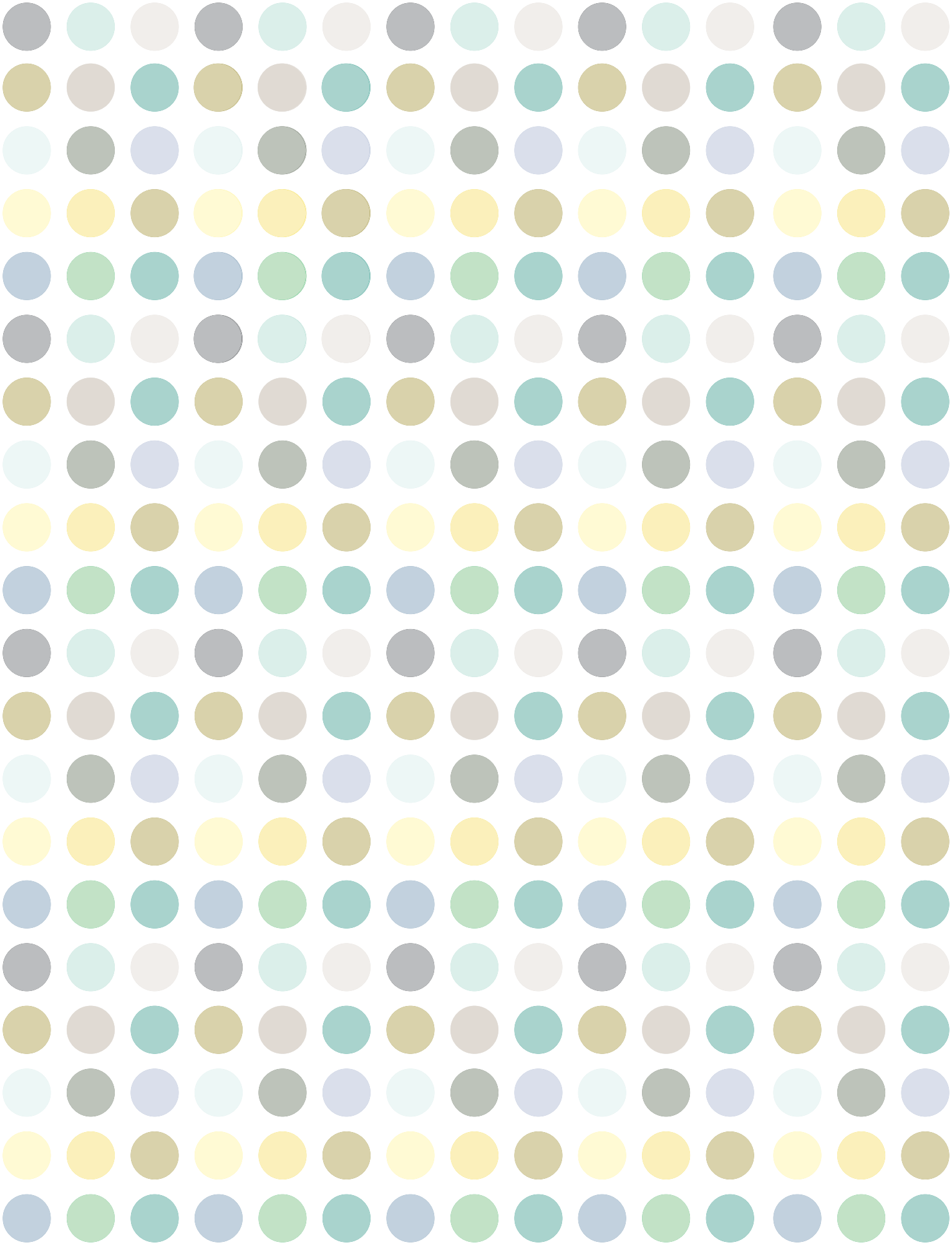
OMISSION AND INDIFFERENCE

REPRODUCTIVE RIGHTS IN MEXICO

ABORTION / CONTRACEPTION / MATERNAL MORTALITY / OBSTETRIC VIOLENCE / WORK AND FAMILY LIFE / ASSISTED REPRODUCTION

RADAR 4°
RED DE ABOGAD@S POR LA DEFENSA DE LA REPRODUCCIÓN ELEGIDA

GIRE
GRUPO DE INFORMACIÓN EN REPRODUCCIÓN ELEGIDA



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GIRE
GRUPO DE INFORMACIÓN
EN REPRODUCCIÓN ELEGIDA

Director / Regina Tamés Noriega

Coordinators / Ximena Andión and Rebeca Ramos

