

Family Planning versus Population Control in Mexico

Emily Chapman

Responding to growing concerns over the inhumanity of population control policies, especially in developing countries, the 1994 International Conference on Population and Development (ICPD) drafted the “Program of Action,” which recognized the right of women to exercise autonomy over their reproductive health. This global shift in development priorities has heavily influenced the reproductive healthcare system in Mexico. Its government-run Progresa-Oportunidades program – in which women receive money for family expenses if they attend regular health check-ups– has been praised by the international community for promoting individual freedom. At the same time, a recent anthropological study has found that indigenous Mexican women participating in the program feel pressured to adopt certain family planning methods. This contrast is the result of various social, ethno-cultural, economic and political factors. Ultimately, the key to creating and implementing healthcare programs that truly guarantee a woman’s autonomy is to alter the global top-down reproductive health paradigm.

At the turn of the 21st century, the global attitude towards women’s reproductive rights made a considerable shift. Previously, reproductive health had been synonymous with population control, as various transnational institutions sought to halt explosive population growth through contraception and sterilization. Responding to growing concerns over the inhumanity of such policies to mothers, especially in developing countries, in 1994 179 nations convened at Cairo for the International Conference on Population and Development (ICPD).¹ The “Program of Action” was drafted at this conference and signed by all countries present. Deriving inspiration from the United Nations’ Millennium Development Goals (MDGs), it recognized the right of women to exercise autonomy over their reproductive health. It also called for greater inclusion of the mother’s needs in all aspects of healthcare.¹

This significant new strategy has shaped subsequent reproductive health programs, implemented by transnational policymakers such as the United Nations and funded by international foundations and financial institutions such as the World Bank. Numerous initiatives – such as midwife training in Uganda¹ and establishment of a universal ‘sex education curriculum’ in Denmark¹ - have reflected greater attention to mothers’ care in particular and reproductive rights in general. Many programs have focused on the non-clinical factors that can influence a women’s reproductive health, including lack of education and chronic poverty. In addition to providing better access to information about reproductive health, keeping young women in school has become a top priority of many developmental initiatives. A strong educational background is important for economic self-sufficiency, which will in turn afford women greater autonomy.²

The global shift in program priorities has heavily influenced the reproductive healthcare system in Mexico. Since signing the “Program of Action,” the Mexican government has

formed a strong relationship with international policymakers, serving as the liaison to civilians.³ The government has permitted external evaluation of its programs, and has turned to the United Nations for assistance in the logistics of implementation.⁴ Impressed by these transparent negotiations and clear communication of program *modus operandi*, international institutions – especially the World Bank⁴ – have commended the government for championing women’s rights.³ Mexico has enjoyed a positive international reputation as a model of gender equality.⁴ Yet Mexico has received the most praise for its

successful Progresa-Oportunidades program. Initiated by the government in 1997, this ‘conditional cash transfer program’⁵ has become “the largest single poverty alleviation program in Mexico’s history” (Levy, 2006: 25). Women receive money to pay for family expenses if they visit health clinics for regular check-ups and send their children to school.⁵

Santiago Levy (2006: 75-76), an economist and former general director of the Mexican Social Security Institute,³ evaluates the impact of Progresa-Oportunidades on Mexicans’ education and health by collecting data from schools, local offices, health clinics and communities. While the program has made little progress in some areas – primary school enrollment has only increased by one percentage point for both girls and boys³– Levy (2006: 77) concludes that Progresa is an overall success. The program has consolidated the “dispersed set of generalized and targeted food subsidy programs and isolated health, nutrition, and education interventions that were in place up to the mid-1990s” (Levy, 2006: 77). It has had a large effect on poverty by allocating a portion of the GDP to households in the lowest income brackets.³ Progresa has also made schools more available to children, especially among those from low-education households.³ And it has made significant progress in civilian

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Emily Chapman is a Political Science Major at Williams College. Address correspondence to ekc2@williams.edu

healthcare, lowering the infant mortality rate by 11 percent³ and increasing the percentage of women receiving Pap tests by 61 percent.³

Levy attributes the continuing success of the program to its responsiveness to ‘operational evaluations,’ which have identified design flaws early on. Modifications that have been made include changes in nutritional supplement distribution practices and prolongment of school scholarships.³ In addition, Progresa provides poor women with cash grants rather than in-kind donations.³ By ‘increasing households’ net income’³ and otherwise stabilizing household finances, the program encourages women’s self-sufficiency.

