



Social construction of obstetric violence of Tenek and Nahuatl women in Mexico

Construcción social de la violencia obstétrica en mujeres Tének y Náhuatl de México
Construção social da violência obstétrica em mulheres Tének e Náhuatl do México

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ABSTRACT

Objective: To explore the social construction of obstetric violence developed by Tenek and Nahuatl women in Mexico. **Method:** Qualitative, socio-critical study conducted through focal groups in which were deepened the childbirth experiences lived in the period 2015-2016. **Results:** Participation of 57 women. Through discourse analysis, it was identified that participants do not have enough information about obstetric violence and/or sexual and reproductive rights. This makes the association of their negative experiences with the legal term “obstetric violence” impossible. Most of their speeches correspond to the legal denomination of “obstetric violence”. Experiences like prolonged fasting or the use of technologies for invading their privacy were narrated like situations they perceive as violent, but have not been incorporated within the legal term. **Conclusion:** Multiple actions against women’s human rights take place within delivery rooms. Most remain unidentified by users, since they have not socially constructed the image of obstetric violence. However, that fact does not make them less susceptible to feel attacked and denigrated during their childbirth experiences.

DESCRIPTORS

Violence Against Women; Parturition; Delivery Rooms; Indigenous Population; Obstetric Nursing.

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INTRODUCTION

In January 2013, the World Health Organization (WHO) declared that Mexico was the country with the highest rate of caesarean sections in the world (46.3%). Since this is a much higher rate than the WHO recommendation of 10-15%⁽¹⁾, the statement activated the monitoring of reasons motivating this procedure in the country. In 2017, this monitoring led to the documentation of two out of every three caesarean sections practiced unnecessarily in Mexico. Such a situation is serious in itself, but even more so when considering that in this same year, Mexico moved to the fifth place among countries where more cesarean sections are practiced in the world, a list in which the Dominican Republic and Brazil occupy the first places with indices of 56.4% and 55.6%, respectively⁽²⁾.

By monitoring these caesarean section rates, the existence of the obstetric violence problem that had long sought to be incorporated into the national public agenda was validated. A variety of definitions are involved in the concept of obstetric violence, but most agree that it is an intentional situation with dehumanized medical treatment by action or omission, in which conditions that directly or indirectly harm women are generated, either through acts of outright physical or psychological abuse, or through the performance of unnecessary procedures involving risks for women and their children⁽³⁻⁴⁾.

The proposal to recognize obstetric violence as a public problem in Mexico was supported by data from complaints raised before the Mexico National Commission of Arbitration (Spanish acronym: CONAMED) regarding obstetric care in the period of 2005-2015. These complaints increased in almost 20%, a figure that could be considered alarming initially, but seems incredibly low for those who study the issue directly with women who have lived the experience of childbirth⁽⁵⁾. This may be a result of the little awareness developed with women in order that they are able to identify obstetric violence.

Although the impacts of obstetric violence in the lives of women, children and families have been broadly documented, data on the reasons motivating it are scarce⁽⁶⁻⁷⁾. In the previous context, when searching for studies addressing the social construction of obstetric violence developed by groups of particularly vulnerable women, none were identified. This led to the following reflection: what is the point of introducing the concept of obstetric violence within the legal framework, if citizens have not built or internalized the problem socially? How will they exercise their right not to live it or on what grounds will they report it?

According to several authors, it is complex to recognize obstetric violence for women who have grown up in contexts where the existence of sexual and reproductive rights is not acknowledged. This difficulty of perceiving acts of violence within the delivery room is even more complicated given the tone of sociological relationships taking place within hospitals. Medical authoritarianism is standardized and tolerated from an imaginary where women have a double

subordination to doctors; firstly, in function of gender, and secondly as a matter of the hierarchy granted by a highly valued profession⁽⁸⁾.

Indigenous women, for example, are among the groups that least report complaints to Human Rights Commissions, even though various studies have documented the particular vulnerability of this group. They have several converging social determinants that enhance their vulnerability to obstetric mistreatment, namely, most are adolescent or older mothers, poor, illiterate and do not speak Spanish⁽⁹⁻¹⁰⁾. Furthermore, these women have culturally grown up in contexts where acts of discrimination and mistreatment in various spheres of their lives are reproduced on a daily basis, particularly in their sexuality and reproductive health. Such a discrimination is reinforced from the institutional scope through childbirth care that has little regard for their cultural preferences, beliefs and cosmovisions⁽¹¹⁻¹²⁾.

