in her eyes and goosebumps rising on her skin, she tells me how deeply troubled she is by the state of sexual and reproductive injustice—both in Coahuila and nationally. As a state lawyer and as an *acompañante*, she encounters these contradictions daily: women and girls continue to be prosecuted, legally and socially, for having an abortion, while the lengthy and costly process of obtaining an *amparo* drains financial resources and places lives at risk. My own skin curls as she speaks.

'The law changed on paper,' she says, 'but not in practice.'

It was precisely this gulf between legality and lived experience, and particularly its deliberate obfuscation by the state through 'legal murkiness' surrounding abortion rights, that pushed Alma toward the *colectiva* and toward what she calls *feminismo de calle* (street feminism), where she accompanies others through their abortion processes. As we rest our hands against the horse's smooth flank, Alma tells me she is committed to fighting this injustice at its root. She believes that struggles for gender, sexual, and reproductive rights must be waged across multiple fronts. This is the work she undertakes as a state lawyer, *acompañante*, advocate, and researcher: dissolving the legal murkiness that places lives in danger, dismantling bureaucratic barriers to access, and restoring dignity in abortion care within a system that persistently re-victimizes those seeking it.

So, when the woman at the workshop asked why abortion remained in the state penal code, Alma answered plainly:

'Because there is no political will.'

When the session was over, Alma's supervisor asked her to come to her office, where she was reprimanded for speaking against the administration:

'How could you, Alma, a state worker, say something that goes against *us*?'

With an audible knot in her throat, she told me she couldn't believe that they couldn't push for the full decriminalization of abortion because it didn't align with the current administration's agenda.

As the sun kisses the horizon behind us and the warm breeze embraces our skin, I ask Alma in almost a whisper:

> 'If we could imagine an ideal situation, what would it look like? What role would *colectivas* play?'

Alma lets out a big wind of air and says:

> 'The ideal situation would be for *colectivas* to stop existing altogether. We exist because the government is not doing its job. They call us their "allies," but we are carrying out the labor they should be doing—and we do it for free.'

Chapter 2

Apapacho as Decolonial-Feminist and Embodied Care

The *Hospital Padrino* strategy originated in Colombia as a response to its high MMR, surpassing Mexico's (Cruz-Barbosa. *et al* 2025, Escobar *et al*. 2024). The strategy pairs, or *apadrina*[5], lower-level community-based providers with higher-level referral hospitals, creating interconnected networks of communication. Midwives, doulas, rural clinicians, ambulance drivers, and hospital-based obstetric teams are linked through shared protocols and through constant communication channels via WhatsApp. At the center of the strategy is the premise that women's lives are not saved only through technology but through timely recognition, trust, and a multifaceted coordination among existing stakeholders. Through the strategy, women are not discouraged from having their pregnancies and births tended to by midwives and doulas. Rather, these birth workers are positioned as crucial partners in women's care, as they are usually the first to encounter signs of complications. Once a complication is suspected, communication is immediate. A WhatsApp message is sent. Images, lab values, signs and symptoms circulate across the network. Decisions are made collectively, often before the woman ever reaches the nearest hospital.

Since its implementation, the *Hospital Padrino* strategy has contributed to a steadily decline in local MMRs (Escobar *et al.* 2024), fact that Dra. María Fernanda Escobar, the strategy's lead and the Chief of the Unit for Global Health Equity in Mexico's National Institute of Perinatology, attributed to the partnership-oriented model that seeks to respect multiple forms of

[5] Kinship in Latin American countries, including Colombia and Mexico, is a network that involves both biological relatives but also fictive or chosen relatives. The *padrino* (godfather) system, known as *compadrazgo* or co-parenting, remakes kin relations by appointing trusted mentors for a child's religious, emotional, and financial support during major milestones, creating a lifelong co-parenting bond with the parents. In this sense, the *Hospital Padrino* is the 'godfather' of smaller community-level care providers.

knowledge. It is this reconfiguration of kin relations through the restructuring of care that birth workers and *colectivas* in Mexico call for—it is not about working against the system, but rather, finding ways to dismantle existing frameworks that prioritize one knowledge over the other. It is about finding ways to work together and restoring women's agencies, their bodies, and their knowledges at the front and center of an interconnected web of care relations. If these partnerships help improve maternal outcomes, how come traditional birth attendants and *colectivas* remain ostracized from care in Mexico?

TRACING MIDWIFERY IN MEXICO

Traditional midwifery in Mexico originated in pre-colonial Mesoamerican cultures where midwives held prestigious social positions as spiritual guides, community leaders, and healers who prepared women for pregnancy, birth, and motherhood (Trueba 1997, Farrell 2022). Pre-colonial Nahua healers (*titiçih*), for instance, practiced comprehensive reproductive care using herbal remedies, steam baths, massage, and ceremonial rituals that connected birth to cosmic creation (Jaffary 2016, Vail 2019). The role of midwives extended beyond physical care to encompass spiritual and ceremonial functions, with midwives being revered as 'the speakers for the goddess, the priestesses of life, [and] the protectors of health' (Farrell 2022: 326). In Mayan communities, in fact, becoming a midwife was considered a spiritual calling tied to one's life purpose and destiny (Rogoff 2011), carrying high social status consistently across different communities.

The colonial period introduced significant tensions between Indigenous midwifery practices and European governance structures. Colonial Mexican midwifery functioned as a 'contact zone' where power-laden exchanges forged hybrid understandings of medicine and the body (Holler 2019a). In conjunction with colonial governance, religious institutions played a significant role in regulating birth practices. The Inquisition maintained oversight through cases involving midwives (Holler 2019b), while the *Provisorato de Naturales and Inquisición Ordinaria* exercised control by associating traditional practices with demonic activities (Encontra 2024). However, Inquisitors' lack of interest in penetrating the birthing chamber itself suggests that traditional practices retained considerable autonomy (Holler 2019b). This imposition of religion led to viewing childbirth as a 'dirty' process, further marginalizing traditional midwives (Ponce López *et al.* 2025), and justifying midwifery as a site for colonial authority's surveillance and

control of women's bodies (Williams and Boddy 2021). Yet, traditional practices showed resilience in eluding hegemonic formulations through the development of a *mestizo* repertoire that mixed European and Indigenous knowledges (Arrom 2018).

Despite colonial pressures, Indigenous obstetric practices and botanical knowledge persisted into the twentieth century among all sectors of Mexican society (Arrom 2018). Pre-Columbian obstetrical knowledge, especially regarding abortifacients, continued to circulate (Jaffary 2016). A notable nineteenth-century Oaxacan law required 'doctors to learn the art of obstetrics from midwives rather than the other way around,' indicating some recognition of traditional expertise (ibid). Unlicensed midwives continued to deliver most Mexican children at home and were respected for their expertise despite attempts at regulation (Arrom 2018). At the same time, medical professionalization systematically displaced midwifery through deliberate policy and institutional shifts. In fact, 'professional' midwifery was created by the biomedical system to eliminate traditional practitioners and gain access to pregnant, parturient, and puerperal women (Carrillo Alvarez 1999). Physicians were able to carry on with this displacement of midwives by undermining their empirical knowledge and promoting scientific medical knowledge through formal educational institutions (Robles and Sandoval 2007). These spaces, in turn, institutionalized training courses aimed to replace traditional midwifery skills with medical knowledge (ibid). By the 1830s, midwives were replaced by university-trained physicians in specific roles, including as medical examiners in sex crime cases when legal medicine became incorporated into the curriculum for male medical students (Penyak 2002). This shift reflected broader gender dynamics, including the *Porfirian* medical profession's efforts to establish national medical practice as a male-dominated profession based on the assumed anatomical weaknesses of Mexican women (Bruey 2018). In 1892, following this progressive displacement of midwifery, professional midwifery was subsequently restricted through regulations limiting scope of practice, which led to the requiring of nursing credentials in 1911 (ibid). By 1967 midwives were no longer hired by hospitals and were prohibited from attending births in institutional settings (ibid), contributing to deplorable maternal-child health statistics (Trueba 1997).

Contemporary institutional metrics document a dramatic decline with midwives prohibited from hospital births and only 1,788 midwifery titles registered compared to 226,179 medical degrees. At the same time, practice-based measures indicate that traditional midwives still attend

30-40% of births, particularly in Indigenous communities where they maintain high social status through community validation rather than State recognition (Trueba 1997, Carrillo Alvarez 1999, Alvarez Romo and Hernández Zinzún 2022). The 1978 Alma-Ata Declaration and subsequent international guidelines fostering 'ethnomedicine' have influenced contemporary Mexican policy, with efforts to integrate traditional midwives into formal health systems (Ponce López *et al.* 2025). While midwives are recognized by the Secretary of Health only when they attend 'professional' government training programs (Chablé Chi 2020), traditional midwives are classified as non-professional personnel, lacking legal recognition as professional practitioners. In this way, current public health policies simultaneously recognize and limit traditional midwifery, with government training programs teaching biomedical standards while restricting autonomous practice (El Kotni 2018b). Notably, the *IMSS-PROSPERA* program focuses on prenatal services and institutional births, with emphasis on 'qualified personnel' in formal institutions to tackle maternal mortality (De Lopez *et al.* 2018), further ostracizing traditional midwives.

Despite institutional pressures, midwives and communities develop resistance strategies. Traditional midwives in Chiapas, for instance, maintain their practices despite systemic violence and multiple control mechanisms (Álvarez Romo and Hernández Zinzún 2022), forming the *Liga de Parteras* organization to advocate for midwives' rights and challenge medical control (Carrillo Alvarez 1999, Vega 2017). Contemporary professional midwives also organize national conferences and meetings to establish midwifery as both profession and social movement (Davis-Floyd 2001), further contesting mechanisms of reproductive governance (El Kotni 2018b). Importantly, contemporary midwifery strategically adopts a hybridized approach, combining biomedical elements while maintaining core traditional practices. *Tének* midwives, for instance, defend traditional practices against biomedical influence while simultaneously incorporating some biomedical techniques promoted by the state (Leyva Santoyo 2025). 'Empirical' midwives, similarly, combine traditional and lay-allopathic techniques learned through apprenticeship (De Lopez *et al.* 2018), creating centers like *Luna Maya* that integrate traditional midwifery with modern tools and evidence-based care, bridging gaps between technology and ritual.

