

Abstract

This qualitative investigation documents various sociological factors that facilitate violations of women's reproductive rights during childbirth in Mexico. It is based on the testimonies of women who received care at public health institutions and on more than three months of observation in hospital labor and birthing rooms. Three patterns of behavior were considered: those of health-care personnel, including insisting on women's obedience, discounting women's knowledge, etc.; those of the women themselves; and those of the institution. It is proposed that attention to reproductive rights necessitates that preventive measures be directed toward changing medical education, modifying mechanisms for daily supervision of medical practice, and changing the complaint mechanisms available to women.

Cette enquête qualitative documente divers facteurs sociologiques qui facilitent les violations des droits génésiques des femmes pendant les accouchements au Mexique. Elle s'appuie sur les témoignages de femmes qui ont reçu des soins dans des établissements publics de santé et sur plus de trois mois d'observation dans des maternités. Trois types de comportements ont fait l'objet d'une étude: ceux des membres du personnel de santé, notamment lorsqu'ils exigent l'obéissance des femmes, ignorent les connaissances des femmes, etc.; ceux des femmes elles-mêmes; et ceux des établissements proprement dits. Cette enquête suggère que l'attention accordée aux droits génésiques nécessite que des mesures préventives soient prises pour changer l'éducation médicale, modifier les mécanismes de supervision quotidienne des pratiques médicales et améliorer les mécanismes de recours à la disposition des femmes désirant se plaindre.

Esta investigación cualitativa documenta diversos factores sociológicos que facilitan las violaciones de los derechos reproductivos de la mujer durante el parto en México. La misma se basa en las declaraciones de mujeres que recibieron atención en instituciones de salud pública y en más de tres meses de observación en cuartos de maternidad y salas de partos de hospitales. Se consideraron tres patrones de comportamiento: los del personal de atención de la salud, incluyendo su insistencia en la obediencia de las mujeres, y una falta de tomar en cuenta el conocimiento de las mujeres, etc.; los de las propias mujeres; y los de la institución. Se propone que la atención a los derechos reproductivos exige que se implementen medidas preventivas—cambiando la educación médica, modificando mecanismos para la supervisión cotidiana de las prácticas médicas y mejorando los mecanismos de quejas o denuncias disponibles a las mujeres.

VIOLATIONS OF REPRODUCTIVE RIGHTS DURING HOSPITAL BIRTHS IN MEXICO

Roberto Castro and Joaquina Erviti

Over the past 10 years, the sexual and reproductive rights agenda has gained prominence in international fora. A range of international conferences, including Human Rights (Vienna, 1993), Population and Development (Cairo, 1994), Social Development (Copenhagen, 1995), and Women (Beijing, 1995), have played a key role in the promotion and protection of human, sexual, and reproductive rights in many countries, often helping to turn discourse into concrete actions.¹⁻⁴ These conferences have contributed significantly to making reproductive rights part of the human rights agenda and have conferred legitimacy to the fight to promote and protect reproductive rights.

Despite many strides, gender inequalities continue to challenge the realization and implementation of reproductive rights. These inequities affect national health policy as well as the delivery of reproductive health services.⁵⁻⁷ Specific proposals have been developed to evaluate the degree to which a state can be held responsible for the failure of health care institutions to respect reproductive rights.⁸ In Latin America, numerous complaints and court cases have informed the political debate and provided evidence that both private and public health care institutions in Latin America frequently violate women's reproductive rights. The Latin American and Caribbean Committee for the Defense of Women's Rights has documented diverse

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forms of violence against women in public health care services in Peru and has exposed a state-run program to surgically sterilize women from the most marginalized and vulnerable sectors of the population.^{9,10}

In Mexico, individuals, researchers, and activists have been gathering evidence of such abuses for several years. Official sources, such as the National Family Planning Survey and the National Reproductive Health Survey, have publicized information on violations of reproductive rights.^{11,12} Findings from the work of academic research have been made public.¹³ The media has also been active in this regard, publishing individual stories or the outcomes of public hearings. One particularly salient example was the Tribunal for the Defense of Reproductive Rights, organized by the Women's Health Network of Mexico City in 1996, during which women testified about the abuse they had undergone in public health institutions. The tribunal, comprising health authorities and government officials, was a precedent-setting event that helped increase the visibility of violations of women's rights committed by health institutions and emphasized the amount of work still needing to be done.¹⁴