Research and Texts / Ximena Andión, Alma Luz Beltrán y Puga, Fernanda Díaz de León, Marisol Escudero, Isabel García, Mariana García, Rebeca Ramos, Brenda Rodríguez, Itzel Silva, Martín Vera, and the National Lawyers Network for Reproductive Choice (RADAR 4th).

Editing / Sara Gómez

Translation / Benton & Asociados, Sara Gómez, Celorio Morayta, Jennifer Paine, and Fionn Petch

Design / María Carral

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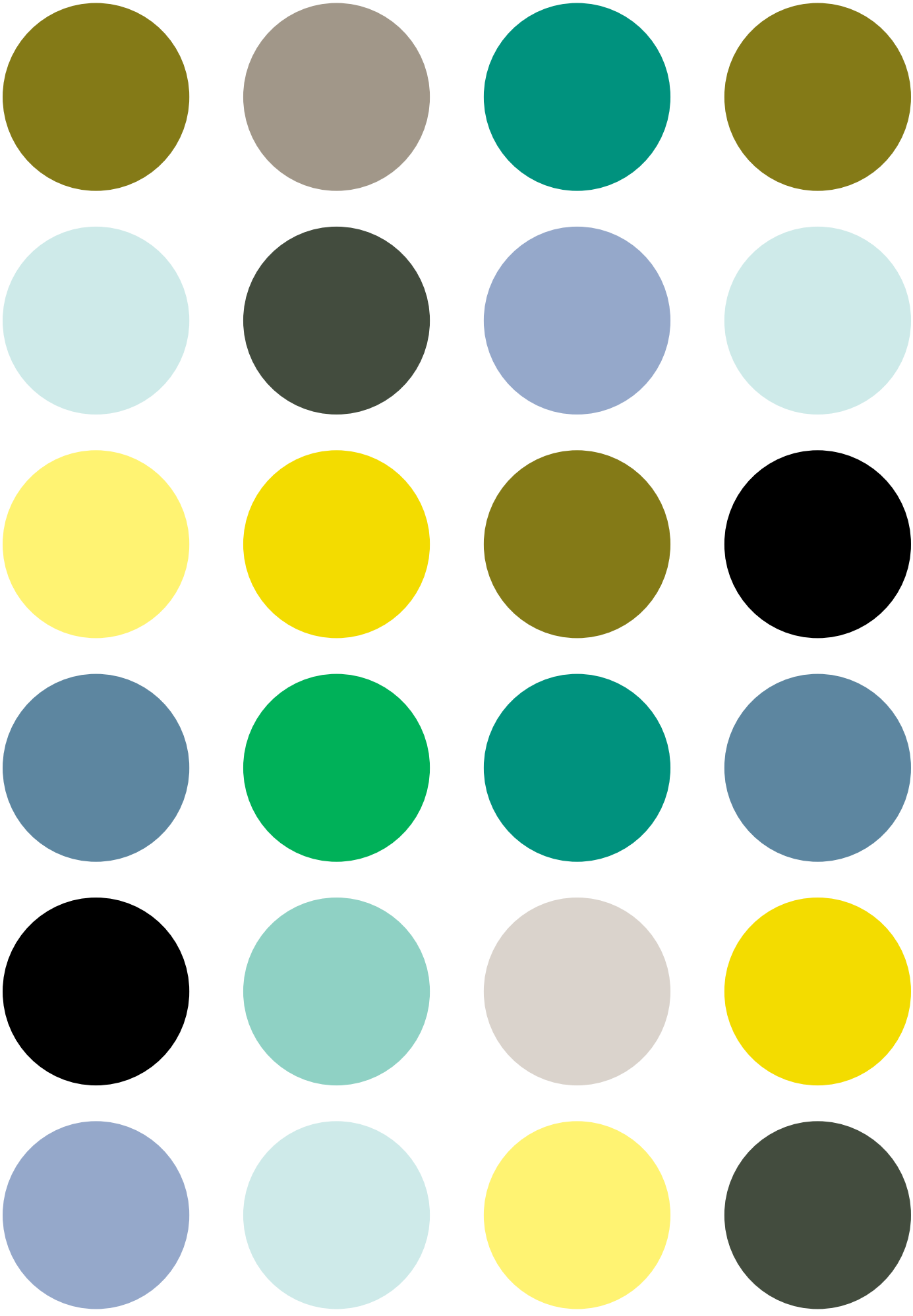


