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Cover Page Footnote

I would like to thank the women who generously shared their stories, which are the core of this article. I would also like to thank my PhD supervisor and my mentors, who generously shared their time and expertise for the completion of the dissertation that made this article possible. Additionally, I am grateful for the support from three National Research Council of Argentina Fellowships, which made my research and writing possible.

CRITICAL VIEW POINTS

“We Aren’t All the Same”: The Singularity of Reproductive Experiences amidst Institutional Objectification in Argentina’s Public Maternal Health Services

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Abstract: Reproductive health services in Argentina are organized in ways that depersonalize, standardize, and fragment women’s bodies and lives. Alternatively, women’s accounts of their pregnancy, birth, and postpartum experiences reveal many nuances and moments of dislocation between experience and language: their immersion in social and material conditions; traces of ambivalence and contradiction; moves between continuity and fragmentation; density of lived time and space; and profound corporeal awareness. Guided by the methodological and conceptual premises of institutional ethnography, this article is a critical effort to explore experiential narratives as a means for apprehending what women perceive, need, and want during their reproductive processes.

Keywords: pregnancy, birth, postpartum, ineffability of embodied experiences, maternal health, reproductive rights

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Situating the relationship between motherhood as experience and institution

Institutional motherhood revives and renews all other institutions.

Adrienne Rich, *Of Woman Born*

In 1976, Adrienne Rich published the first edition of her book *Of Woman Born: Motherhood as Experience and Institution*. There was, she claimed, a strange lack of material analyzing the experience of motherhood and of being mothered. Her analysis—based on personal testimony, other women’s experiences, historical and cultural research, and literary examples—sought “to distinguish between two meanings of motherhood, one superimposed on the other: the *potential relationship* of any woman to her powers of reproduction and to children; and the *institution*, which aims at ensuring that that potential—and all women—shall remain under male control” (1986, 13; original emphasis). Rich’s analysis opened up the issue for political exploration and was followed by much feminist theorizing on the institutionalization of motherhood, as well as on multiple and diverse perspectives on mothering experiences. However, the constant negotiation of the meaning and scope of sexual and reproductive rights, the emergence of new technologies in the field of reproduction, and the fluid reconfiguration of social policies aimed at women who are mothers continues to reformulate and strain the relationship between motherhood as experience and institution.

My own research for the past eight years has sought to explore the relationship between motherhood as experience and institution in a particular time and setting of the 2001 Argentinian economic crisis to the present, and within the public healthcare services in the Midwestern Mendoza province. Since the emergence of interstate system and capitalism, medical discourses and healthcare services are fertile ground for reproducing and reconfiguring the institution of motherhood (Yañez 2013). In Argentina, maternal and child health services are the focus of major health policies and because institutional births reach up to 99% of total births, women's reproductive experiences are deeply influenced and regulated by medical discourses and practices. Despite the fact that Argentina has a law on "respectful birth" practices (2004) and a law to prevent and eradicate violence against women (2009), which includes "obstetric violence," several recent studies have shown the prevalence and implications of violence suffered by women during pregnancy, birth, and the postpartum period because of public and private healthcare institutions (INSGENAR 2003, 2009; Morrone 2008; Schwarz 2009; Canevari 2011; Fornes 2011).¹

In line with the critique of the technocratic model of healthcare (Davis-Floyd 2001) and the above-mentioned local studies, part of my research and writing has focused on revealing—through the tools of institutional ethnography—the social organization of maternal health services in Argentina. I have analyzed the differential allocation of time, space, and resources for pregnancy, birth, and postpartum in relationship to: the regional inequalities in access to services; hierarchical structure of health professions; and textual practices that fragment, standardize, objectify, and translate experiences into institutional records (Yañez 2013). I have also written on the barriers to access, continuity, and comprehensiveness of care in Argentina's "maternal health" services (Yañez 2016). Additionally, I have gathered in-depth personal accounts of women's pregnancy, abortion, birth, and postpartum experiences. These accounts help illuminate how institutionalization and medicalization take a toll on women and their embodied lives. These women's nuanced and, at times, ineffable experiences are antidotes to institutional fragmentation, standardization, and objectification.

In what follows, I share my research findings and revelations from these women's narratives and experiences. I begin by offering an overview of some methodological decisions made throughout my inquiry. I then share some reflections on the value of experiential narratives as subverting the univocal discourses of institutions by retelling and reinterpreting marginalized stories in new ways. The body of the article is comprised of two sections. The first section focuses on the nuances of pregnancy, birth, and postpartum experiences and their social situatedness, ambivalence, contradiction, and their movements between continuity and fragmentation. The second section examines those aspects of experience that are ineffable, inarticulate, in search of what I term *singularity* or *singular*—the uniqueness of experience due to the specific location of that woman in terms of class, ethnicity, sexual orientation, age, and so forth, and due to her family story, her relationships and social ties. I want to be clear that it is not about women's perceptions of institutionalization and medicalization but rather about what they feel and elaborate based on their own experiences. Sometimes, this may be affected by institutional language and interventions, but not always. I conclude by sharing some reflections on the potential of experiential narratives and their embodiments for further work.

A Feminist Approach for Revealing Institutional Regulations

How have women given birth, who has helped them, and how, and why? These are not simply questions of the history of midwifery and obstetrics: they are political questions.

Adrienne Rich, *Of Woman Born*

In order to explore the relationship between motherhood as experience and institution, I searched for a methodological approach that would enable me to explore how women's experiences are permeated by institutional regulations and how health care institutions process these experiences. Institutional ethnography's "analytic goal is to make visible the ways the institutional order creates the conditions of individual experience" (McCoy 2006, 109). This approach begins with a "problematic," which is an "actual or potential disjuncture between experience and the forms in which experience is socially expressed (becoming thereby intelligible and actionable)" (Smith 1987, 50). According to Dorothy Smith—feminist sociologist and founder of this approach—this problematic is "the break on which much major work in the women's movement has focused" (50). Smith describes the project of institutional ethnography as a four-part process that recognizes "individuals are there; they are in their bodies; they are active; and what they are doing is coordinated with the doings of others" (2005, 59). Additionally, language is a fundamental element of this project because it links the local site of experience to the institutional or extra-local by coordinating people's consciousness and subjectivities (94). Grounded in a social ontology centered on standpoint epistemology, Smith's work proposes these disjunctures create exploration and discovery by asking how experience is organized and how it is determined through the social relations that have shaped it (1987, 50).