In recent years, two important public institutions, the National Human Rights Commission and the National Medical Arbitration Commission, have also worked to shed light on reproductive rights violations in Mexico. In December 2002, the National Human Rights Commission presented its "fourth general recommendation" to Mexican health authorities.¹⁵ This document cites administrative practices that constitute human rights violations in failing to obtain the free and informed consent of indigenous populations to use family planning methods. According to the National Medical Arbitration Commission, the second most common complaint in 2001 and 2002 was poor prenatal and childbirth services in health care institutions.^{16,17} Despite widespread criticism of both institutions (the first, for lacking the power to enforce its decisions, and the second, for diverting attention from systemic abuses to the actions of individual health care providers), the information generated has contributed to recognition that violations of

reproductive rights within public hospitals in Mexico is a serious problem.

Denouncing all types of violations of women's human rights that occur in health care institutions is clearly indispensable for achieving gender equity. But complaints and legal actions alone cannot bring about change. A sociological study of the mechanisms that operate between health care providers and their patients, and how they contribute to violations of rights, is also necessary. Additionally, patterns of interaction and communication, as well as submission strategies, that characterize physician-patient encounters must be explored. The physician-patient relationship plays a central role in what we call "violations of reproductive rights during birth." This article is based on a research project whose general objective has been to identify and examine physical and psychological aspects of abuse that women have suffered. Characterizing dimensions of abuse can help to identify violations of reproductive rights and formulate interventions that may diminish the problem and help to empower women to defend and protect their reproductive rights.

The Problem

Considerable evidence has shown that women's reproductive rights are frequently violated in public-hospital settings in Mexico. In some instances, women who have cried out during labor reported being reprimanded by physicians who ordered them to control themselves. Physicians have defended their behavior by arguing that these women are simply paying for the mistake of having enjoyed sex. In some cases, physicians have been extremely authoritarian and repressive. Their actions can only be interpreted within the framework of gender inequity that characterizes these encounters. The following case is typical:

[M]y head hurt a lot. I remember that I told the doctors "It hurts, it hurts." I told them that my head hurt, and they told me, "Restrain yourself, that's how you liked it!"¹⁸

The logic behind this response is surprising: Physicians

want a woman to control herself, to be quiet, to stop complaining, by "reminding" her that at another moment she must have experienced sexual pleasure and, "consequently," she must now live "with the consequences." The response, "that's how you liked it," is similar to others ("But you enjoyed it before, didn't you?" or "But you had a good time, right?") encountered throughout this study, as well as those cited in recent publications.¹⁹ In other instances, women have been blamed for a difficult labor, possibly in an attempt to place responsibility on the woman by accusing her of "not cooperating sufficiently." This approach makes women responsible for the pain they are experiencing and functions in the context of gender oppression. Such treatment is partly the result of the institutional framework that puts the physician at center stage, even during childbirth, and makes the woman merely a participant whose role is only to "cooperate" or "help" the physician.²⁰

This issue merits greater investigation: Why do physicians treat patients in these ways? What are the social mechanisms or power dynamics that justify such repressive treatment and that consider the pain of labor as punishment for women who had presumably enjoyed their sexuality? These repressive actions incriminate women. What norms do physicians think women have violated? What causes physicians to defend their behavior and to perceive women as deviating from these norms? This area of research must keep in mind the imbalance of power within the physician-patient relationship, in which one actor is invested with power/knowledge and the other is "only a patient." The imbalance is even greater during gynecological or obstetrical procedures because of a woman's physical and emotional vulnerability during pregnancy and labor. It is essential to consider this power dynamic in this type of analysis.