In sum, this hybridization represents neither capitulation to biomedicine nor unchanged tradition, but rather an adaptive resistance that preserves cultural meaning while navigating institutional constraints. In this sense, traditional midwives function as custodians of knowledge

that is both appropriated by the formal system and restricted in its autonomous practice. Along this vein, this chapter ethnographically traces the ways in which those who accompany women during their reproductive processes, including birth workers and *acompañantes*, both adapt and resist reproductive governance from below by enacting an alternative, feminist infrastructure of care that is rooted in *apapacho*. This chapter foregrounds how *apapacho*, in breaking apart from the logics that exert control and dominance over reproductive processes, restores connection, dignity, and autonomy in care, effectively transforming care into a collective healing practice.

Apapacho in Birth

Dulce has been tending to women's births, first as a nurse then as a midwife, for over 50 years. She obtained her bachelor's degree in nursing, specializing in obstetrics, and later obtained a master's degree in public health with an emphasis in community health. Like her name, Dulce has an endearing persona, that despite meeting online since she was attending a midwifery conference in the Dominican Republic and I had returned to the United Kingdom for coursework, it was palpable through the screen. Dashes of gold and silver frame her diamond-shaped face, contrasting with her deep brown eyes that are embraced by thick lines of age and perpetual happiness. When she speaks, Dulce's voice is firm but tender, holding a presence that is as grand as she is.

> 'After 20 years of practicing as an obstetric nurse,' Dulce begins, 'I noticed that the *atención* that I was providing, from what I had learned through the healthcare system as well as the actions within the hospital setting, were violent against women. These practices were disrespectful. Everything in the hospital was done unilaterally, that is, from the clinician to the woman, without really tending to how the woman receiving that *atención* feels, thinks, or wants. That realization alone deeply unsettled me, especially as I began to attend more home births at the time.'

Twenty years ago, after decades of practicing in hospital obstetric wards, Dulce attended a home birth for the first time—experience that marked the beginning of Dulce's departure from medical settings. During that birth, everything that she had known from hospital births was turned upside down. The hospital was filled with curt commands, the dismissal of women's preferences, and the insistence of immobilizing the laboring body. During the first homebirth that Dulce attended, she

saw that compliance turned into agency; stillness and immobilization became movement; and silence shifted into singing, speech, screams, moans, and even laughter.

> 'From that first experience, it became clear that a woman knows how to birth, but the system convinces her that she does not; that she needs to be immobilized and intruded upon; that her body needs to be silenced and still. But her body is already intimately aware of how to birth. But the system does not listen to her body… it doesn't let her body speak,' Dulce continues, 'As a midwife and doula, it is my job to help this woman restore that ancient, embodied knowledge—the same one that the institution tries to convince her she does not possess.'

For Dulce, accompanying women during their pregnancies, births, and through their journey into motherhood became a way for her to restore that embodied knowledge. This realization took further form as she began her midwifery education in the south of the country, where midwifery education is formalized and more visible than it is in the north. Seeing this midwifery vacuum in the north, Dulce decided precisely to return to fill it after finishing her training. Nevertheless, despite her efforts and repeated attempts at pushing for visibility, she continues facing a persistent hesitance and resistance from both state and medical authorities alike. For years, Dulce tells me, she has tried directly speaking with state functionaries to advocate for the incorporation of solidified training programs for midwifery education. Dulce firmly believes that midwifery training programs in Coahuila will 'legitimize' the profession, inviting more women to attend their pregnancies and births beyond hospital settings. Still, her requests are repeatedly met with claims, such as:

> *You can't use Chiapas or Oaxaca's midwifery training systems as examples! We are Coahuila—we are not like* those *southern states! Here, we have made progress towards technology and innovation.*

Oaxaca and Chiapas, states that have formal midwifery training programs, including both official licensing programs and traditional midwifery education centers, are among the states with the lowest levels of medically attended births, ranking 30th and 32nd with coverage rates of 96.36% and 89.7%, respectively (Gobierno del Estado de Coahuila 2023). Yet, despite this lower incorporation into medicalized birth settings, both states fall within the mid to low range of maternal mortality with MMRs of 36.72 and 29.5 deaths per 100,000 live births, respectively.

Recall from Chapter 1 that Coahuila, despite ranking 4th nationally in birth coverage also has one of the highest MMRs in the country. These figures complicate linear narratives that equate technological advancement and medicalization with safety, and call into question the assumption that distancing Coahuila from southern midwifery traditions constitutes 'progress' rather than another form of reproductive risk. Dulce attributes these comments and refusals to Coahuila's physical and ideological proximity to the United States, to which both my interlocutors and broader public discourse also agree with. At the same time, I would also argue that these ideas toward 'modernity' and rejecting 'traditional' practices like midwifery also stem from colonial logics that reject Indigenous knowledge and practices as 'backwards' and biomedical intervention as preferable. After all, both Oaxaca and Chiapas are among the states with the highest Indigenous demographics, comprising approximately over 20-35% of their populations, whereas only 0.2% of Coahuila's population is Indigenous (INEGI 2025).

Still, despite this hesitation and overall lack of public awareness surrounding midwifery, the women who seek Dulce for birth *acompañamiento* do so for two main reasons: 1) they are well informed about the risks associated with pregnancy and birth in medical settings, and are, therefore, seeking an alternative mode of care, and/or 2) they have experienced violence in obstetric settings and refuse to return to medical settings for their pregnancies and births. How do women find Dulce? Dulce does not count with formal marketing or public advertising. Rather, the same women whom she has accompanied through their pregnancies and births share their birthing experiences with other women, who then seek Dulce. It is this word-of-mouth among women, including *colectivas* themselves, that weaves these networks together; and it is fundamental in sustaining Dulce's work.

Dulce's *acompañamiento* begins with a consultation during pregnancy. Dulce leverages her nursing background to evaluate each women's pregnancy and its associated risks, as she only takes on low-risk births. Dulce relies on laboratory studies throughout the pregnancy to understand how her physical conditions, like the shape of her womb, inflammation, along with her lifestyle, emotions, and diet shape each woman's microbiome and colon, since each woman's individualized biology and physiology often determine their birthing experience. She follows normative policies indicating the number of prenatal check-ups. During each appointment, she discusses how her patient feels, how her lifestyle has changed, and performs additional laboratory tests. She also cups

her patient's belly with her hands to monitor the shape of her patient's uterus to determine where the fetus is and when the delivery could be expected. During these meetings, Dulce equips her patients with their birthing options, including pool births, and she provides them with a list of the materials needed for each kind of birth type so that they can prepare. She also creates a group chat with her patient and her partner or family members so that they can have access to her at any point.

> 'The approach that midwifery brings into care is that we deeply recognize that birth is a natural, physiological process that becomes pathological when that physiology is interrupted or consistently intruded upon with invasive vaginal examinations and unnecessary procedures and medications. I try to safeguard each birth's unique physiology by tending to women's bodies, emotions, and their knowledges before, during, and after birth in their homes,' Dulce says.

Even though Dulce follows normative policies, she does not delimit her practice to monitoring clinical signs and laboratory tests. She does not perform invasive *tactos* or rely on surgical interventions. Rather, Dulce fosters connection and tries to forge a bond with her patients and their families. She cares not only for their biology or lab results, but for how they feel and what they want. When labor comes, Dulce lets her patients take the lead and guide their own birthing process. Instead of pinning them down and administering a dozen different medications, Dulce instead listens closely, carefully to their bodies, their emotions, and their voices. Dulce uses warm compresses, pressing them gently but intentionally against their skin to soothe the pain and to open their bodies with warmth. Dulce massages their bodies, using warmth, acupuncture techniques, and herbal ointments. She encourages her patients to listen to their own bodies, to let them take the lead and dance, walk, or move how the body asks to be moved. During birth, Dulce holds her patients' hips tightly and carefully in whatever position their bodies choose to birth in; it does not matter if her patient is squatting, kneeling, standing, or even leaning into a partner's arms—Dulce meets her there with the same attention and care as before.

Throughout, Dulce orbits around them, adjusting her care to their shifting needs. She doesn't try to force a position or hold them down for easier access. Instead, if they feel safest gripping the edge of a table or holding onto Dulce's own shoulders, she meets them there. If they want dim lighting and silence, Dulce hushes. If they need music, for someone to hold their hand tightly, or a gentle reminder that they are not alone, Dulce is there. She sits close, breathes with

them, places her hand on their lower back or hip during contractions, and whispers reminders that their pain is part of a larger experience that their body is intimately aware of, *trust your body*, Dulce says. Dulce is *there with* them the whole time.

Upon birth, Dulce ensures that the baby is not taken away immediately for cleaning. Instead, she places the baby on her patient, gently atop of their womb, and lets them dwell in that warm explosion of love from the first skin-to-skin contact and nursing. Even well after childbirth, Dulce stays in close contact with each of her patients, both during the immediate postpartum period and well beyond into the baby's baptism, birthdays, christening, and other milestones. One of Dulce's patients shared with me that the kind of care that Dulce practices was precisely what she had always imagined for her birth—the kind of care where how she feels matters more than her 'dilation,' a space where she is not rushed, corrected, or shamed, and where the person attending her birth does not treat her like a problem to solve but as a shared process of *being with*.

After more than 30 years caring for women in the comfort of their homes throughout their pregnancy and births, Dulce refuses to re-enter hospital settings, saying:

> 'In the 'coldness' of the hospital, the institution benefits, the staff benefits, but not the woman. At home,' Dulce says, 'the woman leads her own birth, and I accompany her in trying to restore what the medical institutions have taken away.'

Dulce's narrative, echoing those from the previous chapter, renders visible how violence becomes normalized within public health institutions, absorbed into routine clinical practice until it no longer appears as violence at all. Dulce did not initially recognize these practices as harmful but simply as how birth was done in medical institutions where she practiced for 20 years. It was only by leaving the hospital and entering the home that this taken-for-granted order was disrupted. In domestic birthing spaces, women's bodies were no longer treated as anti-bodies but as *knowing* bodies capable of guiding their own labor.