INTRODUCTION

For more than 20 years, the Grupo de Información en Reproducción Elegida (GIRE; Information Group on Reproductive Choice) has been dedicated to the defense and promotion of women's reproductive rights in Mexico, within a human rights framework. During this time, we have observed with concern the legal obstacles and lack of implementation of existing law and policy that would guarantee women's full exercise of their reproductive rights. This situation is especially serious in certain Mexican states. To respond to this situation, GIRE created the National Lawyers Network for Reproductive Choice (RADAR 4th) in 2008 to reverse these obstacles and protect women's rights.[1]

This report provides a snapshot of the current status of reproductive rights in Mexico, through analysis of six priority topics for GIRE, without attempting to constitute an exhaustive list of reproductive rights issues:

1. SAFE AND LEGAL ABORTION
2. CONTRACEPTION
3. MATERNAL MORTALITY
4. OBSTETRIC VIOLENCE
5. WORK AND FAMILY LIFE
6. ASSISTED REPRODUCTION

THE REPORT PROVIDES A DETAILED ANALYSIS OF PROGRESS, UNFULFILLED OBLIGATIONS AND SETBACKS TO REPRODUCTIVE RIGHTS IN MEXICO.

This report presents and analyzes the current legal and policy framework for reproductive rights in Mexico, at the federal and state level, as well as the implementation of said framework. It also identifies obstacles faced by women in exercising their reproductive rights.

GIRE's analysis contained in the report is based on comparing documentary sources to the highest human rights protection standards and its goal is to contribute to the design, development and evaluation of law and policy to expand protection for women´s reproductive rights in Mexico. To this end, the report includes recommendations and proposals at the end of each chapter with the goal of providing suggestions or solutions so that the Mexican State can fulfill its reproductive rights obligations. These obligations are particularly relevant after the June 2011 constitutional reform related to human rights.[2]

Methodology

The information presented in this document covers April 2007 to January 2013. We used documentary sources to develop the report: federal and state laws and administrative policies, cases of rights violations documented by GIRE, and statistical data and governmental information obtained through requests for public information. This information was organized and analyzed using charts and graphics related to laws, policies, and data corresponding to each of the report´s six chapters. GIRE developed information tables for federal and state laws and policies for each topic and both GIRE and RADAR 4th lawyers carried out the research to gather the data.

GIRE obtained statistical information from public institutions such as the National Institute of Statistics and Geography, the National Population Council and the Observatory of Maternal Mortality.

GIRE accessed public information by presenting information requests to public institutions responsible for implementing reproductive rights law and policy. More than 600 information requests were presented to the federal and state government agencies (from 31 states and Mexico City) through various online platforms and portals created for public consultation of government information. Presenting the requests and analyzing and organizing the obtained information occurred between April and December 2012.

Obstacles to Accessing and Obtaining Public Information

The State is obligated to produce or process information in accordance with constitutional, international and legal norms. The State must adopt positive measures to generate and process desegregated information, not only to guarantee public policy, but also in order to fulfill its duties.[3] Nevertheless, GIRE faced various difficulties when presenting its requests for public information, following-up on these requests and collecting and compiling the data provided in response.