Violations of women's reproductive rights do not occur only when they are in labor. These rights are violated in other, sometimes more subtle ways, such as in the methods used to obtain a woman's "consent" for sterilization or insertion of an intrauterine device (IUD); excluding a woman from participating in decisions about her labor and delivery (or doing so in an extremely authoritarian manner); ignoring women's requests or complaints; permitting four or

five residents, under the direction of an instructor, to “practice” conducting vaginal examinations while a woman is in full-blown labor; performing a C-section only because the birthing rooms are full; and so forth. In short, evidence suggests that much hospital care during labor falls along a continuum of mistreatment or abuse of women. This abuse, which, in fact, is institutional violence, is both physical and psychosocial in nature and is related to, among other things, the organization of gynecology and obstetric services, traditional ways of training medical residents, and dominant conceptions of women.²¹ This being said, the categories of “mistreatment” and “abuse” are general and ambiguous and require detailed clarification within the framework of women’s reproductive rights. We maintain that it is necessary to carry out research to explore the specific mechanisms of “mistreatment” and “abuse” during hospital births, as well as the institutional conditions (both material and ideological) that make it possible for health care providers to find these forms of abuse “natural” and/or to legitimate the dominant relationship that is established with patients.

The previously mentioned scenarios are not isolated incidents of individual physicians who lack respect for their patients; rather, these tendencies reflect institutional norms that provide fertile ground for violations of women’s reproductive rights.²² Because our concern is with institutional violence, it was considered essential to carry out research that identifies the sociological mechanisms that enable and perpetuate these abuses. This is not only a “quality of care” issue, though we do recognize that more recent indicators for measuring “quality of care” seek to consider the issue of women’s rights and respect for their free will.^{23–25} However, reducing the problem to a simple question of quality is to ignore the more profound issue—the nature of these violations as human rights issues—and consequently contributes to minimizing them or making them invisible.²⁶

We surmise that violations of reproductive rights fall along a continuum from most-serious to less-serious forms of “mistreatment” and “abuse.”²⁷ The general hypothesis of our project is that these moderate forms of mistreatment have the potential to evolve into serious rights violations.

This study has therefore focused on the more “moderate” level in order to first identify the sociological dynamics that make such abuse possible and then to determine what interventions are needed to prevent their reoccurrence.

Methodology

This project’s data were gathered and analyzed in three well-defined phases. Between 1994 and 1996, women were identified who had spoken of abuses they experienced while in labor during in-depth interviews conducted for a project on health and reproduction in Morelos and on health care services in Mexico.²⁸⁻³⁰ These testimonies were accidental discoveries. Between 1997 and 1999, a small investigation was carried out with more than 20 social researchers in Mexico to explore ethnographic material they had collected for various studies. In this way, we were able to gather testimonies from Sonora, Queretaro, Mexico City, and Veracruz. A total of approximately 200 testimonies were compiled from women who reported having experienced various types of mistreatment while giving birth. For the most part, these testimonies came from studies with other objectives and registered evidence of abuse almost accidentally. In 2000, convinced that we were faced with an issue of great importance, which appeared in diverse social research studies without being the object of these studies, we decided to move into the third phase and to carry out formal and systematic direct observation in birth and labor rooms in the two largest public hospitals in Cuernavaca (the capital city of the State of Morelos). The authors, with the assistance of three anthropologists, carried out a total of 64 observations, lasting an average of four hours each. A total of 30 days of observation took place in each hospital.³¹ Observations were handwritten and later transcribed by the observers. A total of 246 hours of observation were completed, with an average of two births per observation day, totaling approximately 130 births (C-section and vaginal).

Both the direct observations and testimonies gathered during the first two phases of this research process are being analyzed using qualitative methodology.³²⁻³⁴ This is not a statistical study, nor is it based on any type of randomized

design. On the contrary, the design of this study is guided by a grounded theory approach. As recommended by this perspective, analysis is based on identifying patterns that “emerge” from the data: in this case, diverse forms of mistreatment, the mechanisms physicians use to exercise control over women, and the ways in which women resist, as well as submit to, this repression. The findings are illustrated with “typical” cases (testimonies) that represent the larger pattern.