Several institutional ethnographies trace the organization of health services and the experiences of people who become "patients" or "users" (Mykhalovskiy and McCoy 2002; Rankin 2003; Rankin and Campbell 2009; Sinding 2010), including the organization of obstetric care provision (MacKinnon 2006). These studies have produced "detailed descriptions of the everyday, often mundane tasks involved in getting and providing care and treatment," revealing "how access is more readily gained, and needs are more routinely addressed, for some patients than for others—knowledge that can allow us to trace the production of health care disparities" (Sinding 2010, 1657). My own research tries to build on these previous studies to contribute to broaden our understanding of how embodied reproductive experiences are shaped by interactions with healthcare institutions.

My fieldwork was conducted in Mendoza province from 2008 to 2015. The first stage sought to record the experiences of women whose pregnancies, births, and postpartum periods had put them in contact with the public health system. Eight women who reside in both urban and semi-rural areas of greater Mendoza were interviewed in-depth. These women were contacted during activist events on sexual and reproductive rights, as well as through territorial ties of friends of neighbors and community leaders. The second stage of my fieldwork focused on the provisions for care (or their absence) at public health institutions. This stage included fifteen interviews with health workers that included certified midwives, social workers, and doctors (pediatricians, obstetricians, and family specialists), some of whom have held powerful positions at the provincial health ministry and special programs. Participant observation was also carried out both at the province's major maternity ward and at urban and rural municipal health centers where pregnancy and postpartum appointments take place.

Below is a table with some basic information about the women interviewed that provides context for their testimonies. The names of the women have been changed to preserve their anonymity and the details provided correspond to the time of the interview.

Table 1
Chart Detailing Context of Women Interviewed

Name	Age	Formal Education	Occupation	Relationship status	Children	Institutions attended
Clara	34	Primary school only	Domestic worker	Married to a man	3 children alive: 13, 10 and 2, 1 died during term pregnancy (he would be 8 years old)	Healthcare center in semirural area, maternity ward at major provincial hospital
Romina	24	High school	Homemaker, occasional jobs in sales	In relationship with a man	2 children: 6 and 2	Healthcare center in her neighborhood, maternity ward at regional hospital, maternity ward at major provincial hospital
Natalia	23	High school	Homemaker, occasional jobs in sales	In relationship with a man	8 months pregnant with her first child	Healthcare center in her neighborhood
Juana	27	High school and some university courses	Domestic worker	Married to a man	2 children: 4 and 5, 1 second trimester miscarriage	Healthcare center in her neighborhood, maternity ward at regional hospital, maternity ward at major provincial hospital
Lidia	27	High school	Homemaker	Married to a man	3 daughters: 10, 2 and a 6 month baby born prematurely and admitted to neonatology unit	Healthcare center in rural and semirural areas, maternity ward at regional hospital, maternity ward at major provincial hospital
Karina	25	High school and some trade school courses	Self employed pastry maker	In relationship with a man	1 daughter: 3 months old	Healthcare center in semirural area, maternity ward at major provincial hospital

Contesting Institutional Standardization through Experience-based Narratives

I believe increasingly that only the willingness to share private and sometimes painful experience can enable women to create a collective description of the world which will be truly ours.

Adrienne Rich, *Of Woman Born*

The notion of experience is central in feminist theory, politics, and practice. According to feminist philosopher Ana María Bach, “we begin in experience and reclaim its value through a constant effort, considering that women’s voices have been not just unheard but disregarded, veiled, subaltern in the context of the androcentric Western system” (2010, 19-20). Bach considers women’s experiences subaltern in the Spivakian sense because it is about the impossibility of speaking when no institution or positions of power listen and legitimate one’s words because the speaker lacks authority. Further, feminist sociologist Rosana Rodríguez has written about subalternity as preventing women from expressing their embodied experiences:

They are rather “talked about” by the various disciplines that name their/our experiences, operating, as pointed out by Spivak, a suppression of women’s words in the telling of experiences, even in those most distinctively female: pregnancy, abortion, childbirth, breastfeeding. Hence the relevance of enabling spaces for the singularity of women’s testimonies (2013, 1149).

There have been extended debates surrounding the use of experience as a source of evidence for feminist research. The perspective of this article relies on Shari Stone-Mediatore’s claims that experience-oriented texts do not seek to prove the truth of individual subjects but contribute to a critical effort to reveal the ideological contradictions of institutions (1998, 119). Stone-Mediatore identifies “marginalized experiences,” those “systematically obscured or omitted in culturally dominant representations of the world,” as particularly necessary for emancipatory endeavors since they reveal how culturally, politically, and economically marginalized people often endure the hidden costs and contradictions of social policies (131).

Further, Smith’s (2005) standpoint epistemology is based on the premise that experience only emerges as a dialogue between what has been lived and the need to evoke it, for oneself or for an audience. Through the telling of their experiences, women can deliberately and strategically reinterpret their lives, deploying the subjective resources that may allow them to exercise oppositional discourses. The act of evoking gathers subjective energy to drive a creative process that may turn experience into radical political consciousness (Stone-Mediatore 1998, 123). Experience, then, is conceived not just as evidence of oppression but also as starting point for a radical re-telling of the complex forces that shape it. Everyday experience is not just molded by hegemonic discourses it also contributes to points of resistance to such discourses that can be strategically narrated in ways that challenge ideologies that naturalize social relations (124).

Linda Martin Alcoff (1999) highlights the value of experience to disrupt it as a mere linguistic phenomenon. She claims, “lived experience is open-ended, plural, fragmented, and shifting not because of the limitations of language, but because of the nature of embodied, temporal existence” (1999, 128). Alcoff criticizes attempts to explain experience as only constituted by macrostructures because they do not properly take into account vivid, personal experience. It is important to pay attention to the descriptions of embodied experience in addition to the different discursive representations that are formulated about such experiences. Both Alcoff and Smith have pointed out that it was women telling each other their experiences that enabled the naming of what was previously unnamed. In Smith’s words, “we learned in talking to

other women about experiences that we had and about others that we had not had. We began to name ‘oppression,’ ‘rape,’ ‘harassment,’ ‘sexism,’ ‘violence,’ and others. These were terms that did more than name. They gave shared experiences a political presence” (2005, 7).

