Naming, framing and shaming through obstetric violence: A critical approach to the judicialisation of maternal health rights violations in Mexico

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Between October 2013 and September 2014, eight cases of human rights violations against Mexican women during childbirth were denounced to human rights oversight bodies by civil society organisations. Cases were petitioned at Mexico’s National Commission on Human Rights (NCHR) as well as at the Inter-American Commission on Human Rights (IACHR), requesting intervention regarding the Mexican government’s acts or omissions on this issue.

The violations occurred during expectant mothers’ failed attempts to obtain care in the public health system, over the course of obstetric care or as a fatal consequence of the care provided, resulting in the woman’s death. The majority of these cases refer to low-income, indigenous and rural women from the poorest and most marginalised states of the country, such as Oaxaca. These cases were litigated pro bono as ‘public interest’ or ‘strategic litigation’ cases (Coral-Díaz et al. 2010), that, while benefitting the victims, simultaneously sought a transformation of the Mexican healthcare system through legal mechanisms and from a rights-based perspective.

The practice of litigating human rights violations against pregnant women is a recent phenomenon in Latin America; even more so, in Mexico. In order for this phenomenon to take place, it was first necessary to argue in the political and legal arenas that access to high-quality and respectful maternal healthcare is a right for all pregnant women. This
has become even more urgent for women who have been historically and socially excluded and discriminated against. Simultaneously, in Mexico a novel type of argument was being framed, using the concept of ‘obstetric violence’ to name and judicialise these violations.

In this chapter, I will examine how this concept was constructed and how it has begun to be used as a tool for demanding justice in human rights oversight bodies. I will explain what we mean by judicialisation in maternal health and how this process is being broached in Mexico by analysing some characteristics and problems of the public maternal healthcare system, in order to understand the context in which judicialisation occurs.

I will analyse one specific case of a violation committed against an indigenous woman from Oaxaca, review the characteristics of the case, the timeline of its progression, the responses from health authorities and the discursive and material strategies adopted by the litigating organisation in constructing and handling the legal case. Through this example, I will share some thoughts about the achievements and limitations of judicialising violations of maternal healthcare, keeping in mind that in Mexico these are incipient, incomplete and evolving processes. In particular, I will analyse the use of obstetric violence arguments and the capacity of judicialisation as a means for compensating victims, as well as its potential for transforming health policy and healthcare delivery to make them less discriminatory and more responsive to poor indigenous women’s needs and rights.

The judicialisation of human rights violations in maternal healthcare and their framing as obstetric violence provide a fruitful ground for anthropological inquiries from a critical medical anthropology (CMA) perspective. CMA can be defined as a theoretical and methodological orientation that is vigilant of structural determinants and power relations around health, illness and health-seeking and whose field of inquiry includes individual and collective responses embedded in those social determinants and relations (Seppilli and Otegui 2005).

The litigation of human rights in maternal health is a social practice that can benefit from becoming the subject of anthropological critique – even more so, when this critique is sensitive to power relations, multiple inequalities and the quest for social justice (Farmer 1999). Unlike the language and practice of law that tends to stress a formalistic, unspecific and universalist reading of human rights including the right to health, CMA provides an analytical lens that highlights their context-specific, relational, disputed, power-related and transforming (as well as transformative) nature in practice.
Moreover, and as Farmer reminds us in relation to human rights abuses, such a critique allows us to understand how violations are related to dominance and the production and reproduction of social inequalities. A CMA perspective also helps to discern the almost inevitable interplay of social class, racism and/or gender discrimination in their occurrence, including in healthcare. In Farmer’s own words:

[Anthropology] permit[s] us to ground our understanding of human rights violations in broader analyses of power and social inequality. Whereas a purely legal view of human rights tends to obscure the dynamics of human rights violations, the contextualizing disciplines [anthropology, history and sociology] reveal them to be ‘pathologies of power’. Social inequalities based on race or ethnicity, gender, religious creed, and – above all – social class are the motive force behind most human rights violations.

(Farmer 1999: 1488)

In particular, we can read the litigation of human rights violations in maternal healthcare through the framing of obstetric violence as a conflictive relational social field (Bourdieu and Wacquant 1995) whose discursive and material stakes are greatly disputed among multiple contenders. Here, a CMA perspective is able to unravel the power dynamics implicit in those contentions; to dissect the differing motives, reasoning and strategies of actors involved in arguing for or against the occurrence of obstetric violence in human rights violations; to understand the underlying meanings attributed to such a conceptual framing in building the legal arguments; to unpack the hegemonic social representations that coalesce around constructions of otherness attributed to subaltern social subjects such as indigenous pregnant women in the clinical encounter; to identify counter-hegemonic representations that arise in subaltern responses during the unfolding of the judicial dispute; and to highlight the socio-political consequences of those contentions and resolutions in victims’ redress as well as in the transformation of the healthcare system from a rights-based perspective.

Judicialisation, human rights and obstetric violence

Judicialisation is defined here as the phenomenon of bringing problems, controversies, requirements and violations of human rights to judicial authorities or to human rights oversight agencies at the national or international levels, so that they can be defined, discussed and legally
resolved; these resolutions and recommendations may include enforceable consequences for the state and its institutions, ones that will frequently require states and their agencies to act in the sphere of public policy. This is possible as part of democratic governance (Domingo 2011) in which the state is accountable for its policies and has an obligation to defend, promote and respect the human rights of all its citizens. Rights, in turn and by definition, are enforceable and justiciable in the framework of international human rights treaties ratified by these countries.

Resorting to legal strategies is a phenomenon that has increasingly characterised Latin America since the early 1990s (Sieder et al. 2011; Couso et al. 2010), in order to resolve social and political conflicts, to make the state comply with existing economic, social and cultural rights, to broaden the scope of rights through jurisprudence, and to intervene in social public policy through the courts and human rights oversight bodies. This process has been referred to as the ‘judicialisation of politics’ in the region (Sieder et al. 2011).