We encountered the following barriers to accessing and receiving information necessary to develop this report: current law and policy,[4] technological barriers within digital platforms,[5] poor quality information obtained in response to requests for information, and the criteria used by officials designated to address the information requests.

The information obtained for this report was deficient as a result of the poor-quality of received responses and the lack of documental record for requested topics. The majority of responses did not comply with the obligation to provide official information in a timely, complete, accessible and reliable manner.

The responses to the information requests had the following characteristics:

A. Many of them were incomplete.

B. In the majority of cases, the provided information was not broken down into relevant indicators.

C. The information did not always comply with the principles of veracity and reliability.

D. There was a tendency to provide the responses in PDF or JPG format, making the information impossible to locate, recuperate, reuse or index.

These barriers make it impossible to use public information as a tool for social empowerment and demand, and they prevent women from making free, well-founded and responsible decisions regarding their reproduction, and truly exercising their reproductive rights.

NOTES

[1] RADAR 4th is currently present in 13 states.

[2] In the past few years, Mexico has made progress in incorporating human rights into its law and policy framework, particularly relevant is the 2011 constitutional reform that: 1) incorporates human rights standards included in international treaties to which Mexico is part into the Mexican Constitution; 2) establishes authorities' obligation to promote, respect, protect and guarantee human rights in accordance with the principles of universality, interdependence, indivisibility and progressivity; and 3) establishes the principles of pro personae and consistent interpretation as criteria in the application of human rights norms.

[3] *IACHR*. Annual Report 2008. OEA/Ser.L/V/II. 134. Doc. 5. February 25, 2009. Vol. III: *Report of the Office of the Special Rapporteur for Freedom of Expression.* Chapter III. Paragraph 162. Available at <http://bit.ly/146k6Os> [accessed: November 9, 2012].

[4] Provisions within legislation related to access to information are often invoked by authorities to justify a lack of organization in their records and inadequate responses to information requests. Officials often respond that they have no record of the information requested in their files, using "lack of information" as an excuse. Legislation also allows officials to provide information as it is found in their records, exempting them from generating and systematizing the information, because of the apparent "excessive work" that this activity would require.

[5] The *Infomex* system, a web-based platform to send and collect information requests, receive responses and file complaints, is available for the federal executive branch, 25 states and Mexico City, as well as other obligated parties such as the National Human Rights Commission. Nevertheless, adaptations of each local *Infomex* platform lead to serious problems in exercising the right to access to information.
We must highlight that, with the exception of Baja California Sur, Tamaulipas and Michoacan, all states have either digital or *Infomex* platforms, or alternate systems to register information requests. It is worth noting that, only 15 states have *Infomex* systems available for requests directed towards public human rights organisms (Aguascalientes, Chiapas, Chihuahua, Coahuila, Guanajuato, Hidalgo, Mexico City, Morelos, Nayarit, Puebla, Sinaloa, Tabasco, Tlaxcala, Veracruz and Zacatecas) and five have alternate remote systems (Baja California, State of Mexico, Nuevo Leon, Oaxaca and Yucatan). For organisms in other states, we had to send requests for access to information by email or though forms that were available on their websites.
A little more than half of the states' judicial branches (17) are part of their state's *Infomex* system and, as such, have accessible forms for receiving information requests (Aguascalientes, Chiapas, Chihuahua, Coahuila, Colima, Durango, Hidalgo, Mexico City, Morelos, Nayarit, San Luis Potosi, Sinaloa, Sonora, Tabasco, Tlaxcala, Veracruz and Zacatecas).

1.

SAFE AND LEGAL ABORTION

1.1 / INTRODUCTION

Access to safe and legal abortion is an essential part of women's right to reproductive health services. Access to safe and legal abortion is based on the right to life; the right to health, including reproductive health; the right to physical integrity; the right to privacy; the right to freedom from discrimination and the right to reproductive autonomy. These rights are included in Mexico's Constitution as well as various international human rights treaties.