Most importantly, Progresa has preserved individual ‘freedom of choice’ – so highly promoted by the UN – for women to accept or reject family planning methods.⁶ The program supplies women with important economic, educational and healthcare-related tools, but does not impose a foreign reproductive health agenda. Instead, it enables the women themselves to determine the futures of their families.

CONDITIONS ON THE GROUND

Official reports have thus portrayed Progresa-Oportunidades in a positive light. Yet most economic, educational and public health analyses, especially those conducted by the World Bank, rarely incorporate the views of civilians affected by the program. In a recent anthropological study, Vania Smith-Oka (2009: 2073–2075) interviews poor women of the indigenous Nahua group who have participated in Progresa. The beneficiaries express several complaints about their experiences at health clinics. In particular, they state that they feel pressured by doctors and other personnel to obey directions and recommended procedures. Indeed, more than 30% of interviewed women claimed that they felt forced when interacting one-on-one with healthcare providers.⁵

Smith-Oka (2009: 2073) refers to the forceful undertone of these patient-doctor interactions as ‘coercion.’ While there have been no accounts of outright violence towards women, Smith-Oka reminds the reader that the term can also refer to ‘manipulation and implied threat.’ Indeed, as many women’s accounts reveal, there is a ‘culture of force’ that characterizes the clinical environment (emphasis added).⁵ While doctors do not perform surgeries against the woman’s will, they certainly promote their own medical agenda and pay little attention to the needs and desires of their patients.

The indigenous women in Smith-Oka’s study claim to feel especially pressured to adopt certain family planning methods. Many women are told that a family with more than two children is too big, and that they should undergo sterilization or use an intra-uterine device (IUD). Again, doctors do not physically force these measures on their patients. Yet most women find that they must continually resist this ‘endless haranguing.’⁵ One woman states that clinic staff tried to convince her to be sterilized three times. Although she persevered in her resistance and ultimately did not undergo surgery, many patients are not as resilient. Most women’s resistance gradually wears down, ultimately roping them into a reproductive health measure that they themselves do not want.⁵

While most indigenous women are manipulated into adopting family planning policies by doctors and clinic personnel, they do not see how they could benefit from smaller families.⁵ They are coerced into adopting limitation methods that will drastically change the future of their families – a grave violation of their ‘social freedom.’⁷ Told from the indigenous women’s perspective then, the Progresa program does not preserve individual ‘freedom of choice.’ As mentioned earlier, the most important component of Progresa’s success is its preservation of women’s autonomy over their reproductive health. Based on reports on the ground, the program is a failure.

EXPLAINING THE DISCREPANCY

Evaluations incorporating indigenous experiences and assessments made by government institutions thus provide conflicting perspectives on the Progresa-Oportunidades program. As discussed earlier, policymakers predicate the formulation of healthcare standards on an equal balance of power between caregivers and beneficiaries. As the following analyses will indicate, this is rarely true in the health clinics of rural Mexico. We now articulate the many causes for the compromise of patient autonomy under the Progresa program. The subordination of supposed “beneficiaries” – and of poor indigenous women in particular – is particularly relevant to reproductive healthcare, as inequality in doctors’ and women’s power leads to infringements of reproductive rights. These violations occur in specific social, ethno-cultural, economic and political environments.

Social Factors: Patient-Doctor Interactions

As mentioned previously, doctors working for Progresa foster a coercive health clinic environment by imposing family planning agendas on their patients, pressuring them to reduce family sizes through sterilization or use of IUDs. Apart from direct insistence that women use contraceptive methods, Smith-Oka (2009: 2075) observes that many doctors also joke with their patients about their various medical needs. This includes teasing women about ‘their weight [or] dietary habits.’ The purpose of this levity is not to lighten the mood during examinations so much as it is an alternative method for forcing ‘patient compliance.’ Threat tactics are often thinly veiled as jokes about terminating program grants or forced sterilization.⁵ Furthermore, the joking is completely one-sided, as most women do not respond to doctors’ jibes. Many misconstrue the jokes as truth, convinced that the doctors are telling them the ‘grim reality.’²⁵

Indigenous women thus feel pressured to adopt family planning methods by their social interactions with doctors. Again, doctors do not physically force their patients to undergo sterilization and other procedures. Yet women feel victimized by the doctors’ jokes, which, while seemingly innocuous, nevertheless cause them great mental and emotional stress. Indeed, the social dynamics place the women in a subordinate position. As a result, they are compelled to comply with their doctors’ orders, thereby compromising their resistance to family planning methods.