Since the end of the 1990s, the judicialisation of public policy in some Latin American countries has included the right to health (Alzate Mora 2014; Biehl 2013; Biehl et al. 2012; Gutiérrez-Rivas and Rivera-Maldonado 2009; Lamprea 2017; additionally, various case studies in Yamin and Gloppen 2011; and Aureliano and Gibbon, in this volume). Rulings by courts and human rights bodies have recognised violations of this right in vulnerable population groups and have legally forced these countries to implement measures that guarantee access to services, clinical treatment and pharmaceuticals, such as the case of antiretroviral therapies for HIV/AIDS patients in Brazil (Biehl et al. 2009), or lawsuits seeking healthcare coverage and access to drugs litigated through the Colombian tutela system (Yamin and Parra-Vera 2009).

This increasing judicialisation of the right to health in Latin America has been controversial. Crucial debates have been opened about the limits or even the counter-productive effects of judicial intervention in public health systems. Questions have been raised about whether the judicialisation of this right, especially through individual claims, is able to improve or limit collective access to services, treatment and pharmaceuticals, and to promote or hamper equity and social justice within the healthcare system (Alzate Mora 2014; Lamprea 2017; Yamin 2011).

Moreover, the judicialisation of the right to health reaches its structural limitations in a context of public healthcare systems that are deeply unequal and unevenly distributed, and whose medical services are deficient, lacking, overstretched and insufficiently financed – situations that
have worsened after over 30 years of neoliberal policies in Latin America (de Currea-Lugo 2006; Lamprea 2014). This may be so even when judicial decisions attempt to promote a restructuring of the public health system for the common good and in order to guarantee the collective right to health (Alzate Mora 2014).

Beyond these debates, the judicialisation of the right to health certainly implies a formal recognition that health, medical care and access to pharmaceuticals are human rights that should be enforceable, precisely because they can be tried in the courts or legally resolved by oversight bodies. In particular, General Comment No. 14 by the United Nations’ Committee on Economic Social and Cultural Rights (CESCR) has contributed to the enforceability of the right to care, specifying that the right to health include access to medical care, and that health services must be available, physically accessible, economically feasible, culturally acceptable and of high quality for everyone without discrimination, above all when those affected are part of disadvantaged and excluded social groups; this is the case with poor, rural and indigenous women who should have access to adequate and effective maternal health services.²

In Mexico, the judicialisation of the right to health is taking place in a more limited manner and more recently than elsewhere in Latin America. Partly this is related to a justice system that until 2011 was not auspicious for protecting human rights, and even less so for litigation that seeks jurisprudence that is rights-enforcing and socio-politically transformative (Pou Giménez 2014). That year, the Mexican Supreme Court of Justice (SCJ) ruled that international human rights treaties signed by Mexico enjoy the same status as the Constitution; and all public authorities have a legal obligation to respect and guarantee human rights in their areas of competence, opening up a window of opportunity for pro-rights litigation.

The concept of obstetric violence deserves a separate mention for at least two reasons. First, it is central to the construction and appeals process, as well as to the enduring political, legislative and juridical effects in the case that we will consider below. Moreover, it constitutes a powerful epistemic construct to name a multifaceted and widely diffuse problem in many Latin American public hospitals, thus contributing to CMA readings of bio-obstetrics as a sociocultural system that reflects and reproduces inequalities and discrimination on the basis of gender, ethnicity and social class.

Following Medina (2009), obstetric violence is conceptualised as follows:
Any act or omission by healthcare staff that damages, harms or denigrates a woman during delivery, as well as negligence in her medical care, expressed by treatment that is dehumanizing and/or discriminatory, in which there is abuse of medication, or natural processes are pathologised, in detriment to her rights to autonomy and reproductive freedom, or informed consent, including as such, the omission of timely and effective emergency obstetric care.

(Paro Libre and GIRE 2014: 1–2)

This broad definition merges the violence perpetrated against women by virtue of their gender (gender violence) with institutional violence; that is, violence that is perpetuated, often in an organised manner and through the exercise of legitimate power, within hierarchical institutions (hospitals, schools, jails, police headquarters, asylums, military barracks etc.) where individuals tend to lose their personal autonomy.

Medina distinguishes between physical and psychological obstetric violence. The first occurs when a woman in childbirth is subjected to invasive procedures, unnecessary drugs are administered or the course of a physiological delivery is not respected – in other words, when a woman’s body is unnecessarily medicalised or pathologised, transforming her into the passive recipient of external clinical decisions. Psychological violence, on the other hand, includes ‘dehumanising, rude, discriminatory, humiliating treatment when the woman comes seeking advice or medical care, or during the course of provided obstetric care’ (Medina 2009: 4).

Although I would argue that obstetric violence lacks some semantic precision, as an umbrella term it is a powerful tool for legal and political action while, at the same time, helping to explain a complex sociocultural phenomenon that commonly happens during institutional childbirth. As I strive to show in the following pages, it makes an epistemic contribution to CMA studies of biomedicine and bio-obstetrics as sociocultural systems, both embedded in and reproducing societal power asymmetries, while they normalise and naturalise ideologically laden medical practices on the grounds of, supposedly, ideological neutrality, moral superiority, pragmatic efficacy and scientific rationality (Martínez Hernáez 2008; Menéndez 1983), and, I would add, an altruistic value-free science at the exclusive service and benefit of mankind.

The context of the Mexican maternal healthcare system

Mexico has reached a very high level of coverage of qualified care during delivery, going from 77 per cent of all births in 1990 to 98 per cent in
The expansion of coverage is the result of deliberate policies after the turn of the millennium, designed so that Mexican women could give birth in institutional hospitals as part of a strategy for reducing maternal mortality.

However, the expanded coverage is not synonymous with quality of care. This is so much the case that no correlation has been found between the reduction of maternal mortality and more widespread institutional delivery care (Lazcano-Ponce et al. 2013). This data reveals, on the contrary, that institutional obstetric care in Mexico is facing a complex and multidimensional problem.