Recent international studies[1] show that abortion is a public health problem, causing nearly 47,000 deaths annually on a global scale, contributing to 13% of all maternal deaths and resulting in approximately five million health complications, some of them permanent. In other words, abortions carried out in unsafe conditions and under restrictive legal contexts are associated with elevated maternal mortality and morbidity.

Similarly, a recent study by the World Health Organization (WHO) demonstrates that making abortion illegal does not reduce its rate. It only reduces the safety of the procedures, negatively impacting women's life, health and liberty.[2]

International and regional human rights mechanisms have repeatedly expressed their concern about the consequences of illegal or unsafe abortion on women's exercise of their human rights. They have recommended that States liberalize their abortion laws and guarantee access to abortion for existing legal indications.

The Committee on the Elimination of All Forms of Discrimination against Women (CEDAW Committee), which monitors compliance with the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), establishes in its General Comment No. 24 on Women and Health that is it discriminatory to deny services related to health problems specific to women.[3] The CEDAW Committee, the Committee for Economic, Social and Cultural Rights, and the Human Rights Committee, all part of the United Nations system, have pointed out that the complete prohibition of abortion violates women's human rights, and that abortion should be permitted and accessible at least in cases of pregnancy resulting from rape, fetal anomalies incompatible with life, and when the woman's life or health is at risk.[4] These human rights bodies have also expressed concern about the criminalization of women who are forced to resort to clandestine, unsafe abortions, placing their health and lives at risk.[5]

Since June 11, 2011, the Mexican Constitution recognizes all rights contained within the international treaties ratified by the State and all authorities are obligated to promote, respect, protect and guarantee human rights in accordance with the principles of universality, interdependence, indivisibility and progressivity, taking into consideration resolutions emitted by international treaty monitoring bodies.[6]

When abortion services are inaccessible for women who need them or when abortion laws are restrictive, States may be responsible for violating women's human rights at both the constitutional and international level. Lack of access to safe and legal abortion is a violation of women's reproductive rights and has a negative impact on their life opportunities, futures, and exercise of human rights.

1.2 / SITUATION IN MEXICO

In Mexico, abortion is generally a crime, although certain legal exceptions are permitted and regulated at the state level. In other words, qualifying women who have abortions under these exceptions or indications are exempt from punishment. These indications vary by state, and are listed in the law and policy section of this chapter.

Mexico City is the only state where abortion is legal at the woman's request, regardless of reason, during the first twelve weeks of pregnancy. Abortion of pregnancy resulting from rape is legal across Mexico.

Nevertheless, women's effective access to legal indications for abortion in Mexican states is precarious or null, representing a major gap between the law and the effective exercise of this right.

In Mexico, access to abortion depends on where a woman lives and her socio-economic status, making it a social justice and gender discrimination issue. Women with information and economic resources can travel to Mexico City or even out of the country to have an abortion, while poor and marginalized women do not have this option unless they receive support from civil society organizations such as the María Fund[7], whose resources are also limited.

In this regard, a recent study documented that the poorest, least educated and/or indigenous women are nine times more likely to undergo an unsafe abortion than women with greater economic possibilities, more education or that do not belong to an indigenous group. In addition, women who live in the country's poorest states are at higher risk for having an unsafe abortion. The same states also have a higher proportion of sexually active women who do not use or know about contraceptive methods.[8]

Restrictive abortion legislation and lack of access to existing legal indications force many women to resort to clandestine abortions, placing their lives and health at risk. It is estimated that the induced abortion rate in Mexico in 2009 was 38 for every 1,000 women between the ages of 15 and 44, for a total of 1,025,669 induced abortions.[9] This means that the number of induced abortions in Mexico has increased from slightly over 500,000 estimated abortions in 1990 to 874,747 in 2006, an increase from 25 to 38 abortions for every 1,000 women of reproductive age, one of the highest rates in the world.[10]

Levels of development, availability of information and women's socio-economic conditions are all factors that directly affect the prevalence of unwanted pregnancy and the rate of induced abortion.[11] Women's age is another factor to consider; various states recorded high rates of induced abortion among adolescents.[12]