Findings

This study began with the assumption that most women who give birth in public hospitals are not subjected to serious human rights violations by medical personnel. Our research focused only on births and C-sections during which rights were violated; even one such case has social relevance, warrants further investigation, and “represents a negation of the individuality of some person as a human being.”³⁵

Analysis of the data has revealed that the severity of reproductive rights violations committed during vaginal and C-section births falls along a continuum of which only extreme incidents—and even here only occasionally—receive public attention. The more visible cases tend to be those in which evidence documents that a woman’s health has been harmed or that her rights have been seriously violated. In these situations, the health care institution is clearly liable or responsible and reparations for damages may be made to institutional authorities, the National Commission of Medical Arbitration, or through the courts.³⁶

At the other extreme are “naturalized types”³⁷ of abuse and violations of women’s rights. These forms of mistreatment are either not considered crimes, and therefore cannot be taken before the courts, or they do not visibly harm a woman’s health, making them difficult to address within the existing frameworks of health care institutions. Inappropriate humor, harsh language (including scolding and humiliation), manipulation of information, and other inappropriate behavior all fall into this category. We contend that studying these “less-severe” acts of abuse and vio-

lations of women's rights in health care institutions is crucial to understanding how and why the more extreme situations arise.

This study has identified three patterns of behavior during childbirth that result in violations of women's reproductive rights:

- Health care personnel using their positions of power and control to intimidate women.
- Women unaccustomed to defending their rights easily accepting the role they are forced into as hospital patients, thereby reflecting and replicating the oppressive situation in which they find themselves.
- Public health institutions, through their structure and mechanisms, discouraging women from pursuing formal complaints.

At this time, our work has advanced primarily in analysis of the first identified category. Consequently, the rest of this article focuses primarily on this element, though the other two are discussed briefly.

The Role of Health-Care Personnel

The hierarchical relationships between health-care personnel and women who are in labor lay the foundation for the eventual violation of reproductive rights. We have identified the following patterns of behavior.

Promoting Conformity and Obedience

From the time a woman enters the labor room she is told, either directly or indirectly, that she must obey the doctor or face serious consequences to her health and well-being:

Everyone repeated that I had to follow the doctor's orders to the letter and that the better I followed them, the less I would suffer.

Women who occasionally questioned the logic of a doctor's orders were treated with disdain and made to feel as if their inquiries were acts of insubordination:

They said: "Here you will do what you are told, not what you want!" and I said, "But it hurts," and they said, "Don't be a whiner! . . . It's doctors orders that we put it back in," and I said, "Listen now I don't feel anything, now I feel fine," and they said, "While you are here you have to accept anything that we put in you!"

Discounting Women's Opinions and Knowledge

Some health care providers are also dismissive of any information and knowledge a woman might have about her health and about the birth process. Such interactions can have both immediate and long-term consequences:

I went to the emergency doctor at the hospital and he told me: "You aren't here to give birth, you are only here to waste my time, because there is a long time still to wait," and I was having pain after pain [regular contractions] and the doctor didn't want to attend to me. . . . Since then, I loathe that hospital."

In other cases, this dismissive attitude has resulted in loss of life. A woman whose baby died at birth reported the following:

It was the carelessness of the doctors, but also my own [fault] for being ignorant, for not knowing that one could demand things: My water broke, and I told them, and they said no, and I said yes . . . And they didn't pay attention to me. . . .

Hospital personnel also provide little if any information to women about their health. Women are not allowed to see their medical file (which is frequently kept underneath the patient's mattress), and women who covertly attempt to read their file are publicly reprimanded in an apparent attempt to discourage other women from such behavior.

Discrediting Women's Suffering

The two previously mentioned scenarios—establishing a hierarchy and discounting women's knowledge—lay the foundation for a third pattern of behavior, the consequences of which may be even more serious: invalidating women's suffering. With intolerance of patient interaction and condescension toward information provided by patients, it is

not surprising that women's responses and reactions to pain are also invalidated. A woman who had a C-section stated:

I felt it when they were cutting me, and I said, "Listen, it hurts, I know that you are cutting," and they said, "It's not anything, you're just nervous." "No," I said, "it hurts, it hurts!" And they said, "It doesn't hurt, it's your nerves." Then I started to cry. . . . I will never forget how terrible it felt. It seemed to me like a pig being slaughtered, and I cried.

Minimizing Women's Roles

The hierarchy, the supposed monopoly of knowledge-possessed by hospital personnel, and the discounting of women's complaints are possible because of, and are reinforced by, the social order within the hospital. This social microcosm makes health care providers the "stars" and puts patients (in this case, women) in "supporting roles," despite the fact that they are giving birth. Against the backdrop of such a microcosm, it is no wonder that patients—even women in the midst of childbirth—are expected to cooperate, to help:

They told me not to give up, that I had to help them speed things up. The doctor said: "I'll help you, I'll help your baby, but you have to follow my instructions. . . ."