At the structural level, services are inadequately distributed over the country; they are under-used in primary healthcare due to lack of equipment, personnel or financial means to operate, while hospitals are overburdened by excessive demand; they face frequent supplies and drugs shortages; financial resources are inadequate or unequally distributed among states, between levels of care or between institutions; and human resources are also insufficient and poorly distributed between units, levels of care, by shifts, specialisation and type or level of training (Lazcano-Ponce et al. 2013). These problems are particularly pronounced in primary healthcare, in the most impoverished states in the country and in rural and indigenous regions (CNEGySR 2009; Freyermuth 2011; Lazcano-Ponce et al. 2013; Sachse et al. 2012).

At the organisational level, the Mexican healthcare system suffers from segmentation and fragmentation in service provision, financing, clinical auditing processes and performance evaluation. System administration governance is weak, as are the mechanisms for supervision, oversight and regulation (Lazcano-Ponce et al. 2013). Moreover, serious problems have been detected regarding technical skills and medical staff knowledge in the provision of maternal healthcare (Walker et al. 2012), as well as the failure to comply with technical norms and guidelines (Freyermuth 2011; Lazcano-Ponce et al. 2013; Sachse et al. 2012).

This issue is reflected, for example, in the medicalisation of physiological birth through the routine use of invasive, unnecessary, painful, dehumanising and even harmful practices on women (DeMaria et al. 2012; Sachse et al. 2012; Valdez-Santiago et al. 2013, Walker et al. 2012). These routine procedures and practices are contrary to national norms and international guidelines that are grounded in evidence-based medicine (EMB) (Chalmers et al. 2001; FIGO 2012).

These problems are deeper than mere ignorance about EMB or norms, or deficiencies in management of the system. They reflect systematic and structural issues of over-medicalisation and the pathologisation
of natural physiological processes, as well as the abuse and ‘dehumanising’ treatment of patients: in other words, of the problem of institutional obstetric violence (GIRE 2013; Medina 2009). One national survey revealed that 40 per cent of Mexican women were subjected to mistreatment, abuse and lack of respect during their last deliveries in the public healthcare system. Available qualitative information points to a systemic phenomenon, especially in public hospitals that attend to women who are disenfranchised, poor and/or indigenous (Castro and Erviti 2003; Valdez-Santiago et al. 2013).

The emblematic case of Irma López Aurelio

A photograph began to circulate on social media on 2 October 2013 and immediately generated strong reactions; it went viral within a few hours. The picture was published by the leading national newspapers and the foreign press, and became the subject of various television, radio and internet news reports both within and outside Mexico in following days and weeks.

The photo depicts a young, light brown-skinned woman kneeling in the grass; her face is framed by straight black hair; she wears rubber flip-flops; and her light dress is raised up in the front by her right hand while she props herself up in the grass with her left. In front of her, where her right hand lifts the hem, a naked newborn is lying in the grass; the umbilical cord stretches from the middle of its navel, rising vertically to what can easily be imagined as the mother’s vulva, which is barely covered by the hem of the dress. Her face displays suffering and desperation; her other mixed feelings can only be guessed at – perhaps incredulity, fear and rage. In her face, a cry for help can be imagined, possibly audible in the moment, or maybe drowned in her throat.

This is Irma López Aurelio, a woman from Jalapa de Díaz, an indigenous Mazatec area with approximately 20,000 residents in the southern Mexican state of Oaxaca. Irma was 28 years old when she gave birth to her third child in the grass and without any assistance, because when she arrived, already in labour, at the community healthcare centre at 6 a.m., the nurse on duty told her to go for a walk and return to the clinic at 8 a.m., when the attending physician’s shift would start. An hour and a half later, unable to restrain the urge to push, Irma gave birth alone on the clinic’s patio, since her husband had run to get help. Someone captured the photo on a mobile phone and posted it on social media. Becoming aware of what had transpired, the clinic staff admitted her; nevertheless, before releasing her and the baby that same night, they charged Irma for
drugs and other materials provided during the care. In Mexico, maternal healthcare should be free of charge in the public health system; charging Irma for medical supplies and drugs represented another violation of her right to health.

The local primary care clinic only attends patients from Monday to Friday during daytime operating hours. This situation makes it impossible to provide obstetric care during the night, the early morning and weekends.

Immediately following these events, the clinic staff and state health authorities tried to deflect attention and responsibility for the situation onto others. First, they argued that this was a spontaneous birth: accidental births that occur suddenly are beyond anyone’s responsibility, such as those occurring in taxis, on the street or when a woman is caught unprepared before she is able to reach a hospital. On the second day, facing devastating evidence that Irma had been denied care, the clinic staff began to argue that Irma was indigenous, that she did not speak Spanish and was unable to explain the situation to the nurse when she first approached the clinic. This version was openly supported and disseminated by the regional health authorities, who stated that ‘the child’s mother distorted the information because she spoke only the Mazatec language and was unable to explain what was happening in Spanish’.

In slightly more neutral language, the Secretary of the State Ministry of Health stated that the publication of the photo was unfortunate in that this contributed to ‘fuelling morbidness’ on social media, and was damaging to the public image of the clinic staff. He again argued that Irma had not received care because she could not make herself understood to the attending nurse. The expectation of the Secretary was that Irma would not contend his official explanation and would keep silent. Instead, Irma decided to speak out and refuted his thesis. Interviewed by various state and national media the following day, she related in correct and perfectly comprehensible Spanish not only that she had not been attended when she arrived at the healthcare centre and explained that she was already in labour, but that even after what had occurred, they admitted her for examination and charged her 400 pesos for the medications and hygienic materials used. Moreover, she stated that she had been subjected to threats and pressure after expressing dissatisfaction and her intention to formally file a complaint.

The broad media coverage revealed the poor state of healthcare services in Jalapa de Díaz and the serious crisis in maternal healthcare, especially in rural and indigenous areas. It also highlighted Irma López’ indignation not only about the treatment she received, but also about
the public statements of the Health Secretary, and additionally revealed her intention not to remain silent and her desire to denounce the issue. Finally, it emphasised the paltry and clumsy response of the Ministry of Health, which, instead of recognising the seriousness of the issue and the systemic crisis that the situation displayed, tried to deflect responsibility onto the victim, in a process of naturalising substandard care and the re-victimisation of Irma, while expecting simultaneously that media attention would cease and the usual amnesia prevail.