The objective of this study was to document the social construction of obstetric violence of a group of indigenous women in San Luis Potosí, Mexico.

METHOD

STUDY DESIGN

Exploratory, descriptive, qualitative, socio-critical study. The intention was to find the emancipatory triggers of change and social transformation of women in relation to their sexual and reproductive rights⁽¹³⁾.

SCENARIO

Participants live in the central part of the Huasteca region of San Luis Potosí (SLP), Mexico. The six municipalities in this region are classified as having "Very high" and "High" degree of marginalization with more than 90% of rural population, a high percentage of Tenek and Nahuatl people, predominance of one minimum wage income and low mean educational level⁽¹⁴⁾.

POPULATION

The study population was composed of women of reproductive age (15-49 years), who had lived the experience of childbirth in public health services in the period 2015-2016. In this convenience sample⁽¹⁵⁾, all mothers of children under one year of age regularly attending the initial education program for parents of the Secretary of Education of the State Government (Spanish acronym: SEGE) were invited to participate. Initially, 70 women were interested in participating, but only 57 were present in the focus groups and signed the informed consent form.

DATA COLLECTION

Data collection was performed through focal groups held in women's localities of origin and lasted between 60 and 80 min. The first generating question "Who has experienced obstetric violence?" remained unanswered or was answered with phrases such as "What is that?", "We do

not understand". The prevailing silence and exchange of stares between participants demonstrated they had never heard the term before. Based on this occurrence, the research team asked mothers to narrate their last childbirth experience by deepening particular issues that made them feel uncomfortable and they would change if they could, in order to avoid that other women had similar experiences during their childbirths.

The strategy of focus groups was relevant to the characteristics of the participating population, because these women had difficulty with talking about their childbirth experiences given the association with sexuality. However, listening to the experiences of others opened the possibility of talking about the issue associated with motherhood that gives them a common identity: being mothers.

Fourteen focus groups were held with a maximum of ten participants and a minimum of six. Each group had six participants on average, which is indicated as a desirable number to trigger group participation. All sessions were audio-recorded with participants' prior consent, then fully transcribed in word software for performing critical analyzes of discourses.

ANALYSIS AND PROCESSING OF DATA

The categories and subcategories of analysis were obtained in an inductive manner by adopting the framework of criteria established by health care regulations (Official Mexican Standard-007-SSA2-2016 and the Clinical Practice Guideline for the care of low risk childbirth)⁽¹⁶⁻¹⁷⁾.

ETHICAL ASPECTS

The research protocol was approved and monitored by the Research Ethics Committee of the Faculty of Nursing and Nutrition of the UASLP (Universidad Autónoma de San Luis Potosí) (CEIFE-2016-181). In all cases, the voluntary participation through prior signature of the informed consent and the confidentiality and anonymity of all participants were guaranteed. Adolescent mothers who still depended on their parents, signed the informed consent and a copy was also sent to parents. In the results section, testimonies were organized by using the word "participant" followed by a number assigned from the beginning of focus groups in order to guarantee anonymity and allow readers to follow the stories shared by women.

RESULTS

Participation of 57 women, whose average age was 28.7 years (maximum of 44 and a minimum of 14 years), 96.4% were engaged in housework, only 3.6% had a profession, 47.8% had completed secondary school, 26.3% had a bachelor's degree, 19% had completed primary school, 5.2% had a bachelor's degree with teaching license, and 1.7% were illiterate. Most participants were in an informal marriage (45.4%), 39.5% were married, 11.6% were female

heads of family and equally important, 3.5% were separated and widowed.

The following four categories were associated with obstetric violence: 1) Discrimination, 2) Negligence, 3) Abuse and 4) Denial of autonomy. These included actions, abuses or omissions that women did not directly associate with the legal term "obstetric violence", but were described as experiences in which they felt damaged, discriminated or denigrated.

DISCRIMINATION

In their speeches, there were many evidences of resistance from health personnel regarding allowing women's exercise of important cultural practices according to their cosmovision and unrepresentative of a risk in themselves. For example, they are not allowed to move during labor without having an epidural block, neither choose positions other than lithotomy.