Only one in six women who undergoes a clandestine abortion seeks or obtains hospital care, meaning a lack of adequate medical care for the other five.[13] According to the organization Ipas México, the number of women receiving hospital care for abortion-related complications has risen every year. Between 2000 and 2008, a total of 1,604,976 women between the ages of 10 and 54 received post-abortion care in public hospitals.[14]

According to data from the Federal Ministry of Health, abortion was the cause of 11% of maternal deaths in 2010.[15] These deaths, entirely preventable, could have been avoided by providing women with access to safe and legal abortion. In addition to these deaths, many women experience health complications due to unsafe abortions; in 2009 alone, 159,005 women sought hospital care due to complications from unsafe abortions.[16]

When women undergo clandestine, yet illegal, abortions under safe conditions, they can still be subject to criminal processes that can result in punishments including fines, medical or psychological treatment or loss of liberty. Based on data obtained through requests for information from district and higher courts, 127 women were sentenced for the crime of abortion in 19 states between April 1, 2007 and July 31, 2012.[17] Mexico's Supreme Court sent the following data regarding the number of women reported/sentenced after seeking post-abortion care in health institutions; between 1992-2007 there were approximately 1,000 criminal cases and pre-trial investigations related to abortion,[18] an average of 62.5 women reported and/or processed in the country per year.

Between 2009-2011, however, after various states approved constitutional reforms to protect life from conception, 679 women were reported/sentenced for the crime of abortion, an average of 226.3 women per year.[19] This is a significant increase compared to the period prior to the reforms, representing an average of 163.8 more women reported/sentenced each year.

1.3 / LAW AND POLICY FRAMEWORK

Every Mexican state establishes when abortion is a crime or not, what procedures a woman should follow to request a legal termination of pregnancy and how the service should be provided by health institutions.

According to Article 73 of the Mexican Constitution,[20] abortion is a matter of state jurisdiction except in a few specific cases for which the Federal Penal Code is applied.[21]

Given the above, abortion is regulated in each state's criminal code and health regulations. Criminal codes define abortion, the people who commit them, the corresponding punishments, and the indications in which individuals are excluded from criminal responsibility.

Health regulations regulate the manner in which medical care is provided. This regulation has concurrent jurisdiction, corresponding to both federal and state authorities. The General Health Law guides the actions of federal authorities and the state health laws guide the actions of state authorities.

Policies regulating access to abortion should be harmonized to the highest standards of human rights protection.[22] If this is not the case, their interpretation and application by judicial and administrative authorities should apply those standards.[23]

1.3.1 FEDERAL PENAL CODE

Although abortion is a matter of state regulation, the Federal Penal Code also defines abortion as a crime.[24]

This law is applied in the few cases defined in Article 2 of the Federal Penal Code[25] and Article 50 of the Federal Judicial Authority Organization Act[26] They include: when the crime is committed abroad by diplomatic officials or personnel representing the Mexican State or consulates; when the crime is committed in an embassy or other foreign legation; or when the crime is committed on national ships and aircrafts. Although these situations are rare, this type of case could exist, and so we present the following chart describing the manner in which abortion is penalized at the federal level.

FEDERAL PENAL CODE ARTICLES 329, 330, 331, 332, 333 AND 334	
ABORTION: DEATH OF THE PRODUCT OF CONCEPTION AT ANY POINT DURING PREGNANCY	
SANCTIONS: WOMAN	1 TO 5 YEARS.
	ABORTION *honoris causa:* GOOD REPUTATION, HAS CONCEALED HER PREGNANCY, AND THE PREGNANCY IS THE PRODUCT OF A LEGITIMATE UNION: 6 MONTHS TO 1 YEAR.
SANCTIONS: THIRD PERSON	WITH THE WOMAN'S CONSENT: 1 TO 3 YEARS.
	WITHOUT THE WOMAN'S CONSENT: 3 TO 6 YEARS.
	WITH VIOLENCE: 6 TO 8 YEARS.
	PHYSICIAN, SURGEON, BIRTH ATTENDANT, MIDWIFE: IN ADDITION TO THE SANCTION ABOVE. SUSPENSION OF PROFESSIONAL LICENSE FOR 2 TO 5 YEARS.
LEGAL INDICATIONS	PREGNANCY TERMINATION RESULTING FROM A "CARELESS ACT".
	RAPE.[27]
	RISK OF DEATH.