Nevertheless, this did not occur. Seeing the turmoil on social networks and in the press, the National Commission on Human Rights (NCHR) – the highest human rights oversight agency in Mexico – decided almost immediately to open an investigation of the case. Founded by presidential decree in 1990, with a mandate to supervise the Mexican public administration’s handling of rights and to promote a culture of respect towards human rights, the NCHR is an autonomous, decentralised and well-financed body. Its different inspectorates have pursued and documented systematic violations of human rights, including cases of abuses in healthcare provision or in the denial of care. The recommendations issued by the NCHR remain the country’s main avenue for achieving restorative justice (Pérez Sauceda et al. 2011) in cases of human rights violations perpetrated by public authorities.10

Media coverage continued to increase, feeding off of new statements, interviews and reports about the case, while over the following weeks, four similar cases of women denied care came to light, three of them in Oaxaca. The following days brought Irma together with GIRE AC, which formally assumed her legal representation and began to construe the argument that Irma had been a victim of institutional and obstetric violence.11

Facing growing pressure from public opinion, a week later the state authorities felt forced to change their strategy. They recognised that the staff of the health clinic had not attended to Irma in a timely manner, putting her and her baby at risk. The removal of the local clinic’s director and the head of the regional health authority were announced, and two new doctors hired. The dismissals took place despite the fact that previously the medical staff of the healthcare unit had acknowledged the lack of material and human resources with which to attend to the women who went there for care during delivery. In the case of rural clinics, these do not have enough birth rooms and frequently lack medicines.12

Although the NCHR investigation was already underway, Irma – as advised by GIRE – filed a complaint to the Commission expressly requesting measures that she considered appropriate for repairing the harm caused, including measures for non-recurrence. Four months later, the
Commission issued a recommendation to the Government of the State of Oaxaca, citing the exercise of institutional and obstetric violence and claiming violations to the right to a life free from violence, the right to equality, the right to non-discrimination and the right to protection; these violations were due to the lack of adequate medical care and the absence of necessary infrastructure for the provision of healthcare services. In this recommendation, the NCHR requested reparation of the damage, and that measures be taken against non-recurrence; but the recommendation failed to state explicitly what these measures should be, except for mentioning generic courses for staff training in human rights and the need of better staff training on filling medical charts and records. This last point left the corresponding decisions about specific measures of reparations and non-recurrence (how to improve the maternal healthcare system) up to the same authorities that had perpetrated the violations in the first place.

Responding to this situation, GIRE publicly stated that the NCHR was not complying satisfactorily with its role as defender and guarantor of the human rights of Irma and her child; at the same time and among other actions, the organisation entered into direct negotiations with the Oaxaca government, with whom it ensured reparations: economic compensation, permanent medical care for Irma and for her child, a grant for the child’s education and a public apology, offered by the Secretary of the State Ministry of Health in a press release in March 2014. Finally, they agreed to transformational measures in healthcare services: opening new positions for medical staff; a state-level staff training plan in human rights, intercultural health and gender equity; a sensitisation programme for healthcare staff about their civic responsibilities as public servants; the establishment of 50 new birthing rooms in the state; and the completion and opening of the basic community hospital in Jalapa de Díaz.

As an additional action, GIRE, together with two other Mexican NGOs, petitioned in a hearing at the Inter-American Commission of Human Rights (IACHR) in Washington DC, exposing the issue of violations of the reproductive rights of four Mexican indigenous women during a presentation on public maternal healthcare provision that highlighted Irma’s case. The organisation argued that these human rights violations present common traits, that these flaws are structural and systemic and that Mexican government policies and programmes on maternal healthcare and the reduction of maternal mortality are not sufficient nor necessarily the most suitable for resolving problems that discriminate against women and jeopardise their security and integrity. GIRE noted that in the face of these violations, opening criminal cases and the penalisation
of the responsible healthcare staff through individual trials is not the best solution; rather, it is essential to find solutions that transform the healthcare system instead.

GIRE emphasised the poor treatment of the victims by the NCHR and their precarious access to justice in denouncing the increasing violations that indigenous Mexican women experience in public healthcare facilities. It argued that the NCHR did not listen to the victims, did not incorporate their demands for compensation in the scant recommendations that it issued, did not include concrete measures to avoid recurrence of these issues, and above all did not provide any information about whether recommendations accepted by the corresponding authorities were being complied with.

The Mexican government was present at the IACHR hearing, with a committee composed of high-level representatives, including the Deputy Secretary of the federal Ministry of Health and the Secretary of Health from Oaxaca. In his statement, the Deputy Secretary acknowledged that Irma’s case was highly regrettable and violated her rights. He explained that this case had provoked reaction and many responses including the adoption of a nationwide ‘zero rejection’ policy on pregnant women by public institutions in the healthcare sector. He added that the country’s 32 federal entities had committed to effecting it immediately. Nevertheless, he denied that what happened to Irma was symptomatic of a systemic and structural problem. Rather than the concept of obstetric violence, he used the terminology of malpractice and spontaneous birth to explain that, by his estimation, the cases similar to that of Irma in Oaxaca represent a very small number of total births (CIDH 2014).

As months and then years passed, following the issuing of the NCHR recommendation and the signing of the compensation agreement with the Oaxacan government, GIRE waited for the Oaxacan Ministry of Health to comply with the agreements. One year after the recommendation and 10 months after the agreement was signed, the organisation issued a press release expressing concern about the total lack of compliance with measures designed to prevent a recurrence, including the incompletion of the basic community hospital in San Felipe Jalapa de Díaz. In the statement, it called on the NCHR to follow up on the recommendation issued the previous year, in order to ensure that the Government of Oaxaca complied with the agreed-upon commitments of ‘guaranteeing that healthcare services be safe, and have necessary infrastructure, and respect the human rights of women’. Four years later, the Oaxacan Ministry of Health still has to comply with most of the non-recurrence measures recommended by the NCHR and agreed upon with GIRE.
Discussion

The case of Irma allows us to reconsider broader questions about actions, strategies, goals and effects of judicialisation on the violations of the rights of indigenous women in the area of maternal healthcare and to analyse them in light of what this concrete example reveals. The discussion is informed by a CMA perspective and includes the following points: the interactions among intervening and disputing actors and some of the underlying meanings and representations behind their actions; arguments used in the judicialisation process; the strategies deployed; and the impact of judicialisation on victims’ redress as well as on the transformation of the healthcare system.