Apapacho, as the 'surrounding someone with one's presence and warmth' (Jarrín and Pussetti 2021) and as an 'ethic of cultivating closeness and keeping together' (López Varela 2021), emerges in the practice of birth workers like Dulce and Sofia, the doula from the previous chapter, not as a rejection of medicine, but as a restoration of care, holding clinical knowledge alongside touch, warmth, presence, and affective attunement to women's bodies. As Dulce emphasizes, the

apapacho in her care also evokes the maternal comfort associated with traditional healing (Gutíerrez Lovera 2023). While Dulce continues to rely on normative policies, ultrasounds, laboratory tests, and clinical assessments, and even teaches suturing as a necessary but secondary skill reserved for moments of complication, these are not the single organizing logics of birth. What makes her care entirely different from those in 'cold' institutional settings, where the coldness becomes a dual characterization of the physical but also the affective *atención* within, is her refusal of the colonial logics guiding protocolized attention in obstetric spaces. Birth workers like Dulce and Sofia embody this refusal in their practice of *apapacho*, restoring the connection, dignity, and bodily autonomy that the colonial/patriarchal medical-obstetric complex takes away from women's births. While *apapacho* offers a new way to think with birth workers' care praxis, it also opens up space to think with care in abortion *acompañamiento* as well.

Rethinking Abortion Care Through Apapacho

When I first asked *colectivas* what abortion *acompañamiento* entailed, I felt my body tense up a little. Mirroring public discourse, I had absorbed the idea of abortion largely through circulating images and rhetoric saturated with fear and religious shame: bloody fetuses, unbearable pain, invasive procedures, and an overall violent transgression of bodily boundaries. These bloody imaginaries cling stubbornly to abortion, especially 'clandestine' abortion outside of medical spaces, ultimately shaping how it is feared and misunderstood. As I engaged further with *colectivas*, this widely shared imaginary of abortion being 'dangerous' to reproductive bodies, especially compared to pregnancy or childbirth, began to dissolve. In fact, several studies have shown that induced abortion is statistically much safer than carrying a pregnancy to term and giving birth (Raymond and Grimes 2012, Stevenson *et al*. 2023), with a significantly lower risk of mortality. These studies indicate that the risk of death from childbirth is roughly 14 to over 30 times higher than that of abortion. While risk increases with gestational age during pregnancy, overall, first-trimester abortions are considered safer for the pregnant person than the risks associated with full-term pregnancy, which include hemorrhage, hypertension and embolism, and with childbirth, which include death (Gerdts *et al.* 2016).

The widespread misconception of abortion being 'dangerous' to reproductive bodies while pregnancy and childbirth are seen as 'natural' processes that the body was 'designed' for is largely

due to the termination procedures that tend to dominate public imagination. These procedures include manual or electric vacuum aspiration, in which a narrow plastic cannula is inserted into the uterus and suction is used to safely remove the pregnancy after the first trimester, and dilation and evacuation (D&E), where the cervix is opened with medication or dilators and the pregnancy is removed with forceps and/or suction. These are medically necessary, lifesaving, and legitimate procedures. When they are managed appropriately, in fact, they can be one of the safest medical procedures; safer, even, than bringing a pregnancy to term (Raymond and Grimes 2012). Medical abortion with pills, by contrast, is a non-invasive method that uses misoprostol, often in combination with mifepristone, to induce uterine contractions and expel the pregnancy during, and at times, beyond, the first trimester. It is this form of abortion that *colectivas* most commonly practice, and the one I learned myself through a *colectiva*-led training that would reorient how I understood abortion care not as a singular biomedical event, but as a process of *being with*.

The certification workshop I took was online, but it felt anything but distant. The screen filled with colorful slides in pink, green, and purple palettes that moved deliberately through what comes before, during and after a medical abortion. This includes how the pills work in the body, what sensations are expected, which symptoms require attention, how to recognize complications, and, as the *acompañantes* emphasized, how to *care with* others and oneself throughout the process. The *colectiva* facilitators spoke slowly, softly, and intentionally, returning repeatedly to reassurance that pain does not always mean danger, that bleeding can be frightening without being pathological—but rather, a necessary sign of the abortion process working—and that the fear often stems from not knowing what is happening inside the body.

As we moved through the modules, abortion began to sound less like a rupture or a violent transgression but as a bodily unfolding imbued with care. Cramping was described in familiar terms like the waves, pressure, and tightening felt during an intense menstrual cycle rather than a medical emergency. Dosing and timing were not the only things that mattered but warmth, hydration, rest, and emotional support took center stage. Words mattered as much as presence, silence, and reassurance. This experience stood in stark contrast with how abortion was framed, or omitted altogether, in public health spaces. For instance, during sexual health brigades that I attended with a community health center, contraception and humor dominated the encounter while abortion was reduced to a footnote of legality and access, only after an attendee enquired about it.

Nevertheless, my interlocutors and broader discourse repeatedly describe entering public health institutions because they believed these spaces to be the 'safest' and most 'legitimate' avenues for accessing abortion and care more broadly. Yet, as these chapters have shown thus far, legality and formal access do not shield reproductive bodies from violent care.

What, then, makes abortion *acompañamiento* so distinct from obstetric care within medical institutions? Why do women, girls, and people with the capacity to gestate, particularly those who lack access to private options, actively seek *acompañamiento* as an alternative? If the violence shaping institutional reproductive care is rooted in a patriarchal and colonial medical-obstetric complex, then *acompañamiento* is grounded in something fundamentally different. It emerges not only as a response to this violence, but as a form of care that actively resists it. In *acompañamiento*, as the certification modeled, care is reconfigured away from surveillance, moralization, and bureaucratic control, and toward relationality, consent, and embodied solidarity. What distinguishes *acompañamiento* is thus not merely the absence of institutional harm, but the presence of *apapacho* as an alternative ethical and affective infrastructure of care that refuses the logics through which reproductive violence is normalized and rendered invisible within medical spaces.

The Interembodiment of Birth and Abortion

Trinidad had never planned to provide abortion care. Instead, she found herself one day in a critical situation that demanded it. Years before the federal decriminalization of abortion in 2021, one of her best friends had become unexpectedly pregnant. Despite being in their early twenties, her friend, Alexa, did not want to mother. Since they didn't have the option to go to a clinic in Coahuila at the time to terminate Alexa's gestation, Trinidad went online to find information about conducting a medical abortion with over-the-counter medications. Trinidad learned as much as she could on misoprostol—the dosages needed for X number of gestational weeks; what *is* a gestational week and how to measure it; which pain medications can be used with misoprostol, and which are contraindicated; the warning signs of incomplete terminations and potential complications. Fortunately, Trinidad had a friend, Dr. Gilberto, who was an OBGYN in Mexico City—federal entity that has provided legal medical abortions since 2007. Trinidad was able to corroborate her information and ask questions to Dr. Gilberto.

> ‘I had heard the term “abortion” before, surely,’ Trinidad says as we sit facing each other in a local coffee shop, our hands warmed by the coffee-filled ceramic mug, ‘I knew it existed. But experiencing it up close, and seeing not from a detached position but as a friend; it wasn’t impactful in the moral sense, but seeing Alexa in pain, her body shaking and bleeding, and the relief that emerged afterwards…’ her eyes drift off to that moment, ‘I was overwhelmed with worry, not only because I knew my friend was carrying something she did not want but also because I was scared of hurting her.’

Trinidad shares that, with her phone on one ungloved hand and misoprostol on the gloved one, she administered the medication vaginally to her friend, following Dr. Gilberto’s guidance from miles away.

> ‘I didn’t know exactly what I was doing, and back then we didn’t have the abortion manuals that we have now, and we just simply did not know that misoprostol can also be taken orally,’ she continues, ‘But I was compelled to help my friend. I had to contain myself and my emotions to be able to do it, but I did it from a place of love, empathy, consideration, of care and *apapacho* for my friend.’

In the decade following that moment, Trinidad has dedicated herself to provide abortion *acompañamiento* to both friends and strangers alike. Although she started doing it on her own, she joined a *colectiva*, where the ‘knitting of networks and creation of safe spaces’ occurred among *colectiva* members and those whom they accompany. Although *colectivas* have a standardized manual and protocol for abortion *acompañamiento*, all starting with a questionnaire to assess each person’s stage and needs, each case is deeply personalized. In some cases, for instance, Trinidad, like many other *acompañantes* I spoke with, provide their own physical spaces for those who need to have an abortion but don't have a space where they can undergo the process in a safe and judgement-free way, saying:

> ‘It is important that those whom we accompany feel embraced and hugged by us, regardless of whether we accompany them virtually only or in-person, because abortion is a process that is full of love and *cariño*, that is healthy, proper, and organic… So really, I have no place in telling those whom I walk with to stop feeling their emotions,’ she takes a sip of her coffee and continues, ‘on the contrary, I can only accompany her *through* those emotions. After all, I can’t change what she is living but I can *be there with* her.’

For Trinidad, providing abortion *acompañamiento* started both from helping her friend all those years ago but also from her own experience giving birth and surviving obstetric violence. During her first birth, she had asked her obstetrician to tie her tubes. However, the obstetrician declined, insisting that she needed written permission from her husband—one that she did not have at the time. This, along with a lack of transparency regarding information about the medical procedures the obstetrician subjected her to without her consent, haunted her and propelled her to fight for reproductive justice by accompanying women through their reproductive choices with care and dignity. Because of this experience, Trinidad insists that obstetric violence should not be limited to birth, and that it actually seeps into every aspect of reproductive care, including abortion.

> 'Even though I have never had an abortion,' she closes her eyes, 'giving birth is like having an abortion. In the end, it is a gestation. So, I try to remember my own birthing experience to describe the pain those I accompany may feel in their wombs—the colic, the stretching sensation that comes with the expulsion of tissue and blood—so that they can know what to expect,' she says as she moves her hands towards her body, dragging them towards her womb, and gesturing movement from within her body and outwards. 'Especially during longer gestations,' she adds, opening her eyes, 'I can exemplify their abortion experience through my own memories of childbirth, and I can tell them, "it's going to hurt this way; you are going to feel like you will defecate; the pain will start from the coccyx and expand forward,"' her hands describe these different sensations through movement, 'and this way, I can assure them that the uterine contractions feel a certain way and that expelling blood clots is normal… and I can empower them to know what their bodies will feel like when words and technical descriptions fall short.'

We cling to that thought for a moment.

> Wondering out loud, I ask: 'It must be hard to be emotionally ready all the time, how do you cope with the emotional acuity of each case, especially since you have to draw from a very intimate and painful experience?'

She smiles with ease, her cheeks hugging her eyes, and responds:

> 'On the contrary, it is easy to *not* feel emotionally drained despite the labor that we perform as *acompañantes*,' her voice offering the comfort of a friend, 'especially because, as we

> hug the women that we accompany, it is like we are hugging ourselves too.' She pauses for a moment, 'it is the same as with the *colectiva* itself—the *apapacho* that we give those we accompany we also give to those within the *colectiva* itself… and it is like I heal myself *through* them.'