Throughout the development of my research on public health services targeting reproductive processes, the lack of audibility of women’s experiences of pregnancy, birth, abortion, and postpartum emerged with great force. Instead, institutions, through their texts, deploy a monotonous narrative of procedures, codes, and protocols, where bodies and subjects appear objectified and fragmented. Institutions homogenize experiences according to the criteria previously built by extra-local decision-making centers (for example, World Health Organization, Pan American Health Organization, National Health Ministries) and applied by local administrators. Hence, the singularity of women’s voices, their inflections, shades, expressions, and silences is suppressed. Under these circumstances, I seek to provide a space to engage with the nuances of women’s embodied experiences of pregnancy, birth, and postpartum.

My decision to conduct and present an analysis of women’s narratives required extensive methodological reflection. In building upon anthropologist Lila Abu-Lughod, I aim to produce “ethnographies of the particular” that challenge generalization and “highlight the constructed quality of that typicality so regularly produced in conventional social scientific accounts” (1991, 475). Abu-Lughod claims, “showing the actual circumstances and detailed histories of individuals and their relationships would suggest that such particulars, which are always present (as we know from our own personal experiences), are also always crucial to the constitution of experience” (476). Moreover, these ethnographies of the particular sidestep deterministic definitions of experience linked to set discourses, showing that “within these limits, people contest interpretations of what is happening, strategize, feel pain, and live their lives” (476). Focusing closely on the singularity of experiences and complicating the nature of relationships among subjects can subvert the most problematic connotations of culture—homogeneity, coherence and timelessness. Everyday accounts have the potential to break the coherence and reveal the contradictions of discourses and institutions, while the flux of experiences keeps us aware of the dimension of time.

In my work, I have tried to avoid the tendency to break down and categorize women’s accounts, since I am not seeking to present similarities and differences among experiences, but rather show the complexity and uniqueness of each experience. I do so to highlight how little healthcare institutions consider women’s experiences and narratives when designing and providing services. I hope my analysis reflects the coherence and fluidity of their accounts, as well as the fragmentariness that emerges at times. I worked to maintain the narratives as they were originally told by the women I interviewed.

Delving into the Nuances of Reproductive Experiences

Each woman’s situation and experience is singular, yet connected to other women’s experiences. In the face of the healthcare services’ limited discourses on the institution of motherhood, women’s accounts broaden our understanding of how women relate to their bodies and reproductive processes. The women interviewed were themselves aware of the diversity of experiences, as in the words of Lidia, “sometimes I hear mothers who have had other experiences, because we aren’t all the same, we all don’t have the same childbirth experience.”(4) Women’s views on the medicalization of childbirth are also varied. While some of the interviewees would have preferred a more private environment and the company of a person they trusted, others value the amount of professionals who were present during their deliveries, which made them feel important and cared for.²

Moreover, Karina, whose daughter was born prematurely and remained in the neonatal nursery for a month, marks the importance of learning to care for a baby while in the hospital when she says, “you know...I learnt a lot there in the hospital. I think that if I had been released just after giving birth, I don’t know. Instead, we were well trained by the time my daughter was discharged.” Some of the nuances of experience revealed in women’s accounts are in stark opposition to the modes in which these experiences are represented in institutional texts and discourse. Other accounts are not oppositional but rather extra-institutional (McCoy 2006, 120-121); they are structured around personal or local relevancies and make use of linguistic repertoires that imprint their own emphasis and frames for understanding experience. These accounts are not useful from an institutional point of view since they do not provide the data needed for record keeping and for the administration of people and resources.

In the following sections, I explore some of the nuances of women’s pregnancy, birth, and postpartum experiences that reveal the contradictions and paradoxes of maternal health policies. This allows us to turn personal narratives into tools for revising what women perceive, need, and want throughout their reproductive processes. Although these aspects of experience are exposed in five different sections, they are in fact interconnected and integrated with each other.

Social Situatedness

Experience shapes us, randomness shapes us, the stars and weather, our own accommodations and rebellions,
above all, the social order around us.

Adrienne Rich, *Of Woman Born*

Social positions and material conditions shape the body, experience, the mode of awareness of bodily changes, the possibility of enjoying or suffering pregnancy, birth, and puerperium. As Allison Bartlett has written, “bodies are not essentialized, static, or homogenous material but are infinitely changeable, actively receptive to their environment and always subject to the conditions of history, culture, and language” (2002, 373). Each pregnancy, each birth, each postpartum is lived in a singular way according to her age, her relationships, her economic, working, housing conditions, the number of children she already has, and many other factors—even for the same woman. For example, Lidia and Natalia commented how different it was for them to be pregnant at seventeen than later in life when they were more mature, more informed, and more aware of institutional premises; or, more capable of making their own decisions.

During observations, one of the professional midwives I accompanied directed my attention to a woman whose pregnancy she had been monitoring at a health center. This thirty eight year old woman had just given birth to her ninth child, a child that had been much longed for, even though she was a grandmother already. According to the midwife, this woman had to work throughout all of her previous pregnancies as an informal laborer in harvest storehouses, which is a physically demanding job. During this later pregnancy, however, she was a registered worker who could take a proper maternity leave, which she explained allowed her to enjoy gestation and have a less demanding postpartum experience. She was very optimistic about this new mothering opportunity. Also at this time, I met a thirty four year old woman who had just given birth to her eighth child. She commented that this daughter had been the only one she had planned for. Both of these women, their pregnancies, and newborns would have been catalogued as high risk according to healthcare institutions due to their age and previous gestations.

One of the clearest disjunctures I have found between women’s accounts and the institutional versions of their experiences is in the perception and definition of risk. While hegemonic medical discourses consider

pregnancy and birth as inherently risky and potentially chaotic and catastrophic, women narrate their bodies as subject to the fragility and precariousness of their living conditions. The assessment of risk is a fundamental organizing aspect of both professional obstetric knowledge, training, and the allocation of human and material resources within healthcare settings. Measuring risk is necessary for the rational administration of the healthcare system's scarce resources, application of focalization policies aimed at populations deemed vulnerable, and identification of possible complications (and justification) of the interventions deployed, particularly in the case of malpractice suits. The concern with risk has less to do with a preoccupation for women's health and lives than with the need to control public expenditure and demographic processes. The concern is focused on the prerogatives of international regulation and finance instead of women's health.