The understanding that "good" patients are women who *cooperate* facilitates the possibility of blaming a woman when complications arise or mistakes are made:

That doctor, I think he was drunk and he didn't take proper care of me: If my baby was really big, they could have done a C-section, right? Not him, he said that I didn't help at all, and, I don't know, the thing was that he pulled, he twisted the cord, that is to say he drowned the child, well I say that he strangled it, right? . . . And then he said to my husband: "Your wife didn't help, it's her fault. . . ."

Threats and Physical Punishment

The oppressive hierarchy, along with disrespect of women's knowledge, allows health-care providers to insist on *best behavior* and *cooperation* from their patients. In numerous testimonies, women recall being warned against

crying out and of the consequences of disregarding physicians' orders:

And the doctors said: "If you keep shouting we won't attend to you," and they yell at you in front of everyone and everyone looks, so it is better not to cry out, and there you are.

Physicians use similar tactics to convince patients to agree to certain procedures. For instance, a doctor might obtain a woman's "cooperation" to do a spinal block by telling her that if she moves during labor and delivery, she could damage her baby, which would be her complete and total responsibility.

Physical punishment is used almost exclusively with women who, because of their poverty, do not have the capacity to assertively demand that their rights be respected, or with women who the health care personnel consider to be openly defiant of the existing medical hierarchy. Examples include women who complain and cry out constantly or who do not obey instructions to be quiet. It appears that women who shout a great deal are punished by being ignored until they learn that it is better to endure the pain in silence. The resumption of care is accompanied by statements such as "that's better my dear," which positively reinforce the recently acquired submissive behavior.

Other forms of "defiance" irritate physicians and nurses even more, such as women who refuse to use contraception. Health care personnel consider this openly rebellious behavior and they openly disapprove of it. Take, for example, the treatment of a woman who was giving birth to her tenth child and refused to use contraceptives. The woman was received in the labor room with overt expressions of scorn and reprobation by health care providers. The labor progressed normally until the woman was moved to the birthing bed. At this point, the following interaction was recorded:

Intern 3 was next to the legs of the woman and stayed looking at her, and Intern 4 was beside the head of the woman and also looked at her. The woman was lying down with very strong contractions. Intern 3 stood with

arms crossed and, looking down at the woman (openly taking a dominant position), ordered: "Get on the stretcher! Or do you want your child to be born here in this filth?" The woman moved all over with evident signs of pain and lack of control and asked, "Ouch! Where Miss?" at the same time as searching with her hand for a way to move to the birthing bed. Intern 3 did not move from her place to help the woman, or take her hand, and said in a cold and punishing tone, keeping her arms crossed and with haughty look: "How come? Mrs. Ten-Children and you don't know!" and she indicated the birthing bed with a look. The woman groaned loudly because of the pain and cried in desperation as she tried to move to the bed and said: "I can't! Help me! Help me!" Intern 3 stayed immobile with her arms crossed, completely estranged from the desperation and suffering of the woman: "Move Mrs. or your baby is going to be born there." The woman looked at her pleadingly and said between the contractions: "Help me please!" Intern 3 did not move and only said: "Move now, Mrs." (as if saying, "don't beg"). Desperate, humiliated, and crying, the woman said to Intern 3: "You are cursed! Why can't you help me?" Intern 3 did not appear to react to any of the signs of pain or needs of the woman and said (with a face that expressed "I am fed up with sentimentalism"): "Hurry up! You really can't move?" Finally, with great difficulty the woman moved unassisted to the bed without saying anything to the intern. The latter finished by saying: "You see! The baby is going to come out all covered in urine and it is your fault."

Using Coercion to Obtain Consent

Surveillance, discipline, submission, and punishment in birth and labor rooms are used to intimidate women into using contraceptive devices, such as an inter-uterine device (IUD). Health care personnel often use group pressure to get a woman to "consent." The following is a typical scenario that the authors observed firsthand (the woman has just given birth):

Physician: Will you insert an IUD?