The social interactions among contenders: Hegemonic biomedical representations of the indigenous other

Reading the case from a CMA perspective allows us to dissect how discrimination and racism against indigenous women are construed in the healthcare system through stereotyping and how they come to foster and then justify human rights abuses. It also reveals how power relations work within the health system so that the weakest chain-links are those who receive the blame and pay the costs vis-à-vis an outcry by victims and the media.

Irma was repeatedly stereotyped by the clinic’s medical personnel, the regional health authorities and, finally, the Secretary of the Oaxacan Health Ministry as an indigenous woman who did not speak Spanish and could not make herself understood to the attending nurse. This argument placed the blame on the victim and constituted the initial justification behind the denial of care. In all cases, the expectation was that Irma would remain silent, not replying to these arguments. This is the case because indigenous women are commonly perceived by healthcare personnel and authorities as docile, uncomplaining and submissive.

This expectation should not be surprising since – as I highlighted in a previous ethnographic study of hospital births (Sesia et al. 2014) – at least three interrelated dominant social representations commonly converge in the medical encounter with indigenous women, in which differences of class, ethnicity/race and gender permeate established and essentialist conceptions about the supposedly passive, acquiescent and compliant nature of the indigenous expectant mother. On one hand, these women are conceived as part of the other, considered not only different, but hierarchically inferior (backward, ignorant, uneducated and unable to speak Spanish well) with respect to us (the medical cadre) that consider
themselves educated, scientific, modern and urban. Simultaneously, the indigenous women are conceived of as obedient, docile and permissive patients who, by nature, do not question the work of doctors or nurses – even less so the official word of a health authority. Finally, it is common to consider them as noble in mind and heart and, in general, grateful for the free maternal healthcare they receive, independently of how they are treated and the outcomes of the care they were given.

If the patients are perceived as inferior, submissive, grateful and ignorant, then they can be the objects of condescending, disrespectful and despotic treatment within institutional healthcare, without these behaviours being considered blameworthy or punishable by those who perform them, but rather as normal, routine and natural. In this context, even refusing care can be conceived as an act without repercussions, since indigenous women are seen as subject-objects that do not complain or make demands on the system. We can see here how otherness is created and differential discriminatory treatment or even denial of care can be justified in the medical encounter through the essentialisation of cultural characteristics. This should come to no wonder since, as Menéndez (2017), a leading voice in Latin American CMA, reminds us, in Mexico everyday racism (and, I would add, institutional violence in health settings) is constituted, normalised and virulently reproduced mostly through singling out specific cultural traits (such as ‘not speaking Spanish’) through which the other is made different and inferior.

Irma’s response was unexpected and caught the clinic’s personnel and health authorities off guard because it effectively broke with this hegemonic stereotyping. In the midst of the media uproar, it took days for the Secretary of Health to take in this unexpected turn of events and change discourse and strategies.

In general, the public healthcare system in Mexico considers its users as recipients of care and not as rights-bearing subjects. When violations such as this occur, it is common that clinical auditing and internal administrative sanction mechanisms at the healthcare facilities are weak, or are simply not activated when the doctor in charge is a member of a union or otherwise protected. On the other hand, and particularly for members of staff who are unable to defend themselves, institutional sanctions are harsh, without taking attenuating circumstances into account such as the systemic structural deficiencies that often inhibit staff from properly doing their jobs. When there is political or media pressure to act and sanction violations – as was the case here – the authorities do not assume institutional responsibility, but rather find accountable persons among the weakest staff and place the blame on targeted individuals.
It is our understanding that the doctors who were fired had temporary contracts and were not protected by the health workers’ union.

Naming and framing through obstetric violence: The arguments used in judicialisation and a cultural critique of bio-obstetrics

In Irma’s case, the concept of obstetric violence was used in order to argue the violation of the right to care during childbirth. The case could have been argued differently and possibly even more solidly, as a violation of the right to health, integrity and security, in addition to Irma’s having suffered discrimination.

Appealing to obstetric violence, nevertheless, was a deliberate strategy for strengthening arguments that these violations occurred not only because Irma is an indigenous woman who was denied care at a public health institution, but also because she is a member of a group of women who all tend to endure similar violations. At the CNHR and the IACHR hearings, denial of the right to obstetric care, a preventable maternal death and a case of substandard quality of care were all argued as obstetric violence, using Irma’s case as a paradigmatic example of the systemic violations that poor, indigenous, pregnant women endure in the public healthcare system.

Framing these diverse violations as obstetric violence permits a shift from the status of an individual victim who accidentally suffered denial of care, mistreatment, poor-quality care or medical malpractice, to being part of a collective of victims. Simultaneously, it allows a conceptual and ideological shift from conceiving of these occurrences as accidental and random situations to seeing them as a structural condition that the public maternal healthcare system tolerates at best, or, at worst, reproduces and even promotes. Framing the issue this way offers the advantage of construing a single legal argument out of multiple, intertwined and combined violations of human rights at the intersection of gender, race/ethnicity and class discrimination – conceptualising them as acts that infringe not against random individuals, but against a collective of women, at the most vulnerable moment in their lives when they are giving birth.