Speeches have also emerged about the threat of having care denied for having had a consultation with a midwife or initially seeking this type of care.

Participant 1: ...*They complain if they know you are coming with the midwife, a woman is no longer allowed to have a child with a midwife because they tell us it is our problem if something goes wrong.*

Participant 2: ...*Yes, they no longer allow us, they send us all to the hospital and if someone is with a midwife, they do not want to receive us.*

Other narratives associated with discrimination demonstrated that regardless of the initial implementation of health policies favoring friendly childbirth (in that sense, with a companion), all these women were denied this right. From their perspective, this situation impacts on the psycho-emotional aspect and influences that their partners do not measure the risks involved in a delivery and do not adopt the necessary measures to plan subsequent pregnancies.

Participant 3: ...*Yes, because if one is in pain and with the husband by their side, this kind of gives us more value and it would be very good.*

Participant 4: ...*I would have liked my husband to be there, as they say, for moral support, which I guess is what makes us feel good.*

Participant 8: ...*Yes, on the one hand, so that he would realize how things are, so that he could also see it, so he sees that giving birth to a child is not nothing and that it is necessary to give it time.*

NEGLIGENCE

In this category, it was identified that women do not consider acts of excessive medicalization as violent, because they are unaware of the childbirth atmosphere. They do not know which activities are of their responsibility and which are of the health personnel's in order to guarantee their children's and their own safety.

The only thing they could identify as violent in this category was the vaginal touch, which they narrated as a painful procedure, but above all, uncomfortable. The procedure is performed by many actors, who seem not to have any communication with one another, since after someone has just finished it, another person enters the room for another assessment.

Other violent actions included in this category are related to the perception of the lack of guarantees of privacy during procedures. In addition, the fact of having been separated from their children after delivery without even being able to see them, which was done without any explanation from the staff. A particularly relevant issue that they identified as a highly damaging experience was the lack of food after delivery. The speech of the next participant is an example of the aforementioned. This woman in a physiological puerperium had to wait about 17 hours to eat something, which happened after her partner asked for care.

Participant 3: ...*You see, I gave birth at 5:30 in the afternoon, my husband came in at visiting time [9:00 in the evening] and I said "I'm starving" he said "What? They have not given you anything to eat? But just now they came up and they brought", and I said "bring me something, I cannot take it anymore". I felt I could not stand anymore and when my mother-in-law went out, she brought me juice and yogurt and some crackers and that was my dinner because they did not give me anything ... then, on the following day, in the morning, they gave me lunch around 10:30.*

In contrast, procedures such as the Kristeller maneuver or administration of oxytocin are not seen as acts of dehumanization in childbirth, but narrated as gratifying acts, since they "help" mothers in the sense that their children are born sooner.

Participant 5: ...*I'm not going with the midwife, it's not the same, here (in the hospital) they put the drip in so that the child is born sooner, to avoid a long suffering...*

Another act that women identified as unpleasant care (without seeing it as obstetric violence), was the performance of episiotomy without informing them of it and consequently, without informed consent. Other forms of violence not previously considered by the research team, were those involving the use of new technologies. These were described as tools that violate women's privacy and dignity inside hospitals.

Participant 7: ...*As her child was being born, because she was born weighing 4,375 (kilos), they all went to make a video, that is, "there" (vulva)... when she was coming out, they had not even cleaned ... they pretended they were cleaning and they were making a video...*

ABUSE OR VERBAL VIOLENCE

This was the category with more speeches, since it is the easiest to identify for women. In this category, the verbalization of phrases by health personnel aimed at disqualifying women's pain was included. There were several testimonies

about orders they received to shut up and stop complaining in moments of great pain.

Participant 2: ... *I complained and cried in pain, it was the first time I felt that way! Then they said: "Do not complain! Do not cry! They said I did not scream when I was (sexually) with my husband, I did not complain!"*

A wide range of abuses could be considered institutional violence, but they acquire the character of obstetric violence when involving frank threats towards women's integrity by showing the power over their bodies and their lives.

DENIAL OF AUTONOMY

In this category, the experiences that impaired the ability of autonomous decisions about one's sexual life within the context of personal ethics, and social and personal cosmovision were organized. Particularly, the experiences related to the imposition of family planning methods, the denial of access to them without justified medical reasons or conditioning the access to a good or service in exchange for accepting a particular method were included.