Nurse: Right! What are you going to use for control, huh?

Woman (unsure voice): I live with my parents.

Nurse (loudly, looking in her eyes): Oh, you live with your parents! Me too, and I'm six months pregnant!

Physician: Should we insert it? It is better that we do or else you will be here again next year.

Woman: And if it hurts me?

Nurse: Do you think that if it hurt the other women they would put it in? If it hurt we would all be like you [meaning: "always giving birth"].

Woman (in a weak voice, without looking at anyone): Yes, but there are other methods . . .

Nurse: What methods? Hormones?

Physician: The IUD is the most effective.

Nurse: And, if you use pills you will get fat and ugly. The IUD won't bother you if you have it checked every three months.

(They all look at the woman, who looks at the ceiling and doesn't say anything.)

Nurse: The IUD is 90% effective. The other methods are only 50% effective. It is not recommended to use hormones. Hormones cause psychological alterations.

(The woman is silent.)

Doctor: So, shall we insert it?

Woman (in a defeated voice): I guess.

Inappropriate Sexual Allusions

Health-care providers try to "justify" various types of mistreatment and abuse of patients. The most common, which requires more in-depth investigation, are allusions to women's sexual pleasure. These allusions can be relatively direct, such as that mentioned above ("you liked it"). Alluding to sexual enjoyment also provides the foundation for repressing women:

The woman asks timidly: "Give me a C-section." The resident responds violently, yelling: "Nooo!!! It has to come out where it went in! Why did you get pregnant? You wanted to: Now, put up with it!"

At times, repressive statements are disguised as jokes:

Nurse (asks the doctor): Are you going to do an episiotomy?

Doctor (with a serious expression but playing the joker):

Of course: to all of them, as punishment.

In extreme cases, physicians seem to have little or no understanding of what happens in the birth and labor rooms. For instance, some physicians have said that patients “like it when you touch them [vaginal exploration],” and others confuse groans of pain during labor with expressions of sexual pleasure. One of our observers recorded the following:

The intern started to speak with me and began by saying that he found it incredible that women have more and more children. He also said that he thought that women must have exquisite sensations of pleasure during labor because there was no other way of explaining why they would have so many children. He said: “Have you seen how they get during the last hours?”

The Role of Patients

Women unaccustomed to defending their rights may easily accept the role they are forced into as hospital patients, thereby reflecting and replicating the oppressive situation in which they find themselves. Thus, women may unknowingly contribute to certain types of mistreatment, illustrated in the following:

Abuse As a “Natural” Response

In some cases, women have actually justified certain kinds of abuse they received from physicians as “logical:”

I was very perturbed but I didn’t lose control, because one drives the doctors crazy, and causes them to, *well it’s logical* that they get exasperated and yell . . .

Women’s uncritical attitude about the quality of services that they receive allows them to adopt a conformist attitude:

So she said: “Since you don’t feel, put yourself in my position.” . . . And I would challenge him, but, you know, when you act like that they treat you even worse . . .

Socialization and Internalization of Norms and Judgments

Women may also internalize a physician’s discourse, which can include pejorative statements and negative judg-

ments about their own behavior:

I didn't cry, I feel like I behaved well, that is to say, I didn't yell. It was fine. . . .

Foolish me, when one is going to give birth one is really foolish, at least I am. . . .

These remarks reflect the oppressive situations many of these women have become accustomed to, even as they contribute to perpetuating this oppression.

The Role of Public Health Institutions

Finally, institutions, either intentionally or unintentionally, discourage patients from making complaints and seeking compensation. These mechanisms help perpetuate violations of rights. In many cases, women do not know the name of the physician who is providing care, which makes it much more difficult to identify an individual who may have mistreated them. In addition, the frequent rotation of health care personnel makes it difficult for women to locate the individuals who attended to them. More overt forms of discouragement warn women that complaints they make now may affect any future medical care they may need. Women, especially those with family responsibilities, who would rather avoid this risk are obliged to keep their dissatisfaction to themselves.

Conclusion

Although abuse and human rights violations clearly do not occur every time a woman gives birth in a public hospital in Mexico, patterns of mistreatment have emerged that require in-depth research to identify the causes of such mistreatment, eventually leading to their eradication.