The use of the obstetric violence frame became possible because the cases filed by GIRE all share specific characteristics that permit the construction of this argument as a structural and shared phenomenon: indigenous pregnant women with scarce economic resources and few possibilities, if any, for accessing the justice system, who have been victims of systematic acts or omissions perpetrated in the Mexican public healthcare system.
In practice, recourse to the conceptual frame of obstetric violence has entailed that GIRE gambled, initially with a considerable degree of uncertainty, on using a novel epistemological category in legal terminology and litigation in defence of women’s human rights and in an attempt to improve the performance of the healthcare system rather than targeting the specific conduct of the obstetric care staff. Irma’s case reveals that this strategy was successful, at least in its purpose of defending the rights of women giving birth. For the first time, the NCHR used this same conceptual framework in its recommendation to the Oaxaca state government. Moreover, the IACHR hearing was the very first occasion that the Commission heard a petition on HR violations because of obstetric violence. After hearing GIRE’s arguments, the president of the Inter-American Commission recognised and legitimised those arguments. She affirmed that the issue of obstetric violence is relevant, disturbing and pertinent throughout the Americas, not only in the case of Mexico.

At the same time, Irma’s case reveals that obstetric violence is not only a semantic category used in the construction of a new legal framework for defending pregnant women’s human rights. It is also an epistemic category that defines a social field of medical performance, providing a radical critique of hegemonic bio-obstetrics whose ramifications are both discursive and material.

Obstetric violence reads institutional childbirth by exposing its rationale, doings and possible effects and by subverting the value of its underlying ideological premises. In bio-obstetrics, various forms of hegemonic knowledge and practices, and different biopowers (Foucault 1977) converge; this constructs – and explains – what obstetric violence names as a systemic and structural phenomenon. On one hand, we find the hegemony of biomedicine as a model of scientific knowledge, organisation of work and practices of care: biomedicine tends to medicalise and pathologise all physiological processes and, in the hospitalisation context, it has a dominant voice in decision making and in the course of medical treatment (Menéndez 2003). On the other hand, and more specifically in obstetric care, biopower or disciplinary control over the body are not exercised over any individual, but rather specifically over the female person/body, with the effect that women’s subjectivity and agency are objectified, made passive and silenced within hierarchical and authoritarian structures of a medical specialty – Ob-Gyn – that is deeply patriarchal in its historical origin, medical practice and socio-clinical interactions (Oakley 1984).

Finally, when women who arrive in public hospitals within the Mexican healthcare system are indigenous, rural and poor, the
intersecting characteristics of otherness that differentiate them on the basis of social class, race/ethnicity and gender begin to multiply, intensify and solidify in stereotypes, relations, attitudes and behaviours that easily become authoritarian, discriminatory and disrespectful on the part of healthcare staff. Such behaviours and attitudes have been naturalised and normalised across the board: from hospital lobbies to delivery rooms (Castro 2014; Sesia et al. 2014). The epistemic category ‘obstetric violence’ can easily account for all these deployments of institutional power.

As Foucault reminds us, naming something is more than isomorphic description: it constitutes a privileged technology of knowledge (Foucault 1968) and a sophisticated technology of power (Foucault 1966). Foucault was primarily interested in studying the evolution of language, the social construction of knowledge and technologies of state power towards its dominated subjects. Unlike Foucauldian discursive power technologies, with the promotion of the obstetric violence category as a way of reading the clinical encounter, to expose its doings and to litigate its consequences, we have a ‘subversive’ or ‘counter-hegemonic’ process of naming, framing and acting. The endeavour is to designate, explain and deconstruct predominant naturalised forms of caring and treating obstetric patients of the healthcare system – forms that, in turn, are technologies of power exerted by the hegemonic biomedical system on its most deeply subaltern social subjects: impoverished, indigenous, expectant mothers. By naming such behaviours and attitudes during maternal healthcare as obstetric violence, by arguing that this problem is systemic within public healthcare and by shaming attending physicians for their obstetric practices and treatment of patients, GIRE and accompanying NGOs engage in an interesting and consistent counter-hegemonic act (Santos and Rodríguez Garavito 2007) against the state, its healthcare system and bio-obstetrics in Mexico.

Because it is rather subversive in what it names, the category of obstetric violence has faced outright semantic, ideological and political opposition from the medical field. Mexican government healthcare officials and professional medical associations have denied the existence of obstetric violence as a problem afflicting the Mexican public healthcare system, and have rejected, sometimes vehemently, its use as a conceptual frame for describing a social problem affecting public obstetric services. It is no coincidence that, during the IACHR hearing, the federal Deputy Secretary of Health did not accept, either in his statement or rebuttal, the argument that the violation to Irma’s human rights constituted obstetric violence. By refuting the argument, he was denying that obstetric care in the country is facing a structural and systemic problem of violence
against female patients. It allowed him to affirm that Irma’s experience was instead an isolated event, indisputably revealing medical malpractice and even discrimination by the healthcare providers, and that, in Irma’s case, this had already been dutifully punished by the authorities.

The dispute is not only about an epistemological category that allows us to perceive and understand the significance of a given social problem from innovative interpretive angles. Here we are also facing that which, by acknowledging its existence, has concrete legal and tangible consequences that seem threatening to healthcare professionals and healthcare officials alike, though not for the same reasons. Recognising that obstetric violence exists and plagues the public healthcare system implies admitting the existence of systemic institutional responsibility of authorities, and the identification, attribution and/or limitation of individual responsibility of healthcare professionals towards women victims. In both cases, this entails adopting sanctions or responses that correspond to the seriousness of the situation. Finally, it entails seriously questioning the hegemonic obstetric practices that are deeply engrained and naturalised in the healthcare system; moreover, it challenges the medical community that controls this care and is not very inclined to listen, let alone to accept the fact that this is a real, tangible and serious problem that requires transformation.

This debate plays out not only in courts and the legislature, with laws and bills opposing obstetric violence, but also in mass media and in street-level public protests. In this struggle GIRE has wagered, both from conviction and strategy, on openly opposing the criminalisation of individual medical conduct, emphasising instead the structural failures of the healthcare system that do not allow its staff to undertake their work in an adequate and timely manner. GIRE has also publicly questioned the idiosyncratic, partial and sometimes plainly unjust responses of healthcare officials – such as applying draconian measures to the supposedly identified culprits, without taking the inadequacies and deficiencies of the context into account.