The energy in her voice carries a soft resolve as her eyes grow smaller with the presence of tears, after all, what Trinidad just said carries weight—not the kind that wears you down, but the complete opposite: the kind that sustains. I couldn't help but also feel sustained by them.

Trinidad's story holds several threads together. It situates abortion *acompañamiento* as a deeply political practice that emerges in response to reproductive injustice and, in particular, to obstetric violence. Yet it also unsettles the tendency to treat birth and abortion as contradictory experiences or as opposite ends of reproductive life. In Trinidad's *interembodied* experience, or paraphrasing Bunkley (2022), the somatic attunement that allows for a shared embodied experience across bodily boundaries, birth and abortion appear instead along the same continuum, held by shared embodied experiences and struggles over autonomy, dignity and care. For *acompañantes* like Trinidad, to fight for dignity in one over the other would be to leave reproductive justice incomplete. This recognition animates the work of *acompañantes*, whose labor is grounded in the insistence that reproductive autonomy requires keeping birth and abortion together rather than apart. Through *acompañamiento*, after all, as Trinidad's narrative and the training show, abortion is neither rendered frightening nor exceptional, but it is understood as another reproductive moment that can unfold with dignity when held through presence, attentiveness, and *apapacho*.

As with birth, the ethos driving abortion *acompañamiento* is *apapacho* as a form of 'care that is not simply gentle or benign but generative, relational, and socially situated' (Whittaker 2023), allowing for the materialization of affect into 'social connection and collective healing' (Aguirre Rodríguez 2024). *Acompañantes*, like birth workers, rely on clinical knowledge, including gestational weeks, medications, and protocols, but these do not organize care on their own. In this way, *apapacho* does not reject medicine nor clinical knowledge, but rather, reorients it, centering the bodies, knowledges, and lived experiences of women. Finally, Trinidad's reflection on how engaging in *apapacho* with those she accompanies and with the *colectiva* itself suggests

that care and healing move in more than one direction. In *being there with* and for others, Trinidad was accompanied, held, and supported in return.

Apapacho: Physiology of Care

I met Carla, a 30-year-old teacher-turned-entrepreneur, through a *colectiva* after they accompanied her through her abortion process. We met online one morning to videochat. Both of her parents, who are devout Catholics, were at work, so we had the house to ourselves to speak in confidence. However, as we began talking, her brother arrived—who was, ironically, a Catholic 'brother' with vows to poverty, chastity, and obedience to the church. Carla excused herself and went to her room instead. She sat on her bed, and I sat on mine, both of us holding a pillow in our arms as if comforting each other despite being miles apart.

Like many of my interlocutors, Carla did not know, at least not at first, that she had options. But when the blue stick turned pink, handing Carla what she felt was like a death sentence, the room seemed to close in on her. She tells me that it felt as though choices were collapsing onto one another, like dominoes falling before she could reach out and stop them. What rose most forcefully the moment she realized she was pregnant was the full weight of having *to mother*. After all, Carla knew what mothering required because she had lived alongside that labor her entire life, even directly contributing to it in helping raise her brother or tending to her father. Coming from a middle-class Catholic family, Carla had not only witnessed her mother carry everyone on her back by cooking, cleaning, caregiving, and absorbing all the emotional labor that held the household together but had also helped her carry the load. Mothering, therefore, as Carla understood it, was a demanding, embodied labor she knew she was not ready to take on despite adamantly wanting to have children someday. This knowledge, however, sat uneasily beside other truths. Carla was in her thirties, in a stable relationship with a man who supported and cherished her, and she had just begun building an entrepreneurial project that she had dreamed of for years. So why not now? Carla wondered. At that precise moment in her life, however, mothering did not feel right for Carla.

It was then when she thought of Karmina, an old school friend whose Instagram stories were always punctuated with green bandanas and purple heart emojis—all icons of the feminist

struggle and abortion rights movement in Mexico. When Carla reached out to Karmina, despite growing apart over the years, Karmina responded. She explained to Carla that abortion was indeed legal and that she had options. With these two simple affirmations, Karmina had opened the room for Carla. Karmina explained that Carla could seek care through both public and private health institutions if she wished; that it was her right, not a privilege. Carla, wanting to do the 'safest,' most 'legitimate' route, chose to go to a public health institution. At the federal hospital, however, the clarity that Karmina had offered Carla quickly dissolved by bureaucratic *trabas* or obstacles, as the staff had asked Carla unnecessary documentation and paperwork. Carla, then, decided to go to a private clinic with her boyfriend. Nevertheless, she instantly regretted the decision as soon as she stepped into the practice: all around her, hanging over the pink walls of the clinic, were framed pictures of happy pregnant women that later became happy mothers with their tiny, perfect pink babies.

When Carla shared with the OBGYN, a woman in her forties, that the reason they were getting an ultrasound was for an abortion, the OBGYN, wearing a confused stare, said:

> *How are you not keeping it? Look! Here is the little bean with its tiny heartbeat! Are you really sure? Motherhood is a blessing, a gift! You might end up regretting your decision if you can't get pregnant later!*

Feeling devastated, Carla began doubting her decision, thinking to herself: *What am I doing?* Carla shared that she was falling for that 'manipulation,' as she walked out of the clinic with a 'baby' in her womb and guilt in her mind. But then, Carla's boyfriend pulled her back to reality, reassuring her that it was her choice, and her choice only.

The days following the OBGYN appointment were soaked with guilt and shame for Carla. She couldn't escape it: *motherhood*. It was everywhere! Her Facebook, Instagram, and TikTok feeds were positively spilling motherhood, cramming pictures and reels of happy babies and happy, glamorous *mom-fluencers*. And she did want it, but not yet. Carla knew the labor required to mother, and she was not ready:

> 'If there is a pill-shaped solution for my problem, just like there is Advil for a headache… why not take it? It's not as if I had cancer!' Carla said.

At the edge of tears, Carla remembers calling Karmina again, asking for help. Karmina, unlike the OBGYN, did not directly or indirectly push her either towards abortion or motherhood. Instead, Karmina trusted Carla to make her own decision, telling her that Karmina would *be there with* Carla every step of the way, no matter her decision. And so, she did. Guided digitally by Karmina, Carla decided to carry on with the three-day abortion process in her boyfriend's house to avoid detection and scrutiny from her Catholic parents. Thinking back to those three days, and with an audible knot in her throat, Carla recalls:

> 'I was suffering in the bathroom, expelling blood clots and dark discharge from my womb. My boyfriend was there, in the other room, but I kept thinking about Karmina and the *colectiva*. I get so emotional thinking about it, I just felt like they were *there with* me in the bathroom, surrounding me, embracing me, giving me *apapacho* and holding my hand… reassuring me that this was my decision.'

As Carla's worlds linger between us, I couldn't help but also feel Karmina and the *colectiva* there with us, holding us closer, supporting us, even from across the screen.

This feeling made me think of Mar, a psychologist in her mid-twenties and an *acompañante* from a *colectiva*, whom I also had the pleasure to talk with online at a different day and time. Mar perfectly captured this feeling that breaks through the screen:

> 'Sometimes,' Mar's voice is soft but resolute, 'it's simply about sending a heart emoji, a heartfelt message, or a phrase to let her know that you are *there with* her, no matter what,' she tells me, smiling gently from across the screen, '*acompañamiento* is about breaking through that barrier, so that those we accompany through their abortion process can feel *apapacho*, even through text. That is what *acompañamiento* is all about.'

After a meeting with the *colectiva*, Mar and I stayed online to talk. Framed by the four corners of my computer screen, Mar's hair is threaded with slivers of purple and her eyes are sharply contoured in dark eyeliner, accentuating a 'cat-eye' shape. Sparkly silver jewelry dangles from her ears as she speaks, and she smiles with the kind of smile that melts time.

Mar is deeply committed to *walking with* women through their abortion care in a safe, judgement-free way. Although the *colectiva* has its *acompañamiento* guides and manuals, for Mar and other *acompañantes* alike, *acompañamiento* is not a fixed protocol but an iterative, co-

produced process that unfolds in conversation with those they *walk with*. Much of this unfolds through screens. Mar says that the digital mediator helps those they walk with to feel safe, and other times, they feel safest staying with someone from the *colectiva* in person, especially when they do not have a safe space where they can carry on with the abortion in confidence. Nevertheless, each case is highly unique, and each member of the *colectiva* adapts accordingly, shifting their care to their specific needs. Despite the digital interface, *acompañantes* like Mar prioritize warmth and *apapacho* throughout: words of encouragement are deliberate and personal; heart emojis soothe moments of fear or anguish; silence, too, becomes a form of care, especially when it comes to knowing when to remain present without filling the space to grief, mourn, or feel relief.

> 'We are *there with* them, at every step, no matter what,' Mar says simply, 'day or night, we listen, we don't judge… we support them. And that matters.'

The care they provide extends to meet individual needs, and when the emotional weight accumulates, the *acompañantes* like Mar and Trinidad turn back to the *colectiva* itself. Their groupchat, originally logistical, has developed as a space of *desahogo*—a place of collective catharsis, release; to hold others and to be held in return. Thinking of Trinidad, I ask Mar:

> 'How do you take care of yourself when you feel overwhelmed?'
>
> 'I take care of myself by taking care of others,' she responds, 'it is like in providing *apapacho* for others, they provide it in return, and we heal together. Embracing the women we accompany and those within the *colectiva* itself is like a form of self-care in a way.'

This same *apapacho* that weaves *colectiva* members and those they accompany together in webs of emotional catharsis and support not only redefined Carla's abortion from guilt and shame to care and support but also transforms care itself into a practice to be *shared with* someone instead of one that is done unilaterally from 'caregiver' to 'care-receiver.' *Apapacho*, in this sense, coproduces how care is practiced, felt, and made meaningful between multiple bodies, effectively blurring the boundary between 'caregiver' and 'care-receiver.' What emerges in Carla's story and Trinidad and Mar's care practice is not simply *acompañamiento* as support or kindness, but rather, as a practice of care that is centered on *apapacho*, where *apapacho* acts as the connective tissue and shared physiology, the same one Dulce describes that animates birth, entangling multiple

bodies together into a *collective biology* where illness and healing are co-produced (Wentzell 2021). Thinking with Emily Wentzell's (2021) work understanding the relational and biological dimensions of HPV research on male participants, their partners, and the broader Mexican society, foregrounds the *colectiva* as a collective biology, an organism of interconnectedness woven together through shared experiences of suffering but also of healing. In this *colectiva* biology, *apapacho* becomes the physiology or affective circuitry sedimented on the 'material arrangement of relations between bodies that allows for certain potentials to act' and materialize in the body(ies) (Brown and Tucker 2020: 236). It is through this accumulation and affective sedimentation of *apapacho*, particularly its capacity to form dispositions and shape subjectivities (Watkins 2020), that *apapacho* becomes a way of '*wordling'* or attuning to 'a singular world's texture and shine' (Stewart 2020: 341), creating a protective field against the violence from the institutions.