Ethno-cultural Factors: Mestizo and Indigenous Power Dynamics

Many indigenous women are also compelled to accept and follow orders because they feel racially and culturally inferior to the doctors.⁵ All doctors and personnel studied by Smith-Oka are mestizo. This is both an ethnic and a cultural identification: mestizo refers to both a Mexican of mixed European and indigenous ancestry and one who, “has lost or eschewed indigenous cultural traits for the mainstream Mexican ethos” (Smith-Oka, 2009: 2074). In fact, mestizos occupy an unusual position in Mexican society, for they must simultaneously fulfill two roles. As champions of nationalism in the post-Revolutionary era, they supposedly represent the Mexican people so long oppressed by European imperialists. At the same time, as political leaders wanting to ‘claim’ the country as their own, mestizos must partially adopt the ‘conqueror’ mentality of their predecessors.⁸

This effort to establish legitimacy in their political authority compels mestizos to elevate themselves above non-mestizos through their language and actions. Embracing these cultural norms, most clinic personnel studied by Smith-Oka maintain a distinct ‘cultural distance’ from their patients. In particular, interviews with nurses reveal that they feel it their duty to enlighten ignorant indigenous patients who are helpless to halt rapid family growth. As part of a societal elite, these nurses and other mestizos promote a reproductive health agenda focused on family planning. And because of their perceived superiority (and by using ‘joking’ tactics, as described earlier), they are frequently successful in obtaining patient compliance. Often, doctors suggest contraception to a woman even when the purpose of her visit is unrelated to reproductive health.⁵ And should the patient fail to comply, nurses often ‘scold’ her for disobeying.⁵

Economic Factors: Trapped in Poverty

Female patients unwilling to follow doctors’ orders often cease to attend regular clinic checkups. These women are at risk of losing their government financial aid because of the original stipulations of the program. Many nurses tell non-compliant women not to, “complain if they take away your [monetary] support” (Smith-Oka, 2009: 2075). Such threats are superficially passive in nature; many nurses also tell women that they alone can decide whether or not they will continue to

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receive support from the government. However, to dismiss these warnings as inconsequential and therefore harmless is to fail to recognize the underlying economic considerations that plague many indigenous women.⁵

For women living in poverty, Progresa’s bimonthly stipend of US\$35 is an important financial resource; among rural households, the grant is equivalent to approximately 25 percent of average family income without the program.³ The program’s ‘cash transfer’ is a significant incentive, and doctors therefore hold great power in their patient interactions. Furthermore, the loss of money is a tangible threat to the women, and one whose consequences are much more immediate than the loss of autonomy. Forced to choose between their reproductive rights and a vital source of finance, indigenous women will inevitably choose the latter.⁵ By necessitating this cost-benefit analysis, Progresa impedes women’s ‘freedom of choice.’

Political Factors: Anomalies in the International Health-care System

At the same time, the conditional cash transfer system does not explicitly violate the women’s rights. Surgeries are performed and contraceptive methods are implemented only with the consent of the patient. The issue of patient consent is central to the legal framing of reproductive rights: a humanitarian relationship between policymakers and beneficiaries is predicated upon it. And the absence of consent establishes two distinct parties: the ‘violators’ and the ‘violated.’

While many women officially agree to participate in family planning programs, their consent is given only after considering the consequences of refusing it. This ‘consent by default’ is not an exercise of reproductive rights, because circumstances predetermine the available options and the ultimate decision. In Overmyer-Velazquez’s report (2003: 20), Consejo Guerrerense, a Mexican coalition representing indigenous women’s rights, states that the consent-based relationship is difficult to articulate under poverty-stricken circumstances. As Amartya Sen, a world-renowned welfare economist and an expert on society’s impact on individual identity,⁹ states in Beutelspacher, Martelo & Garcia’s article (2003: 16), a woman’s perception of herself and of her capacities is heavily influenced by her circumstances and options. The social, ethno-cultural and economic environment heavily influences a woman’s decision to adopt or resist Progresa’s family planning programs.