This article has attempted to show that violations of women's reproductive rights during childbirth, which we call naturalized forms of rights violations, do exist but are frequently ignored because they are not considered criminal acts and do not result in overt, physical harm to patients. This study asserts that understanding these moderate forms of rights violations is key to understanding how more extreme violations come about. This type of abuse turns women into objects, thereby denying them their human

rights and laying the groundwork for more serious rights violations. Whether these more serious abuses become concrete cases or not, and how this occurs when they do, is an issue that demands further research. However, any research must consider a crucial issue: The patterns of rights violations that emerge within health institutions are not random acts. On the contrary, they are, at least in part, the result of a state policy that lacks an adequate gender perspective and bestows on institutions the "right" to influence women's reproductive decisions.^{38,39}

If this hypothesis is correct, interventions must be implemented to address the contexts in which "moderate" abuse takes place. Such interventions would contribute significantly to preventing extreme forms of abuse; they would also call attention to the abuse that many women endure while giving birth and that often goes unnoticed.

In an effort to stop this abuse and violation of rights, we suggest that initially three steps be taken: introducing a gender perspective and developing a greater awareness of reproductive and sexual rights in the university curriculum of health care professionals; implementing daily supervision of medical practice by hospital authorities to prevent these types of abuses from occurring; and, most importantly, encouraging women to voice their complaints by changing the mechanisms available for them to do so.^{40,41} Birth conditions in public hospitals will be improved and violations of reproductive rights will be prevented only when women become aware of their rights and believe both that their voices will be heard and that corrective measures will be taken.

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31. The Mexican public health care system is divided into two broad areas: institutions of social security (of which the Mexican Institute of Social Security is the most important), which provide services for formal private and public sector workers and cover 51% of the Mexican population; and the Ministry of Health, which provides services for the 49% of the population that is not covered by any kind of social security. (<http://www.ssa.gob.mx>, August 25, 2003).
32. B. Glaser and A. Strauss, *The Discovery of Grounded Theory: Strategies for Qualitative Research* (New York: Aldine de Gruyter, 1967).
33. K. Charmaz, "Qualitative Interviewing and Grounded Theory Analysis," In: J. F. Gubrium and J. A. Holstein (eds.), *Handbook of Interview Research: Context & Method* (Thousand Oaks: Sage Publications, 2002), pp. 675-694.
34. Analysis of the interviews was carried out using Ethnograph 5.0.
35. A. Cervantes, "De Mujeres, Médicos y Burócratas: Políticas de Población y Derechos Humanos en México" [Women, Physicians and Bureaucrats: Population Policy and Human Rights in Mexico], In: G. Careaga, J.G. Figueroa, and M.C. Mejía (eds.), *Ética y Salud Reproductiva*

(Mexico: PUEG, 1996), pp. 317-348.

36. It should be stated that what can be prosecuted in judicial terms depends on the laws and justice system of each country.

37. We propose the term "naturalized forms of abuse" to classify those abuses that might not be perceived as such by health care providers, nor at times by the women themselves. In a context of gender inequity, there is an accumulation of behaviors that are based in, and at the same contribute to, the perpetuation of gender inequity. As a consequence, these abusive behaviors can be perceived as "natural" by the actors involved. The "naturalization" of these acts contributes both to making them invisible and to keeping them invisible. In contrast, non-naturalized forms of abuse are those that the actors perceive as abuse, primarily those for which there are specific codes (legal, medical, or of any other kind) that permit them to be identified. To develop this concept we drew primarily on Bourdieu's notion of "symbolic violence." P. Bourdieu, *The Logic of Practice* (Stanford: Stanford University Press, 1990), pp. 122-134.

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39. P. Morales, "El Enfoque de Género en Legislación Sobre Salud y Población" [The Gender Perspective in Health and Population Legislation], In: Z. Alanes and S. Rance (eds.), *Una Alianza por la Salud y los Derechos: Memoria del Simposio Interamericano Sobre Legislación en Salud Sexual y Reproductiva* (La Paz: The Population Council, 1999), pp. 56-62.

40. K. Monadas, A. Jesani, and M. Ramnathan, *Gender and Medical Education* (Thiruvananthapuram: AMCHSS & CEHAT, 2002).

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