While *apapacho* from the *colectiva* co-produced how Carla experienced her abortion, to which she refers as a largely positive and supportive process, I still ask her if she wished that anything had been different:

> 'I felt lonely about not sharing my abortion with my mom…' Carla says, 'It was such an impactful and meaningful experience for me, to choose my own body and life. I mean, making this decision for myself, and being accompanied by the *colectiva*, literally saved my life,' Carla's voice breaks, and she pauses for a second. 'I wish I could have shared this experience with her; to tell her *I'm in pain, mom* and for her to give me that maternal *apapacho* that is unlike any other. Yes, of course, the *apapacho* from the *colectiva* meant everything during my abortion but all I wanted was that solidarity and *apapacho* from my mom. And I couldn't share this with her because I knew she wouldn't understand. She has often judged close family friends who have become pregnant out of wedlock and had an abortion, calling them "sluts" and even demanding their punishment…'

I also struggle to swallow back tears. So far, I had been successful but then, Carla looks directly at the camera and talks to me as if *I* were her mother, her voice pleading amid sobs:

> 'You know what I am going through, mom, as a woman. You know more than anyone! You know what I have done, you know I have had sex because you have done it too, mom. There was a point when I was pregnant, mom, and I couldn't tell you about it. I couldn't tell you I was pregnant and that I didn't want it. Mom, you weren't *there with* me through

my pain. You couldn't be *there with* me through my loss. Even when I was still having some lingering effects from the abortion and you didn't know about it, you kept telling me to stop being lazy and help around the house, to set the table for my brother and my father, and I just wanted to scream and tell you *I am in pain mom! Be there with me, give me apapacho*, but I just couldn't.'

I feel Carla's grief through the screen, driving tears to my eyes. Feeling the weight of this grief we now share settle between us, I tell Carla that I am sorry she couldn't share this experience with her mother, and that, even though it will never compare to her mom's, I send her *apapacho* through the screen—she says she feels comforted by this.

Before we say our goodbyes, she wonders out loud:

'Now that everything is over, I keep thinking… What would have happened if I didn't have Karmina and the *colectiva*? What if I had had God stuck in my head? What if I had become an unhappy mom and my kids unhappy children?'

Carla's final question lingers, not as counterfactual speculation, but rather as something to think with. What *would have* happened without the *colectiva*, Karmina, *acompañamiento* and without *apapacho?* What *does* happen when, women or girls, in Carla's own words, have 'God stuck in their heads'?

Chapter 3

Good Girls, Good Mothers: Disciplining Reproductive Bodies

On January 3rd, 2026, Deisy, an 11-year-old girl from the state of Chiapas, was left on the steps of a hospital's emergency department by her allegedly 18-year-old 'husband' to give birth[6]. He left her there, in active labor, without leaving any of his personal information or contact details. Feminist *colectivas* and the authorities are still searching for this man, seeking to charge him with sexual violence towards a minor. Deisy was discharged on January 21st after fighting for her life due to complications associated with a child pregnancy. What is most disturbing about Deisy's story, leaving aside the fact that a child was forced to gestate and to birth, was how the media and online discourse engaged with it. Different news outlets seemed to contradict each other, insisting her age was 10, 13, 15 or even 17 at the time of her birth. Others similarly referred to Deisy as a 'young woman' or 'teenager' that 'became' a mother despite being an allegedly 11-year-old girl according to the official identification documents presented at the hospital. Still, regardless of her precise age, Deisy is still a *girl*.

Unfortunately, Deisy's story is not an isolated or out-of-the-ordinary event, but a pattern lived by many girls in Mexico. In fact, thousands of girls aged 10-17 give birth in Mexico every day—a statistic that places the country on the very top of child and teen pregnancy in the world (Jímenez Muñiz 2025). According to INEGI (2023), there were 108,760 girls aged 10-17 who gave birth in 2022 alone. Most of these pregnancies (82%) were conceived with men over the age of eighteen (INEGI 2023), who were in a 'free union,' since article 148 of the Federal Civil Code established in 2019 that only adults may legally contract matrimony. Following the latest INEGI

[6] Reports stipulated Deisy's actual age to be 13 and that her parents registered her birth two years later, leading her to have a birth certificate that displayed her age to be 11. I have decided to rely on the official documentation presented at the hospital in writing about Deisy but be aware that this is still contested as of April 2026.

2024 results on child pregnancy, feminist *colectivas* and advocates analyzed the data and elaborated a table to showcase the disturbing age gaps between the youngest 'mothers' who gave birth in 2024 compared to their respective 'partners.' Unsurprisingly, the table quickly went 'viral,' appearing all over social media. This table shows that the largest age gaps include that of an 11-year-old girl who was impregnated by a 47-year-old man, encompassing a 36-year gap, and two 12-year-olds each pregnant by a 50-year-old man, having a 38-year gap. While Coahuila does not appear in the table among the cases with the largest age differentials, the state remains among those with the highest proportions of child pregnancy, with more than 6,000 underage pregnancies in 2024 alone (González 2024).

Deisy's story and others like hers point to the kind of distinctions and boundaries drawn around different kinds of reproductive bodies, what work these boundaries perform, and how these distinctions are ultimately constructed and perceived by Mexican society. As I will show across this chapter, the distinction between girl/teen/woman is a biopolitical one that is meant to discipline reproductive bodies through biosocial constructions surrounding 'good motherhood' and thus, womanhood. To clarify, this chapter does not seek to trace how maternal subjectivities are constructed and experienced by girls and women, nor to examine how health professionals define adolescence or motherhood, or even how motherhood might be 'empowering' for girls, as much of the existing scholarship does. Instead, I deliberately depart from these approaches by interrogating how the very constructions that separate child from teen pregnancy, and that normalize motherhood as an appropriate outcome, operate as disciplinary technologies over reproductive bodies. These distinctions and biosocial constructions do not simply describe pregnancy in minors but actively legitimize the commodification and exploitation of girls' reproductive labor—an overlooked and invisibilized component of reproductive injustice.

DRAWING THE LINE BETWEEN CHILD/TEEN BODIES

During the month of November 2025, Professor Kimberley Brownlee delivered the three-part public lecture series for the 2025 Annual Uehiro Lectures at the University of Oxford on 'Reproductive Rights.' During the third installment on 'Girls' Rights Against Gestational Labour,' Professor Brownlee compared child gestational labor to other forms of child labor and to organ donation to argue that (1) gestation, like insidious forms of child labor, including slavery,

prostitution, and sex-trafficking, poses significant risks to children's physical and psychological wellbeing, and (2) just as children are protected from serving as life-preserving organ donors, because of the kind of momentous decision it entails, they must also be protected from the life-cultivating work of gestating and mothering.

Some of the members of the audience, most of whom were seemingly White men, were concerned about the implications of this line of reasoning, voicing questions along the lines of:

> *'Well, a 16-year-old girl is physically and psychologically more mature than a 10-year-old, what happens then?'*
>
> *'If a girl has started menstruating, doesn't that mean her reproductive body is ready for its purpose? Shouldn't gestating and mothering therefore be allowed?'*
>
> *'If a girl does not have the right to gestate and mother, does that mean she does not have the right to sex?'*

Bringing these questions with me during fieldwork made me consider the assumptions they rely on. Would we pose the same questions about *boys*? Would we ever suggest that a 16-year-old boy *should* become a father on the grounds that he is more physically and psychologically 'mature' than a 10-year-old? Or is it only girls who are rendered 'mature enough' when child pregnancy needs to be justified?

When it comes to drawing the line between child and teen bodies, menstruation often appears as a threshold—a biological event that magically transforms children's bodies into 'mature' ones ready to gestate and to mother. Yet this biological deterministic logic collapses reproductive capacity into 'maturity' and 'readiness,' without turning to look at how children are affected by the physical, emotional, and developmental harms that gestating and mothering entail. Scholars linking environmental and reproductive injustice further complicate this biological determinism by articulating the ways in which environmental violence, through the unequal exposure to chemical toxicity and pollution that disrupts endocrine systems, can lead to earlier menses (Weiss *et al.* 2024, Colangelo 2024). Similarly, studies have also shown that a history of sexual abuse in childhood can also accelerate menses in children (Boynton-Jarrett *et al*. 2013). Would it still hold that children's reproductive 'readiness' renders their gestational and maternal labor permissible under these conditions?

Lastly, what does it mean to ask whether denying a girl the right to gestate also entails denying her sexual freedom? The difference between the 'right to gestate' and the 'right to sex' is control. The assumptions underlying this question reveal how girls' sexual autonomy remains conditional only insofar as it begets the possibility of gestation and mothering as forms of social punishment and control.

Despite biomedical narratives that aim to rank and differentiate bodies at the 'inflection point' of 16 years old simply because infant health indicators, including infant mortality, seem to stabilize at a population level (Phipps and Sowers 2002), child (10-12 year olds) and teen (13-19 year olds) bodies materially register the harms and risks of gestating and childbirth virtually the same (Chakole *et al*. 2022, World Health Organization 2024). Some of the justifications for making the distinction between 'child' and 'teen' bodies include biological rationales that emphasize the physical underdevelopment in girls under 15, including immature pelvis leading to cephalopelvic disproportion, uterine immaturity associated with preterm delivery, and feto-maternal competition for nutrients (Ali Kiani *et al.* 2019, Bednarz *et al.* 2024, Gibbs *et al.* 2012). However, the World Health Organization (2024) claims that girls and teenagers aged 10-19 face higher risks of obstetric complications, including death. Unlike infant mortality, maternal mortality stabilizes when reproductive bodies reach their twenties (Ali Kiani *et al*. 2019), not when they are still children and teenagers. At the level of the body, after all, 'teen' pregnancy *is* child pregnancy. Therefore, hereto after, I make the explicit choice to name pregnant 'teens' as children to refuse the normalization of child pregnancy and the adultification of children's bodies as a justification.