1.3.2 STATE PENAL CODES

Abortion laws differ from state to state, generating a context of legal discrimination in which a woman's right to terminate a pregnancy varies depending on her place of residence. The regulations are diverse and, in general, restrictive, except in Mexico City where abortion in permitted in the first trimester of pregnancy.

In all Mexican states, abortion is a crime with legal indications that eliminate criminal responsibility. Based on a review of the legislation, we can conclude that abortion-related law and policy, in the majority of states, lacks a gender perspective and scientific basis. In more than ten Penal

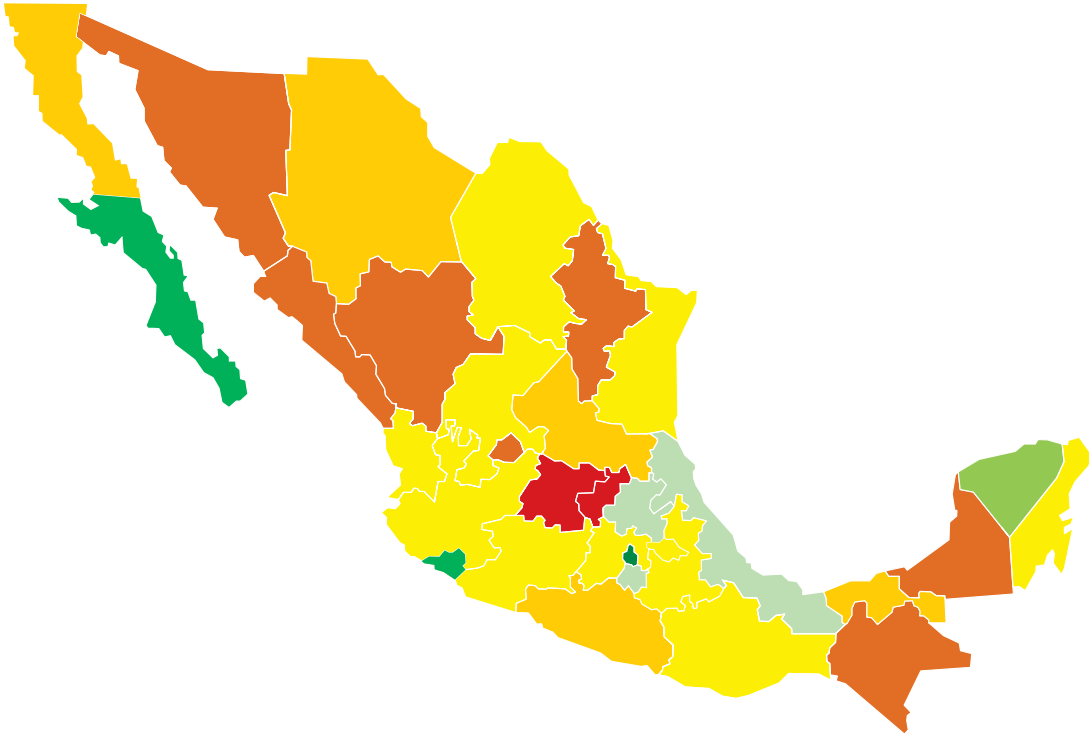
Codes, the woman is referred to as "the mother"; in 28, abortion is defined as "the death of the product of conception", contradicting the WHO's definition of abortion. The WHO defines abortion as the termination of a pregnancy, which begins at implantation[28] rather than "conception"; in other words, when the fertilized egg attaches to the wall of the uterus, and not at the moment of fertilization, or when the sperm and egg join, the moment to which the term "conception" apparently refers. In addition, although the term "conception" is included in state legislation, according to Article I of the Constitution, this definition should be interpreted as implantation, based on the jurisprudence set by the Inter-American Court of Human Rights in the case *Artavia Murillo et al. ("In Vitro Fertilization") vs. Costa Rica.*[29]