Participant 2: ... *They tell me, as always, I'm used to reprimands.*

Participant 4: ... *They say you should operate, that it is not obligatory, but they tell you and repeat, first, well, then, they nag you because you do not want it, but they tell you it is not obligatory.*

Participant 4: ... *They told me that if I did not put the IUD, they would cancel the Seguro Popular... [public health protection system].*

DISCUSSION

The problematization of obstetric violence requires recognizing the convergence of two types of violence widely known in contemporary society, namely the gender and the institutional. Institutional violence implies practices exercised by public servants (health personnel) within an institutional context (hospital), which denigrate or harm in a real way or perceived as such, the safety and autonomy of women in a moment of particular physical and psycho-emotional vulnerability⁽¹⁸⁾. Gender violence, in turn, involves a series of disqualifications done to women that originate in the contemplation of their bodies like entities whose meaning is reproduction. Childbirth is represented as a consequence of a voluntary and enjoyed sexuality, and in the patriarchal and Christian imaginary, such a situation must be paid with suffering⁽¹⁹⁾.

From this perspective, obstetric violence is a complex object of study. First, because it has been naturalized historically, and then, because its deep understanding compromises the convergence of multiple disciplinary views. In this complex context, discussions on the relevance of recognizing it as a public health problem are fundamental. Women who suffer obstetric violence, particularly indigenous women⁽²⁰⁾,

have difficulties with identifying it within contexts where they have been historically denied the exercise of their sexual and reproductive rights autonomously, and their right to live a life free of violence⁽²¹⁾.

Contributing to the visibility of obstetric violence experiences in groups of historically violated women, in this case, indigenous, is part of the professional commitment. It involves recognizing that these women have less tools to demand respect for their human and sexual/reproductive rights, and less psychosocial resources to develop resilience strategies and empower themselves individually or collectively when searching for guarantees that the harm will not be repeated.

The narratives shared by women showed how they are denied the right to experience their childbirths within their cultural cosmovision framework, as well as the persistent criminalization towards midwifery. Such aspects are contrary to the General Law of Health in Mexico, which establishes respect to intercultural health, the health personnel's sensitivity towards women's right to choose freely how to resolve and address their sexual and reproductive health, and the avoidance of social impositions that are not derived from scientificity, but from ethnocentric positions⁽²²⁾.

The need for a companion during labor and delivery must be recognized in health policies, and in Mexico particularly. Although the Initiative for the Humanization of Assistance to Birth (Spanish acronym: IHAN) is currently under implementation, it is not mandatory in all public maternities. Unlike other countries, such as Chile and Uruguay, in Mexico, there is no specific law for protecting women's right of having a companion during labor and delivery⁽²³⁾. This represents a significant threat to the health of the mother and child, particularly given the documented benefits of the presence of a companion, which helps in reducing the need for pain medication, cesarean and birth by forceps, and affects the progress of less prolonged labor⁽²⁴⁾. Parents' joint experience throughout the process, especially in childbirth, strengthens affective-social ties in the dyad and the triad⁽²⁵⁾.

Women identified the experience of being touched repeatedly to monitor the progress of delivery as uncomfortable and even denigrating, particularly because it was performed by a multiplicity of health actors. Reports from other studies state that the performance of this procedure in a context of lack of information and the little empathic attitude of the staff can trigger post-traumatic stress similar to that of a rape⁽³⁾. Episiotomy was also identified as an aggressive practice, basically because women are not informed of its performance or the reasons for doing it, and only realize about it in cases of complications due to lack of care measures. The need to discourage the indiscriminate practice of episiotomies has been highlighted recently. According to monitoring data, this procedure is performed in up to 80% of childbirths, which is notoriously high for the WHO recommendations of the maximum of 30%⁽²⁶⁾.

Another act that participants begin to dimension as violent is the health personnel's attitude of including them into family planning programs, which is clearly framed as an act of power that has been described by other authors. It occurs from a position of discipline and subjection, where there is room for threat and punishment more than post-obstetric counseling by infantilizing women and without recognizing them as subjects of their sexual and reproductive rights⁽²⁷⁾. Imposing contraception methods on indigenous women has also been associated with racist prejudices in which, consciously or unconsciously, the birth of more indigenous people is to be avoided⁽²⁰⁾.