What, then, does drawing the line between child and teen pregnancy do and for whom? As this chapter will show, this biopolitical distinction, based on the paradoxical and simultaneous adultification of girls and infantilization of women, serves the medical-obstetric complex as a patriarchal/gendered system by obfuscating the oppression of reproductive bodies. This chapter turns to this obfuscation to explore how patriarchal/colonial logics surrounding motherhood, womanhood, and girlhood are reproduced, embodied, and enforced by men and women alike. I do this to understand why child pregnancy persists even when abortion is legal and health/education coverage ostensibly exist, and why solidarity, even among women, becomes limited. I don't mean to imply this embodiment of patriarchal logics and resulting limited solidarity is an individual, interpersonal failure, nor I mean to place blame onto women themselves. Rather, this patriarchal

embodiment is due to broader pathogenic ecosystems of misogyny that become embodied, after all, as Simone de Beauvoir (1948) reminds us, 'the oppressor would not be so strong if he did not have accomplices among the oppressed'. Nevertheless, this chapter seeks to trace how patriarchal-colonial logics construct difference in reproductive bodies as a way to normalize, regulate, and extract biopower through both biological and social reproductive labor.

Anti-girlism as the anti-body logic of girlhood

There is a large purple dildo standing upright on a table. Condom wrappers lay scattered nearby, their metallic edges catching the sunlight. Spread beside them is a fan of brightly colored pamphlets advertising free sexual and reproductive health services at the clinic. Shielded by nothing but a tent, Dr. Juan and I are embraced by the thick midday sun as students and professors shuffle between tables at a sexual health brigade in a public school. Dr. Juan is an OBGYN at IMSS who has also served for the past three years as the Chief of the 'Module of Friendly Services for *Adolescents'* in a community health center. Some students pass by quickly, pretending not to see the display. Still, the lingering stares from male students were drawn from afar as they slowly and albeit reluctantly make their way closer to the booth.

'Would you, young men, like some free condoms?' he called out.

'Yes!' The boys answered in unison, their voices erupting in laughter.

Dr. Juan reached for the purple dildo, gripping it confidently and lifting it into view.

'Then,' he said lightly, 'first show me how to properly put one on.'

The group exploded. '*Ew!' 'No way!' 'I'm not doing that!' 'I'm not a faggot!'* They shoved each other forward, retreating and advancing in turns. Dr. Juan smiled, unflinching. With a small flick of his wrist, he pointed at one of the boys and placed a condom in his hand. The boy's face turned crimson. He hesitated, then brought the wrapper to his mouth, tearing at it with his teeth.

The crowd roared.

'No, no, no,' Dr. Juan said calmly, his voice steady. 'That's not how you open a condom. You'll break it and get someone pregnant.'

Still blushing, the boy tried again, fingers fumbling as he carefully opened the wrapper. He rolled the condom down the mannequin, his friends grinning as they filmed from behind their phones.

Applause broke out.

'Alright,' Dr. Juan said, 'you're not done yet. Take it off properly.'

The boy tugged at it quickly, roughly.

'No,' Dr. Juan interrupted, gently. 'Pinch the tip and roll it up slowly.' His hands were floating above the mannequin, softly motioning the movements to mimic.

The laughter softened. The crowd leaned in, then applause broke out once more.

When the demonstration ended, Dr. Juan handed out condoms to the group, all grinning and energized. Before they left, he gestured toward the pamphlets.

'These services are free,' he reminded them. 'Checkups, contraceptives, tests. No judgment. No cost. Any questions?'

There were none. They took the condoms and moved on, pockets full, still laughing.

A few moments later, a group of female students approached the table. The atmosphere shifted. They stood closer together, their expressions quieter, focused, the skin on their foreheads folding over in curiosity.

When Dr. Juan asked if anyone knew how to use a condom, they shook their heads.

'That's okay,' he said softly. 'Let's learn together.'

When Dr. Juan invited one of them to try, there was a brief pause. Then a girl stepped forward, her shoulders slightly tense, fingers hovering above the table. She picked up the condom, turning it over in her hands, unsure which way was up. Another girl leaned in beside her, pointing softly.

'No, that side,' she whispered, guiding her fingers.

Seeing that they were still grappling with opening the wrapper, a third joined them, mimicking Dr. Juan's earlier gesture. Together, the three of them worked slowly, carefully, rolling the condom down the mannequin. When it finally sat correctly, their bodies relaxed all at once. One of them clapped and they all high-fived each other as they grinned wide.

‘Okay, now take it off,’ Dr. Juan said.

Again, they moved together. One held the mannequin steady, another pinched the tip, the third rolled it upward with deliberate care. They nodded to each other as if confirming each step. When they finished, they exchanged another round of high-fives; triumph glowing from their faces.

The questions came quickly after that. They asked about different contraceptive methods, about side effects, about what to do if a condom breaks. Their voices overlapped, hands lifting, eyes intent. One of them asked about abortion—whether it was legal, how it worked, where someone could go to get one. As she spoke, two girls beside her glanced at each other, leaning in close, whispering something I couldn’t hear. They nodded, eyes fixed on Dr. Juan, waiting. More questions followed. *Could parents find out? What happens if someone is under eighteen? Is the morning-after pill the same as an abortion?* They stayed clustered around the table, bodies angled inward, refusing to drift away. The heat pressed down around us, the noise of the brigade continuing in the background, but the girls remained focused, deliberate. Each answer seemed to open space for another question. They listened closely, correcting one another, repeating instructions back in their own words. When they finally stepped away, they did so slowly, still talking among themselves, pamphlets folded carefully in their hands.

This vignette is not about the ‘inherent’ differences in ‘maturity’ between boys and girls, but about how responsibility is unevenly embodied along gendered lines. The boys and girls that gathered around Dr. Juan’s booth were roughly the same age, yet their engagements were registered very differently. The boys’ laughter, hesitation, refusal, and homophobia were excused as expressions of youth, immaturity, and discomfort. Whereas for the girls, they listened closely, carefully asked questions, and held on to pamphlets. But this ‘seriousness’ on girls’ part should not be read as their ‘inherent maturity’ over boys but as a conditioned and embodied response to a responsibility that had already been assigned to them. Public discourse frames reproductive knowledge, risk, and consequence as a girl’s responsibility, while boys’ detachment is tolerated, even normalized. In this way, girls appear more ‘mature’ not because they are inherently so, but because of the internalization and embodiment of the expectation of assuming responsibility for reproduction and its consequent male reproductive dependency (Brownlee 2025), which exculpates boys, and men in extension, from both reproductive responsibility and consequence. This construction of ‘maturity’ relies on the *adultification* of girls as a central mechanism of the

anti-girlist logic of girlhood, where girls are treated like adults and are assigned adult responsibilities and accountability simply for being *girls* (Brownlee 2025). Anti-girlism is misogynistic in that it materializes its hatred or contempt for girls as 'female' in its practice, treating 'girlhood' as incompatible with the forms of freedom, autonomy, and youth more readily afforded to men and boys for being 'male.'

This anti-girlist logic also relies on the *womanization* of girls through biosocial constructions of 'good motherhood.' For instance, on February 2nd, 2024, Marely Cruz, a girl from Coahuila, celebrated her *quinceañera*. Months later, in September 2025, she announced on Facebook that she was pregnant and expecting to give birth when she turned sixteen. The news first appeared through her own public social media account and circulated quickly through local Facebook pages, news media, and community reposts, accumulating reactions within hours. In the photograph she shared, Marely stood smiling at a gender-reveal celebration, holding her protruding belly with both her hands as a blue sign behind her announced she was expecting a boy. The comments that followed were warm and abundant. Heart emojis stacked beneath the image. *Congratulations, Blessings, How joyful!* users wrote. Some proposed organizing a baby shower. Others offered prayers for a healthy pregnancy and an easy birth. While barely a handful of users expressed concern about Marely's age, their comments were quickly folded into a broader chorus of encouragement. Her pregnancy was framed as an event already underway, something to be celebrated, supported, and prepared for. Marely's gestation is rendered celebratory precisely because it aligns with socially acceptable constructions of 'good motherhood,' where the *quinceañera* as a rite of passage into 'womanhood' allowed the reclassification of pregnancy into 'motherhood.' These overlapping rites of passage worked together to normalize her gestational labor as appropriate, expected, and even desirable.

While Marely's gestational labor was embraced as a moment of joy and communal support, other pregnancies from girls and women alike, are met with condemnation and punishment, particularly when they disrupt dominant narratives of 'good motherhood,' and thus, 'womanhood.' For instance, in March 2025, Renata, a fifteen-year-old girl from Saltillo, had been hospitalized and was fighting for her life after taking abortion medication on her own to terminate a six-month pregnancy. The news post spread rapidly, drawing hundreds of comments within hours. The thread grew long and tangled, branching into replies, counter-replies, edited messages, and deleted posts.

The first comments appeared almost immediately. Some women writing as mothers emphasized presence, guidance, and responsibility, stating that girls who abort are uneducated and must lack parental support. Others challenged the framing of the news itself, accusing the outlet of sensationalism and revictimization. These comments were met with swift rebuttals. Users insisted that reporting facts was not revictimization, that Renata was not a victim, that at fifteen she 'knew *exactly* what she was doing.'

Language sharpened quickly. Words like *killer, karma, punishment, sin* appeared repeatedly. Commenters debated whether Renata was a girl, an adolescent, or *ya una señora* ('already a Mrs.'). Some argued that children do not get pregnant, and that, because of this, she was already a woman. These claims clash with others under different news posts of adult women undergoing abortions. These comments often *infantilize* women who terminate their pregnancies, stating that they are not 'mature' or 'educated' enough to make their own decisions. Still, for both Renata's case and those of adult women who undergo obstetric complications or even violence from terminating their pregnancies, most comments (predominantly shared by other women) celebrate and even demand their suffering and embodied harm, claiming it a 'just' punishment for their 'transgressions.' Interestingly, while the 'crime' committed for which these women and girls 'deserve' punishment is somewhat about 'killing babies,' it is mostly about their having non-reproductive sex. After all, these comments argue that a girl who has sex *is* a woman. The logic from these comments follows: If she 'becomes' pregnant because of her 'promiscuity' and decides to terminate, she becomes an *un-mother* and, therefore, an *un-woman*.