The health professionals interviewed commented that the potential risk of pregnancy and childbirth arises from the unpredictability of reproductive processes and the impossibility to determine which cases will present complications. According to one OB physician at the major maternity ward in Mendoza province:

I believe that this is the most important problem in our practice, and in Obstetrics it has a lot to do with... because motherhood (illness is also a social fact) but motherhood is a state...it is a physiological matter, not an illness, but it can turn into one, a very serious one. Hence, treating pregnant women as "users," to use a term, as if we were monitoring a physiological event, and not as patients (except in some cases) is a difficult endeavor. It implies a constant negotiation of each particular situation because pregnancy can get complicated at any moment. So, I can't offer any guarantee to the woman who comes to me with a positive home pregnancy test in terms of what will happen to her in nine months.

Unfortunately, we have to take into account something that has been accepted and agreed upon by the International Federation of Gynecology and Obstetrics: there are no indicators as to when labor becomes complicated and that complication may mean an adverse event or the death of mother or baby. In the words of the OB physician who was the former Provincial Director of Maternity and Infancy Services this is why "childbirth, as long as possible, must be attended at institutions where there is the possibility of performing surgery, where there is an intensive care unit nearby, where you have an anesthetist at hand." However, the same former director of maternity services commented later in the interview:

Epidemiological studies conducted by the Department of Maternity and Infancy Services and by the Department of Epidemiology have shown that coinciding with economic crises, such as the 2001 crisis in the country, maternal and infant mortality increases. Moreover, if you look at the regions where mortality increased the most, you can see they are the most impoverished areas. This is a portion of the population living on the verge; the smallest imbalance leaves them really vulnerable ... [t]he other important issue here is not losing sight of the fact that the causes of maternal mortality, in countries like ours, underdeveloped, are almost totally preventable.

Hence, the link between risk of death or complications and living conditions appears as part of policy makers' decision-making practices. However, the texts designed to process women within institutional healthcare (e.g., partograph and perinatal medical record) and the courses of action they determine pay little attention to social and material conditions. As Robbie Davis Floyd (1987) and Emily Martin (2001) have shown, medical discourses and practices around reproduction are more concerned with possible deviations from the standardized times and expected development of pregnancy and birth than with the diversity of women's experiences and conditions, and usually attribute these deviations to failures in women's bodies.

Women narrate their bodies as dependent on their and their families' social, economic, and labor conditions. Precarious employment, constant moving, the need to care for their other children, their own or family members' chronic health problems, and several other factors have an effect on their ability to care for and connect with their bodies through pregnancy, labor, and postpartum. In talking about her second pregnancy and birth, Clara says that she lived them with much satisfaction as her husband had a stable job; they were able to pay the rent on time, and buy everything they needed to welcome the new baby. Her third pregnancy found them almost unemployed, evicted from one place to another as they were not able to pay the rent, then living in a relative's garage, almost unable to make ends meet, all this during the 2001 crisis. In this context, Clara realized she was pregnant quite late and when her due time was coming. She did not realize the baby had stopped moving and died. In Clara's understanding, "our story is based on the fact that my husband does not have a proper job, so our family always tends to falter."

In Juana's account, the possibility of choosing an institution for her deliveries is subject to her economic situation. She prefers a smaller hospital with more privacy and personalized care but is further away from her home. Because she does not own a car nor has the money to pay a taxi to get there, she decides to go to the nearest hospital. Lack of money and social insurance affects her contraceptive choices and she has to stick to an intrauterine device that the public healthcare center offers for free, which guarantees some continuity although it causes complications to her health by excessive bleeding and chronic pain. As a non-registered domestic worker, she does not have sick leave, prescribed rest during pregnancy and postpartum, or supported time to go to check-ups—all of which further compromises her health and contributes to complications. Additionally, two sisters, Romina and Natalia, express differences in their experiences within public health institutions and their cousins who have social insurance and go to private clinics. Their cousins benefit from the privileges of being able to choose institutions and health professionals, access lab tests and medication in a timely manner, and receive continuous and personalized care while Romina and Natalia are continually denied these options.

Ambivalence and Contradiction

In the most fundamental and bewildering of contradictions, [the institution of motherhood] has alienated women from our bodies by incarcerating us in them.

Adrienne Rich, *Of Woman Born*

Ambivalence, according to the Freudian definition reformulated by Jane Flax, "refers to affective states in which intrinsically contradictory or mutually exclusive desires or ideas are each invested with intense emotional energy" (1990, 50). Rich shows how, through the mandate of unconditional and relentless maternal love, the institution of motherhood strips the experience of mothering of the possibility of ambivalence. Given the conditions in which mothering is organized in our Western capitalist societies, where privatized and individual responsibility for children is the norm, ambivalence—the alternation between anger and resentment with moments of gratification and tenderness in the consideration of one's own needs or the urge to put children's needs first—is a central element of mothering experiences (Rich 1986, 23).

Reproductive experiences are generally imbued with ambivalence, which cannot be recorded through or incorporated into institutional texts that only offer dichotomous classifications. For instance, the maternal and infant high-risk questionnaire used in Argentina inquires whether pregnancy was planned or not. However, these categories are not always mutually exclusive. For instance, Lidia comments that she and her husband did not plan their third daughter, but they were not using contraceptive methods either. Or

how Natalia talks about carrying out physically exhausting activities during her pregnancy as a teenager that could have produced an abortion, but she recalls not doing them consciously. Further, Clara explains that she tried to interrupt one of her pregnancies with pills, but they did not work and had the opposite effect of “reaffirming” her gestation.

Even when the interviewees talked about their wanted pregnancies, tensions seemed to emerge between their own needs, their bodily changes, and the needs of the fetuses/babies. When asked about the changes she feels as part of her pregnancy experience, Romina initially said that everything had been “alright,” that she has not changed anything and she has gotten used to the new condition. However, a few moments later she asserts that everything changed, for example, sleeping positions, eating habits, and dressing. She also complains about the shifting attention to her unborn daughter and not on herself, her body. Correspondingly, Natalia comments, “when you become a mother you are there for the child and not anymore for yourself.” Lidia and Karina also express ambivalence towards the experience of preterm labor, where tensions appear between the need to wait for their babies to gain a bit more weight and get their lungs developed, on the one hand, and the exhaustion, pain, and discomfort of the prolonged confinement and interventions on the other.