The legal framework of reproductive rights thus does not account for these external pressures on indigenous women. And it is these very environmental factors that ultimately lead to the violation of their rights. The failure of the program to protect individual autonomy, as well as Mexico’s history of state-run sterilization campaigns, have compelled Consejo to dismiss even the possibility of consent for indigenous women. Under these circumstances, ‘freedom of choice’ for indigenous women seems absurd.⁴

As we have seen, lack of autonomy for indigenous women is not a novel phenomenon. Indeed, it is not unusual in international law as a whole, which inherently places indigenous populations in an ‘ambiguous position.’⁴ The reason for this

inability to clearly identify indigenous people in an international political context lies in the 'fundamental state-based privilege' that is the cornerstone of the UN and other major transnational organizations.⁴ It is an international paradigm that is based on the Westphalian concept of state sovereignty – the ability of a state to exercise its 'domestic power' without fear of external pressures. As the defining unit of international politics, the 'state' can be further expanded to derive the 'nation-state.' The 'nation-state' is bound by the territorial borders of the state but is also characterized by population homogeneity.⁴ In the context of the Peace of Westphalia, the characterization of this homogenous population is highly specific: European and Christian. Self-proclaimed 'civilized nation-states,' an exclusive 'club' of Westernized countries, created the foundations of international law which continue to influence global politics today.⁴

Labeled by Hobbes and other political theorists as 'savage people,' indigenous populations were an important foil to the 'civilized nation-state.' Excluded from the collective community of the 'nation-state,' indigenous people do not enjoy the rights to which citizens are entitled.⁴ These 'individual freedoms' of 'sovereignty and legitimacy'⁴ include the 'right to self-determination.'⁴

In this way, the individual rights of indigenous people are compromised by the global political paradigm. As outsiders to the state-based hierarchy of sovereignty, they do not benefit from the autonomy guaranteed by the Hobbesian 'social contract.' Furthermore, the scope of individual sovereignty is purely political. Applied to the global health policy, it fails to incorporate the social, ethno-cultural and economic conditions that influence the rights of indigenous women so heavily. Ultimately, the international state-based healthcare system falls short of addressing the needs of indigenous women, leaving them with no choice but to continue to suffer violations of their reproductive rights.

Conclusion

Until recently, there has been little international concern for these shortcomings in the healthcare bureaucracy. In fact, most national governments have been extremely reluctant to concede rights of self-determination to indigenous populations. In 1993, the Working Group on Indigenous Populations at the UN drafted a Declaration on the Rights of Indigenous Peoples. Despite the efforts of a special committee consisting of indigenous groups, state representatives and non-governmental organizations (NGOs), the Declaration has yet to be approved.⁴ Overmyer-Velazquez (2003:16) notes that the rejection of the Declaration is surprising, given that it is 'not legally binding.' The lack of support for the document is most likely because of its potential to 'set future precedent' in the global status of indigenous people.⁴

The aversion of national politicians to transforming the international policy paradigm reflects a deeply ingrained arrogance towards the plight of indigenous populations. Many political elites believe that indigenous and impoverished people should not have autonomy, claiming that lack of education and other resources renders them incapable of leading their own lives. In a reproductive health context, this

condescending attitude translates into the portrayal of poor mothers as uncontrollable birthing machines. Policymakers must implement extensive family planning methods, therefore, for this is 'what is good for them.'¹⁰

At the same time, recent transnational discussions about the future of global reproductive health have sought to replace this top-down reproductive health paradigm. At a Foundation Roundtable held at the Woodrow Wilson International Center for Scholars in 2009, both government officials and organization leaders emphasized the need for 'open debate' and 'community-based approaches' in an effort to extend reproductive rights to the poor. In particular, Bert Koenders, the Minister for Development Cooperation for The Netherlands, cites the private sector as an important source of finance and policy insight. Most importantly, the speakers at the Roundtable agree on the need for a division of labor that is distributed equally among different sectors. Scott Radloff, a director in the U.S. Agency for International Development, assigns the following roles: the public sector should aid people who cannot afford to pay for their healthcare, the private sector should serve those who can, and NGOs should direct external advocacy campaigns. Rather than relying solely on a powerful government body whose policies would reach beneficiaries through 'trickle-down,' this proposed system utilizes the strengths and expertise of many different sectors to ensure that individuals will ultimately be able to exercise their reproductive rights.¹¹

The struggle to guarantee the reproductive rights of women will doubtless consume great amounts of effort, time and money. Yet there is also new hope that all women – regardless of social, ethno-cultural and economic background – will one day be able to decide their own futures and the futures of their families.

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