In this debate, the positioning, interests and concerns of healthcare officials do not always coincide with those of the service providers; the latter resist what they perceive as a disturbing and offensive term that entails blaming them for being violent persons, beside the fear that they will bear the blame, even when health facilities present conditions that do not allow them to perform their work satisfactorily.

Beyond convergences or divergences, it nevertheless remains clear that naming and framing the problems of maternal healthcare as obstetric violence has become an anathema to many physicians, above all those who
work in public healthcare institutions in obstetric care. Unsurprisingly, and despite the fact that GIRE’s position of non-criminalisation has been open, repeatedly pronounced and public, the reception of this posture and proposals ‘has been costly, because, being lawyers, it is assumed that we want to put doctors behind bars’, according to the organisation’s director.\textsuperscript{20} In this context, GIRE may be over-optimistic in wagering that it would not incur opposition from the physicians’ professional associations in the current proposed federal bill that includes the term \textit{obstetric violence}, since the proposal avoids criminalisation of medical practice.\textsuperscript{21}

The impact of judicialisation on victim redress and on the transformation of the healthcare system

Besides the legal petitions, GIRE resorted to multiple extra-legal strategies, among them media visibility, public shaming, political pressure and direct negotiation with the Oaxacan Ministry of Health. Applying political pressure and openly shaming the public health system through mass media coverage was particularly effective. The combination of these strategies opened a door for reaching successful compensation agreements from a perspective of human rights and restorative justice: first, negotiating redress from a comprehensive approach that included, but also went beyond, simple economic compensation; second, the fact that the public healthcare system accepted responsibility for the damage caused to Irma and her child and publicly apologised for it; and third, by jointly defining the claims and transformative measures for the Oaxacan public healthcare system, in order to avoid repetition of these occurrences.

The publicity that Irma’s case received in the media also had the ripple effect of encouraging other victims to come forward and denounce similar violations. In the following weeks, several other cases began to crop up in the press in Oaxaca and elsewhere, and several women or their families petitioned the state human rights oversight agencies or the NCHR in relation to maternal healthcare violations. Some of these cases were picked up by GIRE, which began to defend other women who had suffered similar abuses. Here we can see how judicialisation can be successful insofar as other women see it as a legitimate and effective avenue for seeking redress in their own cases.

Judicialisation seems to prove successful in Irma’s case by considering that all the claims for compensation were accepted and were carried out by the government of Oaxaca. Nevertheless, it remains to be seen whether future administrations in the state government will continue honouring the long-term agreements of providing complete medical care
throughout Irma and the child’s life, and an education grant to support the child’s schooling, since there are no established mechanisms that assure long-term compliance with these agreements.

Conversely, we can identify serious shortcomings in what judicialisation can achieve in the intent to transform the healthcare system, beginning with the content of the agreements themselves. The definition of the measures that the healthcare system needs to take in order to guarantee access and improve the quality of maternal healthcare obviously surpasses GIRE’s level of expertise. GIRE is dedicated to advocacy and the legal defence of women’s reproductive rights, not in the field of the maternal healthcare system, and even less in the specific context of its working and performance in the state of Oaxaca. The agreed-upon measures did not include, for instance, a commitment to advancing the restructuring of maternal health services in the state, starting with the regional network that encompasses Jalapa de Díaz, Irma’s community.

Judicialisation finds its major limitation precisely in effecting the transformation of the healthcare system. Four years after having signed the agreement, the Health Ministry of Oaxaca has not complied with the majority of the points included. The local clinic continues to face the same shortages as in 2013. The community hospital under construction has not opened its doors yet. The Ministry of Health in Oaxaca has implemented some workshops on human rights sensitisation and obstetric violence eradication among health personnel in some jurisdictions, but this amounts to a drop in the ocean. And the problems besetting the Oaxacan maternal healthcare system do not show any signs of improvement (Sesia 2017). Questions arise here in assessing the impact of judicialisation: how, through which mechanisms, in how much time and who can verify satisfactory compliance with the agreements? And what does ‘satisfactory compliance’ mean for the different parties involved? In this case, it seems clear that the expectations of Irma (the injured party), her family and her representatives were noticeably different and encompassed more than those of the healthcare officials, for whom compliance signified formal closure of the legal proceeding, without implying any structural transformation of the system. In this context, reforming healthcare through judicialisation seems to amount to beating the air.

These concerns are not new, since the literature on health, human rights and litigation warns about the intrinsic limits of using the courts as a tool for potential transformation of the healthcare system (Cook 2013; Yamin 2011). Above all, it underscores the major contradiction that the legal approach in human rights violations ‘consists of appeals to the perpetrators’ (Farmer 1999: 1493), who can be expected to be recalcitrant.
Nevertheless, some interesting developments have taken place, within and beyond the judicialisation process initiated by GIRE. The visibility of Irma’s case, the discrediting of the public healthcare institutions, the pressure and political costs that this broad coverage of the episode entailed, the coming forward of other women denouncing similar occurrences and the Commission’s decision to investigate the human rights violations caused the federal healthcare system to make important agreements with the states, such as the ‘zero rejection’ policy for pregnant women. This agreement remains in force at the time of writing.

In hindsight, though, it seems that, more than attaining its intended goals, the judicialisation of this case was successful in exposing the multifaceted problems plaguing obstetric care in the public healthcare system, including the discrimination, rejection and mistreatment experienced by many indigenous women. The expression ‘obstetric violence’ is incisive and unsparing towards attending health personnel: naming and framing the issue in such a way allows full and unforgiving disclosure of what often happens in institutional care; and it places blame and shame on nurses, doctors and health authorities alike.

In 2015, the Mexican Federation of Ob-Gyn Organisations issued a public statement against the inclusion of obstetric violence in states’ legislation on gender violence; and they condemned its use as a valid conceptual category, especially when used to refer to the (ab)use of established obstetric practices. Such staunch opposition, though, did not stem the tide: obstetric violence has become a powerful construct in framing human rights violations in obstetric care and it has acquired much greater political recognition, social legitimacy and public popularity in naming and making visible an increasingly recognisable problem in Mexican healthcare delivery.