Denying ambivalence brings forward decisions that do not consider the real needs and desires of women. As Alejandra Ciriza has written, “the urge to produce a way out may alleviate the tension but it provides a linear reasoning that gives dilemmas, particularly our feminist dilemmas, a repressive unity” (2008, 39). The institutional impossibility to process ambivalence results in repressive resolution that homogenizes answers and searches for the fastest solutions available to allow for the efficient administration of time, resources, and people.

Continuity - Fragmentation

To connect what has been so cruelly disorganized ... [t]here is an inexorable connection between every aspect of a woman's being and every other.

Adrienne Rich, *Of Woman Born*

Bodily experience, and particularly sexual and reproductive experiences, may be described as a continuum—a flow of sensations and states that are intertwined and impact each other, and sometimes the boundaries between them are not discernable. Juana's interview had almost no intervention from me as an interviewer and her narrative describes with overwhelming continuity the experiences of pregnancy, childbirth, postpartum, curettage, failure and complications of contraceptive methods, abortion, and the severe effects on her sexual and reproductive health resulting from malpractice and lack of institutional care. The frontiers between postpartum and new pregnancy appear blurred, involving breastfed babies and her body not yet recovered from a C-section. In the face of the complexity of experiences like Juana's, the healthcare system only offers discontinuous, fragmented, and hierarchical services organized around the level of risk. The institutional texts focus on a “discrete present.” The perinatal medical record is activated separately for each new pregnancy and gathers very little information on previous reproductive, non-reproductive, and sexual experiences.

Juana's account also describes moments of fragmentation during her hospital stay. She recalls her C-section as a succession of intervals of consciousness-unconsciousness throughout which doctors, nurses, instruments, and clothes appear and disappear. In these circumstances, the moment of birth is not part of her conscious memory as she got to meet her daughter hours later, when she woke up and recovered her

speech asking for her baby to be brought to her. There is another kind of fragmentation of experience in which the relation between reproduction and sexuality does not explicitly appear in women's accounts. References to sexuality are not included as part of reproductive narratives because they are taken for granted, not requiring explicit mention. That is, we may be in front of the mutually reinforcing relationship between motherhood and heterosexuality in their institutionalized forms, which "have to be treated as axioms, as 'nature' itself, not open to question" (Rich 1986, 43). Or, this absent link could be due to institutionalized motherhood's construction of woman-mother as fundamentally "being-for-others," which entails the denial of her own sexual desires, a sort of "asexuality" that fragments experience (Contratto 1986). Women's contact with the healthcare system during pregnancy and birth reinforces the separation of sexuality and motherhood.

Not only do medical discourses generally deny the sexual character of reproductive processes—maintaining privacy is not important for the development of labor—but when sexuality appears in the scene it comes in the form of stigma, justifying pain and suffering on the basis of a supposed sexual pleasure that led to the pregnancy. Many of the women I interviewed report being told phrases such as, "You weren't calling for your mother when you had your legs spread." These institutional prescriptions create "contradictions about women's bodies as heteronormative sites of pleasure and sexuality on one hand and of asexual, selfless sources of maternal nurturance on the other" (Malacrida and Boulton 2012, 748).

Density: Temporality and Spaces

[T]he woman who continues to mother will find the rhythms and priorities of her life changed in the most profound and also the most trivial ways.

Adrienne Rich, *Of Woman Born*

Feminists have developed a critique of Western culture's conception of time. The linear, incremental, and developmental time that rules our lives "values climactic events, dates, and heroes of history while erasing the quotidian and those who do the work of the everyday: the working class, migrants, women, and children" (Bartlett 2010, 121-2). Institutionally, pregnancy time is counted in weeks, reflecting the distribution of capitalist production in work-weeks (Simonds 2002, 564). Postpartum time and children's development continues to be charted on this week-based time keeping system. Childbirth is also subjected to strict and linear time keeping. Reproduction is tied to industrial production processes, where cervix dilation progress is measured in set intervals of time charted in the partograph (Martin 2001, 59). The time of experience is not measurable and linear as institutional time. In experiential accounts, time and space become denser during critical moments such as childbirth, abortion, and complications during pregnancy and postpartum. Body awareness is also intensified, even against the alienation driven by institutional discourses and practices. Pregnancy time, as recalled by the women interviewed, is not lived in weekly progress but rather flows or slows down according to the level of bodily (dis)comfort and the changing material and emotional conditions. Is it a coincidence that Lidia's preterm labor (around twenty eight weeks) started the day her husband departed for work in another province and leaving her alone with their two daughters?

Time during hospital stays for pregnancy, childbirth, postpartum, or caring for a premature baby is organized according to institutional rhythms, including rotation of personnel, visiting hours, nursing rounds, resident supervision rounds, meal times, and so forth. These temporal markers sneak into women's accounts. Many women have a chronological memory of how their labors went, which indicate they have to manage their contractions and sensations around institutional times. Nevertheless, there are also hints

and even awareness of other ways of perceiving time. In Juana's account of her second birth, time becomes denser as contractions intensify, and as she feels more and more abandoned in the laboring room for seven hours. The doctors changed duty and forgot to assign her to someone in the incoming team. Hence, several hours of laboring means something different for a woman who is being cared for, soothed, and reaffirmed than for a woman who is relegated to an invisible corner in a room full of other laboring women where professionals come and go, but nobody seems to notice her. Being left out of the records denies any possibility of requesting attention and care. Moreover, it leaves her out of institutional time and in a state of limbo. When someone finally did notice her, her experiential time accelerated rampantly to the point that she fainted.

The intensity of pain during labor is also a factor minimizing or magnifying the perception of time, as Natalia's and Lidia's accounts reveal. For Natalia, time became dense and stretched when her contractions started getting painful and she was denied the company of her mother. For Lidia, the absence of pain during her preterm labor left her in a state of indetermination, waiting for something to happen or someone to provide a diagnosis. Just as in pregnancy and birth times, postpartum time is divided into distinct stages by healthcare research and records: the initial or acute postpartum period (first six to twelve hours), the sub acute postpartum period (two to six weeks), and the delayed postpartum period (up to six months) (Romano et al. 2010). In contrast to pregnancy and birth with a relatively measurable beginning and end, postpartum is probably the most variable moment of the reproductive and sexual continuum in terms of length, intensity, and changes both physically and emotionally. For hegemonic medical discourses, this period is mostly associated with the return of the woman's body to a non-pregnant state.