Under Renata's news, users insulted one another directly, correcting spelling, questioning intelligence, dragging personal lives into the exchange. Commenters accused others of being puritanical, ignorant, immoral. Some wished Renata would die. Others laughed. A few asked where her parents were. Feminism was invoked as both a defense *and* an insult. Several other comments were deleted mid-thread, leaving gaps marked only by *Deleted comment.*

These contradictory reactions articulate how a medico-legal logic of caring for women and girls extends far beyond formal institutions, becoming embodied and enforced by men and women alike. Within this logic, care is no longer oriented toward the woman or girl herself but toward the preservation of fetal life which reflects a moral order where respectable motherhood, the nuclear family, and social conformity take precedence. In this way, women are *infantilized* and seen as

incapable or immature enough to make their own decisions while girls are *adultified* into accepting responsibility and *womanized* for engaging in sexual acts that deserve punishment. Reproductive anti-bodies are thus 'framed outside of socially acceptable models of womanhood, motherhood, and citizenship' (Jolly 2025: 867), where these constructions become modes of institutionalizing anti-girlism as a form of disciplining reproductive anti-bodies. This anti-girlist logic, in turn, places women and girls along the same categorical class because doing so normalizes, justifies, and obfuscates the commodification and exploitation of their reproductive labor.

'Good Motherhood' as Technology of Discipline

> 'Motherhood has always been, and continues to be, a colonized concept—an event physically practiced and experienced by women, but occupied and defined, given content and value, by the core concepts of patriarchal ideology' (Fineman 1991: 274).

Olivia was sixteen at the time of her first sexual relationship[7]. Back then, she lived on the outskirts of town, where the roads were still unpaved and the sky was tarnished a permanent gray from the factory fumes. Most families in the area, including hers, depended on the factory for work. It shut down decades later in 2022, but at the time, it structured daily life, providing shifts and wages for entire communities.

> 'I was in love with my boyfriend,' Olivia tells me as we sit across from each other one Tuesday afternoon drinking coffee, 'So, when he said he wanted to play with me, I said yes. I didn't even know that what we were doing was sex until I got pregnant.'

Six months after her first sexual encounter with her boyfriend, and without knowing that she was pregnant, Olivia was looking for part-time employment at the factory to contribute to her family's finance. During the onboarding process, Olivia underwent laboratory work to ascertain her health status. However, the test results came back positive for pregnancy. Olivia was astounded, *how could have this happened?* She wondered.

[7] Recall from Chapter 1 that Olivia is in her forties and works as a domestic worker as she waits for surgery at IMSS to remove an ovarian cyst that has been growing for years. Olivia finally received her cyst-removal surgery in February of 2026 at a different IMSS facility. The surgeon removed a 2 kg mass and conducted a nonconsensual salpingectomy during the procedure. He did not offer any explanation to Olivia.

Olivia tells me that growing up in a Catholic working-class family meant never talking about sex. Even in public school, sex was whispered in hallways and framed as the 'marital embrace' between a man and a woman. But the practicalities of sex, the biology and physics behind it, were never openly discussed—at least not with and among girls. Boys, on the other hand, shared the 'nitty gritty' details of sex through pornographic magazines with other boys. So, Olivia tells me, when her older boyfriend insisted on 'playing with her,' he knew exactly what they were doing.

> 'I remember feeling scared and confused,' Olivia continues, 'but I was even more scared about telling my mom… but when I finally confessed, I had to leave home. I moved in with my boyfriend, dropped out of school, and we got married because that is just what you have to do.'

After not knowing about her pregnancy for six months, Olivia went to the remaining prenatal checks alone, since her 'husband' had to also drop out of school and work in the factory to support them.

> 'When I was in labor,' Olivia says, 'it finally dawned on me that I was no longer a child but a woman, a mother. I couldn't go with my friends and play or go to school to learn… all of that was over the moment I gave birth. I had to tend to my children and my husband.'

Although Olivia did not work in the factory to contribute to her family's finances, she still contributed to the political economy of her family by performing unpaid gestational and maternal labor. Through this labor, the State asserts and extracts biopower from reproductive bodies (Foucault 1978, Isard 2025), reconfiguring them into sites through which broader class relations and patriarchal-capitalist structures stabilize. In this way, the political economy of the family, crystallized through gestation and childbirth as forms of reproductive labor, as Olivia's story delineates, renders reproductive and domestic labor as natural, commodifiable, and invisible (Engels 1884).

Even decades after Olivia's pregnancy, her story continues to be echoed by girls and women in Mexico. Like Olivia, sexual knowledge for Carla, whose story we delved into in Chapter 2, did not arrive through formal education or intergenerational conversation, but through late-night internet searches, whispered conversations with friends, and fragments gathered and stitched together over time. Unlike Olivia, Carla first had sex at twenty-one with her current boyfriend. She

knew, in a basic sense, what sex was, yet her relationship to sexual health remained distant and shadowed by silence. Now in her thirties, but not ready to mother, Carla had recently received abortion *acompañamiento*—an experience she described as profoundly supportive, but one she could not share with her parents, especially her mother.

Growing up in a middle-class Catholic household, Carla never felt comfortable speaking with her mother about sex, her body, or desire. Gynecology appointments became spaces of discomfort. She often attended them alongside her mother, sitting in the same waiting rooms, sharing the same physician, acutely aware that her sexual life was something she could neither fully discuss nor fully hide. She described her gynecologist as 'conservative,' even 'pro-life,' a figure who reinforced her sense that reproductive care was not neutral but, Carla says, moralized. Carla had stopped attending church with her parents at twenty, a decision that, Carla insists, subtly, but permanently, reshaped her relationship with her mother. She recalled moments when her mother expressed open prejudice toward women in their community, including close family friends, when one of them became pregnant out of wedlock and had an abortion. Religion, she explained, was not a distant abstraction in her household but a daily grammar, structuring the conversations that could be shared from across the kitchen table, and which had to linger into the margins of late-night curiosity.

Carla was initially confused when she tested positive for pregnancy. Much of what she knew about birth control came not from clinicians but from circulating online narratives warning of side effects, hormonal disruption, weight gain, and mood changes. Carla wanted to avoid such disruptions by not relying on hormonal birth control and to rely instead on physical barriers like male condoms and on the pull-out method. That one time when this latter method failed, Carla relied on emergency contraception, or 'Plan B.' However, Carla and her boyfriend were unaware that Plan B does not work during ovulation, which, as Carla regularly tracks to prevent pregnancy, was exactly the cycle phase that she was in. As a teacher-turned-entrepreneur, Carla situates her own experience within a broader landscape of silence and vulnerabilization, especially among girls. Sex education, Carla says, is the State's responsibility and it is not about encouraging sex per se, but about naming power, consent, and bodily autonomy early, insisting:

> ‘It’s important,’ Carla says, ‘to equip children with sexual health knowledge and with their bodily autonomy so they don’t feel pressured to “prove their love,” or to give in to what a boyfriend asks and become pregnant.’

Rather than treating Carla’s discomfort or silence as false consciousness or through a liberal script of autonomy denied (Mahmood 2006), they become constitutive effects of an ethical formation in which ‘good womanhood’ is practiced through modesty, deference, and labor, where the State, religion, and heteronormativity entwine to regulate her sexuality (Jacqui Alexander 2005). Thinking with Black feminist theory further situates Carla’s story around racial-colonial histories that organize gender itself, where reproductive governance precedes and structures ‘gender’ by making women bear the labor and liability of managing sexuality through labor, including tracking her reproductive processes (Hamper 2020, Massey 2024, Spillers *et al.* 2007, Aganthangelou and Ahmed, 2020).

At the same time, linking Carla to Olivia through labor clarifies how class reorganizes, rather than dissolves, the reproductive labor imposed upon bodies in becoming and maintaining ‘good women,’ and therefore ‘good mothers.’ While these demands emerge differently across Carla’s entrepreneurial middle-class world and Olivia’s working-class factory town, both remain disciplined through the labor required to perform respectable femininity, sexual propriety, and maternal responsibility, becoming a way of ‘doing gender’ or ‘becoming women’ and mothers through labor (Butler 2004, Oyěwùmí 1997). In this sense, reproductive governance operates through the embodied demand that reproductive bodies align themselves with normative scripts of ‘good motherhood’ and the forms of labor that such a designation entails, including the affective, bodily, moral, and social reproductive labor necessary to sustain heteronormative domesticity and the broader patriarchal-capitalist social order (Hartman 2008, Spillers *et al.* 2007). Failure to embody these ideals often risks gendered illegibility, especially as this failure disrupts the broader social-economic order that ‘good motherhood’ maintains at the level of both body and family.

Good Girls, Good Mothers… Good Feminists?

The CJEW is enclosed within concrete walls, its entrance marked by official signage and the low hum of activity inside. The waiting area is quiet but never empty. Women arrive alone or with

children, some holding folders thick with papers, others clutching their phones tightly in their hands. A receptionist sits behind a desk, asking questions in a steady voice, sliding forms across the counter. Each woman is asked to fill out a basic registration sheet: name, age, municipality, and to check the box of the type of violence experienced (psychological, physical, domestic, sexual).

Rocío meets me in one's of the offices down the hall. Like most of the women working at the CJEW, Rocío is a psychologist in her fifties with a master's degree in family therapy and has worked at the center for a year. Before that, she worked as a counselor in middle schools. Now, her days are divided between tending to *usuarias* or 'users,' the women who come seeking services, and traveling across municipalities to give workshops and lectures in schools and municipal government offices. Most women arrive, she tells me, because of physical and psychological violence, most often within domestic settings. They come in what the center formally terms 'victim quality.' Once registered, each 'user' is assigned a social worker. In the orientation area, she is then assigned a lawyer. A longer form follows, detailing the violence experienced and helping determine the legal route to be taken. Alongside the legal process, every 'user' must undergo a psychological evaluation. Rocío explains that this evaluation results in a 'technical opinion', a legal document requested by the Public Ministry. The number of psychological sessions depends on the severity of the case and the woman's emotional state in direct relation to the reported violence. During these sessions, they screen for congruency in time, mode, and space to secure a conviction.

As Rocío speaks, cases layer over one another. Many women, she says, carry an 'ideal of the family' that makes them reluctant to proceed. Even when their husbands are abusive and violent towards them, they do not want to be 'the one who destroys the family', because, in this context, as seen in the previous section, women's reproductive, domestic, and maternal labor holds the integrity of the political economy of the family, and thus, broader societal structures, together.

Rocío speaks, too, about her own family. She is a mother of two adult daughters, both with children of their own. Her son passed away a few months ago due to substance abuse. When she speaks of him, her voice clearly softens. She tells me she encourages her daughters and 'users' alike to construct a reality rooted in family and partnership; to be, in her own words, 'good mothers'

and ‘good wives’. Whereas in men-only rehabilitation centers where she gives workshops, she urges young men to ‘seize every opportunity’.