Since 2014, the NCHR has fully adopted the term, and issued 37 recommendations against obstetric violence cases between 2015 and 2017. This number represents over 50 per cent of all recommendations in cases of health-related human rights violations and 20 per cent of the total number of recommendations in reviewed human rights abuses in those three years. In 2017, the NCHR issued a general recommendation against the occurrence of obstetric violence within the public healthcare system; this is one of only three general recommendations that the Commission has issued towards the healthcare system in the almost 30 years of its existence. Meanwhile, 20 Mexican states have incorporated legislation against obstetric violence, the great majority after 2014; others are discussing similar proposals, including now in the federal legislature.23
In conclusion, reflecting on these issues can contribute to an understanding of the complexities, advantages and limitations of rights-based litigation as an instrument to pursue social justice in health. This production of knowledge does not need to be an end in itself. It can also be useful for designing strategies and when engaging in emancipatory politics (Biehl 2013; Santos and Rodríguez Garavito 2007) for the many critical medical anthropologists who are also involved in social activism with the goal of ensuring that the public healthcare system in Mexico becomes more equitable, better performing, less discriminatory and more just and respectful of all women patients.

Notes

1. For experiences elsewhere in the Global South, see Gauri and Brinks 2008; Lamprea 2017; and Mæstad et al. 2011.
3. For coverage data see: Indicator 31 in: https://public.tableau.com/views/IndicadoresdeResultado/IR2?:embed=y&:display_count=yes&:showTabs=y&:toolbar=no&:showVizHome=no (accessed 31 October 2019). ‘Qualified staff’ refers to physicians: medical students who finished their training and take the mandatory one-year social service programme in primary health clinics, general practitioners, resident physicians and specialists.
6. The case is emblematic in being the first (of the 32 registered and eight cases) to be catapulted into the public light by mass media, the first case to be legally represented by GIRE, the first to be litigated nationally and internationally as a case of obstetric violence, and additionally the most advanced in terms of resolutions achieved. The facts presented here were reconstructed in countless news stories between October 2013 and January 2015, in Proceso magazine; national newspapers El Universal, La Jornada, El Excelsior, Milenio and Reforma; in foreign media such as El País, Univisión, Telemundo; and various internet news agencies and in radio reports. I also reviewed the recommendation issued by the NCHR (available online), the petition made by GIRE to the CIHR, Irma’s complaints to the NCHR, and a series of press releases by GIRE during litigation of the case. Finally, I reviewed a video recording of the hearing at the CIHR available online, and I conducted an extensive interview with ‘RT’, the director of GIRE in September 2014, in order to clarify the legal and extra-legal channels taken by Irma and GIRE since October of 2013. I use the woman’s real name because it is public knowledge.
9. Equivalent to approximately US $30 at the time.
10. The Commission has been criticised for not fully complying with its mandate: not always ensuring effective compensation for victims of rights violations, not providing enough follow-up to ensure compliance with its own recommendations, not adequately informing or involving victims in the development of recommendations and reconciliation agreements, not sufficiently utilising international human rights treaties in its recommendations and reports, not promoting the structural reforms the country needs with regard to respecting and
guaranteeing human rights. Finally, there has been ongoing scrutiny about the fact that the recommendation, the NCHR’s strongest instrument for enforcing HR, is used insufficiently; its reception and acceptance is not mandatory and, when formally accepted, authorities frequently do not comply with it. See Magaloni and Mayer-Serra 2014.

11. The Information Group on Reproductive Choice (GIRE) is a non-profit organisation that promotes women’s reproductive rights in Mexico. Founded in 1991 by a group of Mexican feminist intellectuals, it is dedicated to systematising and disseminating scientific, secular, rational and unprejudiced information about reproductive rights and promoting public policy and legal reforms that guarantee such rights, beginning with freedom of choice in motherhood, the right to abortion and the right to quality reproductive health services. Since 2010, it has begun strategic public-interest litigation against violations of reproductive rights in the national and international arenas, including in cases of maternal mortality and obstetric violence (information from the web page https://gire.org.mx, and interview with ‘RT’).


15. The IACHR is the human rights oversight body of the American States Organisation. When the national appeals channels are exhausted, and human rights organisations can show that the state has failed to comply with its obligations, they can undertake the appeal at the IACHR (Macaulay 2011), not only to denounce and publicly document the failures and violations committed by the authorities of the country but also to generate ethical, political and media pressure on their government. Even though IACHR resolutions are not binding, resolutions may well affect the actions of the Mexican government because of the Commission’s moral stature and Mexico’s sensitivity to international pressure (Domingo 2011).


17. See, for example, the movement among health care staff #YoSoy17 that arose in 2014, from the criminalisation of medical malpractice without authorities taking a share of the structural responsibility (https://www.proceso.com.mx/374625/crean-movimiento-yosoy17-en-respaldo-a-criminalizacion-de-médicos and https://es.wikipedia.org/wiki/Movimiento_YoSoy17). As an example of the antagonism of the association to the concept of obstetric violence, see this news article: http://www.milenio.com/region/Medicos-movimiento-YoSoy17-alistan-marcha_0_386961543.html. For an example of the intersection of antagonism and the legal category of obstetric violence in criminal law, with the opposition to changing the forms of care during delivery, see: https://www.milenio.com/estados/medicos-oponen-tipificar-violencia-obstetrica-delito.

18. With the exception of serious acts that are criminally punished and punishable, such as forced sterilisation (GIRE 2013).


22. Public maternal health services should be organised into networks where primary health clinics cluster around a secondary-level hospital to which women requiring emergency obstetric care are referred. Primary health clinics and the referral hospital need to fulfil certain requirements in terms of equipment and infrastructure, availability of human resources and drug supplies, as well as in obstetric emergencies training, geographical location and distance, and transport.

23. After a failed attempt to include obstetric violence in the legislation against gender violence in 2015, a new legislative proposal to eradicate obstetric violence was submitted in the Senate by the new party in power in December 2018 (http://comunicacion.senado.gob.mx/index.php/informacion/boletines/43015-presentan-reformas-para-erradicar-violencia-obstetrica-y-asegurar-atencion-materno-infantil.html).
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