However, many women experience it as a time of transformation, transition, and adjustment "when not only time and space blur but language, thought and priorities blend into a gaga of sleepless nights, hormonal rushes, and shifts in subjectivity" (Bartlett 2010, 120-121). The lack of "normal" postpartum references in the narratives of the women interviewed may be related to this blur. Women only refer to postpartum experiences when there were physical or emotional complications that required contact with the healthcare system. This may also be explained by the naturalization of both "normal" pregnancy and postpartum, which suggests as long as you bear a living child, everything went right. As feminist health researchers Marie Campbell and Frances Gregor write, "it is only when something goes unaccountably wrong that we stop and notice the organized complexity of our lives that we otherwise navigate so easily" (2004, 31). In general terms, pregnancy, birth, and postpartum imply, with their constant changes and need for physical and emotional adaptation, "a time set apart from other life, although life goes on around us and mothers participate in it at the same time as we are becoming mothers" (Bartlett 2010, 123).

The same intensified perception applies to space(s) throughout the critical moments in the reproductive continuum. Juana's account of her second trimester fetus who was born alive and stopped breathing in her arms while she was home alone with her two small children in a harsh winter evening after being denied a hospital abortion even though the pregnancy was deemed unviable, reveals the densification of space where the outside becomes hostile and the inside too small and isolated to contain so much pain and desperation. Juana also vividly describes both the operation room where she had a C-section and the delivery room where her vaginal birth occurred. The first comes out as a space ruled by order, cleanliness, machinery, and a myriad of depersonalized figures going around in scrubs, caps, masks, and gloves. The second is pictured as a transit site, laid out in order to facilitate the fast circulation of women and staff between stretchers and "boxes," reduced to their minimal expression.

Space also becomes denser in Karina's portrayal of her stay with her daughter in the pre-discharge rooms for mothers whose newborns have been hospitalized in neonatology services. There, according to Karina's perception, mothers are tested as to how ready and capable they are to take care of their babies. This space appears prison-like, where inside and outside are clearly delimited and movement between them highly restricted. Only mothers are allowed in the rooms and fathers can only visit in a corridor. Other family members have limited once a week visiting hours. Karina talks of feeling depressed by the isolation and enraged at the "grotesque" nurses that seemed to be there only to make her stay a nightmare by imposing absurd and arbitrary rules in terms of her use of time and space and disrupting her attempts to create intimacy with her baby. This example contributes to the reinforcement of institutionalized motherhood and heterosexuality by upholding the idea that mothers are the exclusive caregivers of these babies and presupposing that they would have male partners as their main supporters.

In Karina, Lidia, and Juana's narratives the corridor is a recurring hospital space that has not been acknowledged as part of its routine organization. Women are left in the corridor after delivery while waiting for a bed to be available in the postpartum rooms. Sometimes they spend hours in that limbo—alone or with their babies—watching as doctors, midwives, nurses, and stretcher-bearers go by. A midwifery student I interviewed reveals that she was appalled to see women there alone, feeling cold and soiled, and almost abandoned. The hospital where these experiences take place proudly boasts about being part of initiatives to foster breastfeeding, yet women are expected to practice early breastfeeding in these less than favorable conditions of the corridor. There are no marks of familiarity or intimacy in these spaces. Institutional life goes about without observing birth as a transcendental moment.

I recall waiting for an interview in a hospital corridor, near the delivery room and the area where women spent part of their labor. A pipe had broken and there were workers trying to fix it using drills, hammers, and other noisy tools while the water was already entering some of the rooms. I also remember daunting images of women with tiny newborns at their breast in hospital beds, folded unto themselves and their babies, talking softly and slowly, as if trying to make a nest in an unfriendly environment. I can also recall the crowded and precarious space—called residence—for those mothers whose babies are hospitalized in the neonatology unit and live in distant areas of the province. Amid bunk beds they drank *mate*, played cards, reported on their children's progresses or downsides, comforted each other, and talked about their other children and their suspended lives. They had created "a room of their own" within the coldness and depersonalization of institutions.

Embodiment

I am really asking whether women cannot begin, at last, "to think through the body."

Adrienne Rich, *Of Woman Born* (original emphasis)

Due to the processes of vigilance and standardization to which women's bodies have been subjected within healthcare institutions (Martin 2001), their accounts reveal perceptions that are aligned with medical representation and language, which tends to fragment, alienate, and reify the body. However, there are also expressions of integrity, profound sensoriality, and even admiration toward the capabilities of their own bodies. On the one hand, interviewees narrate their bodies, and particularly their bodily processes related to sexuality and reproduction, as something external that happens to women and must be controlled or tolerated (76-77). Natalia's dissociation with the sensations of her body, its pains, and its changes during the pregnancy of her first son, reveals this disconnection. The same could be said of Juana's resignation

towards successive unplanned pregnancies and continuous postpartum complications such as, curettage to remove placental rests, infection of C-section stitches, and uterine prolapse that keeps compromising her wellbeing. Finally, the clearest disconnection appears in Clara's chronicle of her third pregnancy, where her visibly pregnant belly appears external to her and she must carry it along as part of her belongings in her constant relocation to care for a terminally ill relative. Clara does not notice that her baby has stopped moving and it is only when contractions start that she goes to the hospital and is told he died three days before.

On the other hand, there is a prevalence of awareness in these women's accounts of their own bodies and their sensitivities and sensations that have not been completely erased by the abstraction and fragmentation performed by institutions. Romina comments on the many changes undergone by her body during pregnancy and the consequent need to accommodate her daily life around them. Natalia says that even though she refused to acknowledge her first pregnancy, her body kept sending messages through pain and previously unknown sensations. Lidia repeatedly mentions the thirst and hunger she felt while being under observation for preterm labor. Both Lidia and Karina put emphasis on the discomfort, the restriction of movement, and the anxiety of waiting indeterminately. Juana offers vivid sensory descriptions of each episode of her complex reproductive experiences: the prevailing white and smell of alcohol of the operation room, the freezing cold she feels in the delivery room, the noise of the amniotic sac breaking, and the location and intensity of her pain.