The delayed food provision was perceived as an act against women's well-being and comfort. When analyzing the case in depth, is found a situation implying in serious risks for the dyad, because during pregnancy, fasting glucose figures are 20% lower than those of a non-pregnant woman in conditions of prolonged fasting (more than 12 hours). The risk of hypoglycemia is higher for the mother and the newborn, particularly for the latter, since fasting is also intimately related to the delay in breast milk production⁽²⁸⁾.

Other experiences associated with their imaginary of discrimination and denigration and unreported in other settings were video recordings or photographs taken by the health personnel. Regardless of the reasons for these actions, the psycho-emotional situation during labor particularly makes these women vulnerable to these acts that invade their privacy and their right to privacy. Other studies have narrations of similar facts that make women feel betrayed by health personnel, and consequently avoid the later return to these professionals for addressing aspects related to their own health and to their children⁽²⁹⁾.

CONCLUSION

The objective of this study was to explore the social construction of obstetric violence developed by a group of indigenous Mexican women. The findings demonstrated the occurrence of obstetric violence within Mexican health institutions, even though women do not have enough information to identify it under this theoretical-legal term. The acts they identified as more aggressive or denigrating are related to forms of verbal abuse by health personnel, while some have considered acts of excessive medicalization as "desirable", since they are unaware of their possible adverse events. New forms of aggression were identified, including the experience of being recorded or photographed with mobile phones without any request for authorization to do so. Strengthening the agency of the most vulnerable women on their human and sexual-reproductive rights, and defend these within delivery rooms, are part of the nursing role and with which they should be concerned about.

RESUMEN

Objetivo: Explorar la construcción social que sobre violencia obstétrica han elaborado mujeres Tének y Nahuatl de México. **Método:** Estudio cualitativo-sociocrítico, mediante grupos focales se profundizó en las experiencias de parto de quienes vivieron un parto en el periodo 2015-2016. **Resultados:** Participaron 57 mujeres. Mediante análisis de discurso se identificó que las participantes no poseen suficiente información sobre violencia obstétrica y/o derechos sexuales y reproductivos, lo que las imposibilita para asociar sus experiencias negativas al término legal "violencia obstétrica". Sus discursos corresponden en su mayoría a lo que desde el marco legal se ha denominado "violencia obstétrica", sin embargo, experiencias como el ayuno prolongado o el uso de tecnologías para la invasión de su intimidad fueron narradas como algo que conciben violento y que no se ha incorporado dentro del término legal. **Conclusión:** Múltiples acciones que atentan contra los derechos humanos de las mujeres tienen lugar dentro de las salas de parto, la mayor parte no son identificadas por las usuarias, puesto que no han construido socialmente la imagen de la violencia obstétrica, ello no las hace menos susceptibles sin embargo, a sentirse agredidas y denigradas en sus partos.

DESCRITORES

Violencia contra la Mujer; Parto; Salas de Parto; Población Indígena; Enfermería Obstétrica.

RESUMO

Objetivo: Explorar a construção social que as mulheres Tének e Nahuatl do México elaboraram sobre a violência obstétrica. **Método:** Estudo qualitativo-sociocrítico; por meio de grupos focais, houve um aprofundamento nas experiências de parto daquelas que passaram por um parto no período de 2015 a 2016. **Resultados:** Participaram 57 mulheres. Mediante análise do discurso, foi identificado que as participantes não possuem informação suficiente sobre violência obstétrica e/ou direitos sexuais e reprodutivos, o que as impossibilita de associar suas experiências negativas ao termo legal "violência obstétrica". Seus discursos correspondem na sua maioria ao que, a partir do marco legal, foi denominado "violência obstétrica"; entretanto, experiências como jejum prolongado ou uso de tecnologias para a invasão da sua intimidade foram narradas como algo que concebem ser violento e que não foi incorporado ao termo legal. **Conclusão:** Múltiplas ações que atentam contra os direitos humanos das mulheres têm lugar dentro das salas de parto, a maior parte não é identificada pelas usuárias, visto que não construíram socialmente a imagem da violência obstétrica, mas isso não as faz menos suscetíveis de sentir-se agredidas e denegradas nos seus partos.

DESCRITORES

Violência contra a Mulher; Parto; Salas de Parto; População Indígena; Enfermagem Obstétrica.

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