Violence, she insists, begins long before marriage when women ‘choose’ to marry men who are already abusive, admitting:

‘Gendered violence is everywhere.’

Still, Rocío is clear that she does not consider herself a feminist, stating plainly but without defensiveness or without my direct asking:

> ‘Although I come from a matriarch and am myself a mother of two daughters, you would expect me to be a feminist, but I am not. I believe in equality. There are injustices towards men, and I feel like there is this legal, social, and cultural gap. There are men who don’t have where to go to if they’re not allowed to see their children despite paying for their welfare. Women have their center here, but the authorities are sending men to the general institutions. How is that equal treatment? That is why I’m working on a workshop on “New masculinities” where we break those paradigms of women having to stay home and where men don’t feel discriminated against if they participate in the family, so that men can finally say “I am not being discriminated against because I allow my wife to work,” and so that they can one day have centers dedicated to men.’

The CJEW and those within work to ‘empower’ women, but what does it mean to fight for ‘equality’ when these very systems were not created to treat women and men equally? As Amia Srinivasan (2021: 10) reminds us in the context of sexual violence, crimes often perpetuated by men towards women, the law often ‘deliberately stacks the deck in favor of the accused’, in this case, men. In fact, the very creation of women-focused institutions like the CJEW implicitly admits the State’s systematic failure to recognize women and men equally in front of the law—pattern that crystallizes in Mexico where there are 10 femicides daily committed by men, most leading to no conviction at all (García Pareja *et al*. 2023). In a context where the law as a system is not designed to treat everyone ‘equally’, then ‘equality’ becomes a way of institutionalizing men as the ‘universal’ citizen.

For a woman, then, to access the CJEW resources, which stands for the Center for Justice and Empowerment of *Women*, she must arrive in a ‘victim’ quality. This reasserts the State’s

position as protector and savior of 'battered women,' delimiting 'empowerment' and 'justice' based on the categorization of women as 'suffering subjects' (Robbins 2013) who must demonstrate their *gendered citizenship* through victimhood. Much like the survivors of Chernobyl who were required to prove their biological victimhood to access citizenship rights and State support (Petryna 2002), here, reproductive bodies must prove their womanhood has been violated in legible, institutionally recognizable ways (e.g., type of violence experienced: domestic, sexual, psychological…) to be constructed as worthy of full state recognition, legal rights, and protection through the CJEW's services. Ultimately, the State positions itself as arbiter of who counts as an intelligible, proper woman worthy of protection and recognition.

Seen this way, the CJEW embodies a White neoliberal feminism that gives way to stigmatizing what the State considers to be unintelligible and illegitimate forms of womanhood and citizenship associated with 'un-gendered' or 'un-woman' bodies (Snorton 2017). This mechanism of gendered illegibility and non-citizenship further embodies the 'savior ethos' of 18th century Englishwoman Jane Bull whose 'White imperialist femininity' facilitated the criminalization of the native, unmarried, sex-working, enslaved women and those engaging in non-reproductive sexuality in the name of 'protecting women' (Lewis 2025). Differently put, by delimiting empowerment and justice to legal and economic 'liberation,' the State reasserts itself as protector and savior of women, but only after defining womanhood as being dependent, not combative of, the State and only after her *gendered citizenship* is violated. Within this framework, those who disrupt State order or challenge the patriarchal-colonial logics underpinning State care are rendered unintelligible as proper, good women, and instead, they become *un-gendered, un-woman*, and therefore, *bad* feminists who exist outside of socially acceptable models of womanhood, motherhood, and citizenship:

> 'No one can understand you better than another woman can,' Mar says from across the screen, 'but not every woman can. After all, what is the point of having women in positions of power if they keep bringing men, as in, *the idea of men* to the table?'

Mar, the *acompañante* introduced in the previous chapter, is known within her family as the 'feminist sheep,' or, in Ahmed's (2017) words, the 'feminist killjoy' who always 'ruins' family dinners. Outside the home, Mar is more readily recognized as one of those *pinches feministas*

locas—the same 'fucking crazy' feminists reprimanded for painting walls, vandalizing buildings, and disrupting public order.

> 'We're constantly explaining ourselves,' Mar says, her voice steady but tired, 'constantly proving ourselves—as if being a feminist were something bad, as if fighting for justice were worse than what they do to us.'

Mar tells me about a reproductive rights conference she once attended, where a woman in her 50s approached her and said: *'I have a daughter who keeps making poor decisions,'* referring to her daughter's repeated involvement with violent partners, *'but honestly, what worries me most is that my son might end up marrying one of those* pinches feministas locas *who vandalize buildings and paint over walls.'* Without hesitation nor confrontation, Mar remembers responding:

> 'Instead of blaming your daughter,' she told the woman, 'Teach your son to respect women. Your daughter could be killed by a violent partner—like ten women are every day in Mexico—and the people who would be out on the streets demanding justice for her would be us. Those same crazy feminists.'

Thinking of how the State formally recognizes who counts as a 'good woman' and a 'good feminist', I ask Mar:

> 'What does feminism mean for *you*?'
>
> 'For me,' she explains, 'being a feminist means questioning what you're taught. It means freedom. It means having options.' She pauses, then adds, 'even though I'm a lesbian, abortion is still my fight. It affects me as a *woman*. And once I understood that feminism was about options, I knew I wanted that for everyone.'
>
> 'As a psychologist,' she carries on, 'feminism acts as my compass in order to disrupt colonial and imperialist notions that not only inform the field of psychology but those that are deeply engrained in our society and that may still be there in my mind. That is why I try to work from a decolonial, feminist, intersectional, and anti-imperialist lens to resist imposing moral hierarchies or universal narratives onto the deeply situated reproductive experiences of those whom I accompany.'

‘What makes your practice as an *acompañante*, and the *colectiva*’s practice as a whole, so different from State/health projects?’ I finally ask her.

‘We as *acompañantes* are punk, warm, friendly, and feminist,’ she softly laughs before continuing, ‘and I wish there could be a bridge between the State, with their white, bright lights and cold atmospheres, and the warmth and punkness of *colectivas*. We don’t have to agree on everything but at least collaborate toward a common goal.’ Her voice sharpens slightly. ‘I wish they would put women and people with the capacity to gestate at the center, and leave behind religious, capitalist, and personal interests.’

Conclusion

What would it mean to imagine a State that is 'punk', 'warm', and capable of offering solidarity to all and not just *some* women? Can we not think of and enact different (and intersectional) ways of 'empowerment' and 'justice' for *all*?

During the 8M march in Saltillo, a TERF *colectiva* publicly claimed ownership over what was, in principle, a collective demonstration and requested the presence of the *Policía Violeta*, a police unit composed of women officers, in exchange for maintaining a 'peaceful' protest. The *colectiva* explicitly claimed the need for the police force to 'protect female participants from violent males posing as women', alluding to transwomen. Although this unit's feminist branding appears to signal protection among women, Lola Olufemi (2020: 31) reminds us that 'the police are deployed to do the state's bidding and are enmeshed in the oppressive consequences of this task… [which] is why, despite neoliberal feminism's insistence, increased numbers of women entering the police force can never transform its practice'. In this way, Olufemi says, the State proves itself to be yet 'another arm of patriarchy' (p. 25), mimicking the language of equality, empowerment, and freedom while enacting the opposite. This scene is a powerful illustration of care obfuscation in practice: through its ostensibly 'feminist' police force, the State attempts to demarcate the official, State-sanctioned 'end' of the march, even as the continuation of participants beyond the police line makes visible those who remain outside the acceptable bounds of womanhood, citizenship, and State-recognized feminism. At the same time, the presence of the police force crystallizes the very limits of feminist politics that seek protection through the same institutions that engender reproductive and gendered violence, confirming that 'the master's tools will never dismantle the master's house' (Lorde 2018).

How might we, as feminist scholars and medical anthropologists, move from here? How can we begin to imagine a world in which violence, not only within obstetric settings but across social life more broadly, becomes unthinkable? What would it mean to cultivate forms of solidarity that, like *apapacho*, extend beyond individual bodies into collective webs of care that hold us all?

This thesis engages with these questions by entering into conversation with feminist scholars and decolonial medical anthropologists who urge us to move beyond liberal frameworks of rights, recognition, and even mainstream feminism, as it often becomes complicit in colonial projects (Grande 2003, Lewis 2025), toward deeper interrogations of coloniality, embodiment, relationality and care. These scholars remind us that colonialism was never simply about land or governance alone but about extracting vitalities from land and bodies alike (Prates 2025, McGuire-Adams 2020), reorganizing bodies through gender, race, labor and reproduction (Lugones 2018). Indigenous and Black decolonial feminist scholars urge us to rethink these constructs by practicing a 'radical listening' (Fonseca and Guzzo 2018) and through 'fleshing' (Alaoui 2020), ultimately moving beyond universal feminist epistemologies detached from corporeal life. This thesis engages with these scholars in asking not only to critique violence in the afterlife of colonialism but to attend to the embodied and relational practices through which people survive, care, and make kin through, and at times, beyond gender and race (Haraway 2016).

This thesis enters these conversations by tracing how reproductive injustice is not only reproduced through infra-structural violence and obfuscation but also contested and re-imagined through *apapacho* as a feminist-decolonial and embodied practice of collective care. Chapter 1 extends medical anthropological and postcolonial critiques of technocratic and biomedical care beyond questions of availability, foregrounding *care obfuscation* as a practice that normalizes violence within institutions and bodies in examining how care is experienced, deferred, legitimized, and obscured. Chapter 2 moves beyond postcolonial critique in co-theorizing *apapacho* with birth workers and *colectivas* as a practice of *being with* that places women's embodied knowledges at the center of an interconnected web of care relations that co-produce collective healing. In an attempt to tend to the broader, underlying structures of gendered violence that engender violence beyond obstetric care, Chapter 3 looks into the biosocial constructions surrounding different kinds of reproductive bodies to show how drawing the line between child/teen/woman, or perhaps even blurring it, works to normalize, extract, and obfuscate women and girls' reproductive labor. Taken together, the chapters of this thesis invite us not only to incarnate coalition against intersecting forms of oppression (Lugones 2018), but to *walk with* birth workers and feminist *colectivas* in enacting accountable forms of solidarity rooted in *apapacho* in care and beyond.

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