In another type of antithesis, women's testimonies reflect both a sense that their bodies failed them and a sense of trust in their own bodies and their ability to cope and adjust. During observations at the hospital and healthcare centers, I heard several instances that reflect a sense of failure. For instance, one young woman commented "I couldn't have my baby alone, I had to be helped," while another woman said "I can't push." In a post-curettage check-up, a twenty eight year old woman told the midwife she was afraid there was something wrong with her body. She had gone through three pregnancies, but two had ended up in miscarriages and she wanted to have more children. In Juana's narrative, her body constantly collapses, making her lose consciousness. Nevertheless, trust is also present in women's accounts. Natalia refers to the importance that her body did not reject an intrauterine device she had inserted for contraception. A twenty five year old woman, who successfully used an IUD as contraceptive method for eight years and then was able to embark on a planned pregnancy, positively states, "I think I have a body that accepts things." Additionally, Juana comments that despite being labeled "high-risk," she lived her second pregnancy "without feeling that risk," carrying out her daily activities normally. Even though Clara's doctors told her that she could never have another child, after a few miscarriages she proudly recalls that she was able to carry another pregnancy to term and give birth to a healthy daughter.

Focusing on institutional discourses of breastfeeding, Alison Bartlett has pointed out that "it becomes apparent that women are constructed 'as' bodies, rather than as embodied subjects," but listening to the women themselves they come out "as subjects who have their own corporeal logic and knowledge that may be seen as in excess to biomedical reasoning" (2002, 378). If we listen carefully, some of the testimonies reveal ways of talking rooted in the body—ways that express a deep connection with its languages, its subtle messages, its cries, and silences, as well as with the bodies of other women close to them. Juana comments that despite the recurring negative pregnancy tests and the fact that she was taking contraceptive pills, she could "feel" that she was pregnant but she could not explain to her husband or the interviewer exactly how that feels. Clara explains how, after being so disconnected from her third pregnancy and losing her child,

she felt forced to retreat into herself for months in order to forge a new relationship with her body. She is now deeply aware of the messages her body sends her and of its memory when she states,

It is as if my body started reprogramming, it informs me an important date is coming, so my breasts start aching, my ovaries ache, and I feel something similar to contractions. So I start wondering why this is happening to me, why I feel these pains, and then I remember...oh, it's the date of the baby's death ... I get nostalgic; I feel the need to be alone.

A different kind of connection surfaces in Natalia's account between her body's expressions and those of other women sharing labor and postpartum in hospital rooms. Particularly, those of her cousins who "explained their experiences as if they were me; the cries they let out, the pain they endured, and everything." Natalia was bewildered at the incapacity of the hospital staff, especially the nurses who were measuring her dilation, to empathize with her pain.

Rich proposes that women should explore "the possibility of converting our physicality into both knowledge and power" (1986, 284). This exercise has the potential "to heal—insofar as an individual woman can, and as much as possible with other women—the separation between mind and body," to never again lose ourselves both psychically and physically (40). Rich also suggests that in the face of mandates that would have us "*become* our bodies—blindly, slavishly, in obedience to male theories about us" (285; original emphasis). Some women attempt to exist in spite of our bodies as a way of escape. The key is not just gaining control of our bodies, though that is a prerequisite, but we must touch the unity and resonance of our physicality, our bond with the natural order, and the corporeal ground of our intelligence.

The Ineffable, Inarticulate Knowledge of Embodied Mothering Experiences

In the interstices of language lie powerful secrets of the culture.
Adrienne Rich, *Of Woman Born*

What is the language available for women to speak about their embodied mothering experiences? What aspects of experience fall outside institutional discourses but are not yet expressed as extra-institutional or oppositional discourses? What parts of experience are yet inarticulate? These questions may only be answered partially. As I have discussed in this article, both Rich and Smith point out that this is a work in progress. Evoking a quote from Susan Sontag, Rich asserts that she is "convinced that there are ways of thinking that we don't yet know about" and in these ways lie the potential for change, for regaining power over ourselves (1986, 283). There is a hiatus between lived reality, which happens in our bodies, and the possibility of fixing it into words.

We are our bodies, but at the same time we cannot provide a whole narrative description of what happens to us. Sensations are entangled with feelings, perceptions, words, and sometimes we find ourselves in states we cannot account for. Alcoff writes about this gap between experience and language:

Sometimes experience is in excess of language; it is sometimes inarticulate. Feminism did not invent sexism from scratch; it provided a new language through which old experiences could be described and understood such that present and future experience can be modified. Certainly, discourse impregnates and affects experience, but saying, as Scott does, that *experience is a linguistic fact*, or that discourse is a condition for

the intelligibility of every experience, is to erase all that experiential knowledge that is not susceptible to linguistic articulation.

If significant experience has to pass the test of discursive formulation, we are set to exclude the inarticulate from the realm of knowledge, including those forms of oppression that are not yet susceptible to be expressed under current discursive regimes. An improved point of view would conceive experience and discourse as imperfectly aligned, with dislocation zones (1999, 126-7; my translation; original emphasis).

Similarly, Patrizia Violi writes on the relationships women have with the oppressor's language are also productive when considering the (dis)alignment of embodied experience and language. Violi suggests:

In a world where the only possible subjectivity—that is, the one that can be spoken, represented and hence reflected upon—is male subjectivity, the price that women have to pay in order to become subjects is the loss of their own singularity, the split-up from the deepest levels of self, the relinquishment of the diversity of their own experience (1991,154; my translation).

Experience always leaves an unutterable trace, but it is precisely this trace that makes differently situated accounts possible. In short, Rodriguez indicates that to provide testimony is to “make use of words in a situation of language impossibility” and “[t]he subject that takes the floor is revealing an understanding that—however precarious—constitutes a new contribution to knowledge, which was previously unaccounted for” (2013, 1150; my translation).

The accounts gathered throughout my research reveal traces of experiences that are not yet articulate. Natalia has failed to explain (even to herself) why she was unable to tell her family and friends about her pregnancy when she was a teenager. Romina has found it impossible to specify what she was scared of during pregnancy. There are pauses and silences in Juana's and Clara's accounts when evoking their memories of suffering and loss. The woman sitting next to Lidia during her interview at the residence for mothers were amazed at Lidia's thorough descriptions of birth, since she did not remember anything about her own birthing experience as she explains, “because even though I was conscious it is as if I had blocked my mind not to remember.”

As interlocutor telling these women's stories and experiences, I feel there are remnants in their testimonies. There is also a responsive gesture in my own body toward these experiences, something like a sensation through the uterus, something I cannot wholly put into words. This ineffable experience is evidence that we are (still) connected to our bodies and have unique but connected stories. I envision these unmapped territories emerging collectively through different forms of expression such as, poetry, music, and images. As Violi writes, “so far, this is certainly just an outline, a road barely initiated though already visible; but it may be that it has not yet revealed the huge creative potential that it entails, the infinite wealth and energy that difference can develop when it is not hidden, denied, or humiliated, as it has been for centuries” (1991,162; my translation).

However, these ineffable remnants of experience can be conceived in another sense according to the double etymology of the term. Besides referring to that which is “incapable of being expressed,” ineffable can also designate that which “must not be enunciated” (Hollway 2015, x). The ineffable excess of experience may be a coping mechanism in the face of the violence and depersonalization of medicalization; it is a way of refusing to find the words that may bring back painful memories and revive the trauma. Or, more promisingly, it can be something unique that each woman keeps for herself, something only she can access, which cannot be appropriated by institutions and their discourses or by researchers and our interpretations.

Importantly, there is something else that is not explicitly mentioned by women but can be read between the lines. There is a presence emerging subtly but distinctly in the interviews—instances of solidarity among women. There are numerous instances of solidarity: more experienced women giving advice and comforting younger first-time mothers in labor rooms; a woman breastfeeds her hospitalized sister's baby; women in the waiting room of a healthcare center recommend each other to friendlier institutions and strategies to avoid mistreatment during childbirth; women taking care of their daughter's, sister's, sister-in-law's, friend's, and neighbor's children during postpartum depression or so that they can go to a medical appointment; women standing alongside other women through pregnancy, abortion, birth, and postpartum when there is no partner to share the load with; women in the residence for mothers sharing their postpartum experience and the ups and downs of their hospitalized babies; and a mother who fiercely negotiates with hospital staff to attend to her teenage daughter in labor. The presence and care of these women for each other, some of them close and some unknown, helps alleviate, overcome, and survive the violence and depersonalization these women experience because of their passage through healthcare institutions.

Epilogue: Lessons of Embodied Wisdom for a Dim Present

[T]he power of women to choose how and when we will use our sexuality and our procreative capacities ... in all its many implications opens the gate to a new kind of human community.

Adrienne Rich, *Of Woman Born*

As I write the final version of this piece, the Senate in Argentina votes down a promising law that would legalize abortion and make it accessible through universal healthcare coverage. Despite the negative vote of the Senate, the proposed law has opened up an intense social debate around reproductive justice and the ability of women, and gender nonconforming people with gestating capacities, to make their own autonomous reproductive decisions. Among the conservative views expressed by members of the Senate who voted against the law, we heard that women from the country's interior (outside the capital city) were "mostly contrary to abortion" because women's "natural" role is as mothers; thus, women should sustain unwanted pregnancies and give up the newborns for adoption. The blatant sexism and classism of the arguments voiced by those senators were countered by the anti-oppressive arguments put forth by feminists and supporters of a reignited women's movement that was later replicated by the more progressive senators in the Chamber's debate. Feminists and progressives sought to account for the situatedness of women's experiences and the multiple factors leading to a decision to seek an abortion. I believe this piece resonates deeply with those arguments because it reveals the need to make connections between the many ways in which women struggle for autonomy over our own bodies and lives.

In the face of the subalternization of their voices within healthcare institutions, the women interviewed give testimony with the will to make their experiences audible. The situatedness of these experiences speaks to the unique relationship each woman has with her body, her sexuality, and the twists of her reproductive story—all of which frame and shape their social and material conditions. As Leonor Calvera has argued, women have to inscribe our experiences through "patriarchy's tolerance threshold" in a discontinued, fragmented manner, which constrains the ability of these accounts to achieve the necessary political impact. However, these experiences can break the silence, "the 'epistemic hierarchies' of dominant discourses and the institutions that sustain them" (Calvera quoted in Rodriguez 2013, 1154; my translation).

Against the homogenizing effect of institutions and their texts, experiential narratives reveal nuances, differences, ambivalence, and contradiction. They disrupt abstraction and reification to uncover the density and corporality of subjects. They expose segmentation and separation for the tensions existing between the continuity of bodily, sexual, and reproductive processes, and the fragmentariness introduced by interventions. Women's narratives refuse the discrete, labeling techniques for apprehending "patients" or "users." While experience sometimes gets silent, leaving an inarticulate trace, it offers an ineffable remnant that highlights its personal character as a mode of political intervention.

What are institutions to do with these accounts? While there is no possibility of institutions apprehending the entirety, diversity, and complexity of experiences, they should be willing to listen. In the accounts of the women interviewed lie many of the answers for healthcare institutions to improve access, continuity, and comprehensiveness of their care.

What do these accounts mean for us, feminists activists and researchers? Sharing these experiences is not just necessary as a "source of knowledge, but also as a point of departure for new practices. For many feminists, the current world requires embodied and transformative words, which are capable of restoring meaning to the lives we live and of disarming unjust conditions, both between individuals and in general social relations" (Ciriza et al. 2009-2011, 8; my translation). To shake the limits of institutions, we need to keep creating spaces for the emergence of these embodied knowledges that will lead us towards ever expanding horizons of autonomy and solidarity.

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Notes

1. The law defines "obstetric violence" as "that which healthcare agents inflict upon the body and reproductive processes of women, through a dehumanized treatment, an abuse of medicalization, and the pathologization of natural processes" (Argentinian Congress 2009, 6).

2. In a 1999 study that questions the critiques on the medicalized birth in Canada, Bonnie Fox and Diane Worts found that women who lack family and social support, and whose living conditions are complex due to the presence of other children and their responsibilities as sole economic providers for their households, accepted and even sought medical intervention. Intervention was viewed as resources that helped them lighten the load of the privatization of care work. An additional day in the hospital meant a reprieve from housework tasks and caring for the newborn until they got home. Nevertheless, this can only be applied if healthcare services actually provide help to women with their newborns and their own recovery while in the hospital. In the large provincial hospital where I conducted observations, women were not allowed companions during their postpartum stay after vaginal deliveries, even when they had had complications such as serious tears or painful episiotomies.

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