A. MAP OF LEGAL INDICATIONS

The only legal indication for abortion that exists in all Mexican states is when the pregnancy is a result of rape. In ten states,[30] an abortion can be carried out under this indication during the first trimester, while the period in which the termination can be carried out is not defined in the 22 remaining states. The latter protects human rights by allowing women to decide whether or not to continue a pregnancy that puts their life or health at risk without the pressure of a time limit.

Regarding other legal indications, a review of the state Penal Codes demonstrates the following: pregnancy termination resulting from a "careless act" in 30 states,[31] risk to the woman's life in 25 states,[32] fetal anomalies in 14 states,[33] severe risk to the woman's health in 13 states,[34] artificial insemination without the woman's consent in 11 states,[35] socio-economic reasons (for women with 3 or more children) in one state,[36] and at the woman's request in the first 12 weeks of pregnancy in one state.[37]

ABORTION IN MEXICO



ABORTION IN MEXICO

STATES	LEGAL INDICATIONS[38]
GUANAJUATO	RAPE
QUERETARO	PREGNANCY TERMINATION RESULTING FROM A "CARELESS ACT"
AGUASCALIENTES	RAPE
DURANGO	PREGNANCY TERMINATION RESULTING FROM A "CARELESS ACT"
SINALOA	RISK TO THE WOMAN'S LIFE
SONORA	
CAMPECHE	RAPE
	PREGNANCY TERMINATION RESULTING FROM A "CARELESS ACT"
	SEVERE RISK TO THE WOMAN'S HEALTH
NUEVO LEON	RAPE
	RISK TO THE WOMAN'S LIFE
	SEVERE RISK TO THE WOMAN'S HEALTH
CHIAPAS	RAPE
	RISK TO THE WOMAN'S LIFE
	SEVERE GENETIC OR CONGENITAL FETAL ANOMALIES
GUERRERO	RAPE
	PREGNANCY TERMINATION RESULTING FROM A "CARELESS ACT"
	ARTIFICIAL INSEMINATION WITHOUT THE WOMAN'S CONSENT
	SEVERE GENETIC OR CONGENITAL FETAL ANOMALIES
CHIHUAHUA	RAPE
	PREGNANCY TERMINATION RESULTING FROM A "CARELESS ACT"
	SEVERE RISK TO THE WOMAN'S HEALTH
	ARTIFICIAL INSEMINATION WITHOUT THE WOMAN'S CONSENT
BAJA CALIFORNIA	RAPE
SAN LUIS POTOSI	PREGNANCY TERMINATION RESULTING FROM A "CARELESS ACT"
TABASCO	RISK TO THE WOMAN'S LIFE
	ARTIFICIAL INSEMINATION WITHOUT THE WOMAN'S CONSENT
JALISCO	RAPE
MICHOACAN	PREGNANCY TERMINATION RESULTING FROM A "CARELESS ACT"
NAYARIT	RISK TO THE WOMAN'S LIFE
TAMAULIPAS	SEVERE RISK TO THE WOMAN'S HEALTH
TLAXCALA	
ZACATECAS	
COAHUILA	RAPE
STATE OF MEXICO	PREGNANCY TERMINATION RESULTING FROM A "CARELESS ACT"
OAXACA	RISK TO THE WOMAN'S LIFE
PUEBLA	ARTIFICIAL INSEMINATION WITHOUT THE WOMAN'S CONSENT
QUINTANA ROO	
MORELOS	RAPE
VERACRUZ	PREGNANCY TERMINATION RESULTING FROM A "CARELESS ACT"
	RISK TO THE WOMAN'S LIFE
	SEVERE GENETIC OR CONGENITAL FETAL ANOMALIES
	ARTIFICIAL INSEMINATION WITHOUT THE WOMAN'S CONSENT
HIDALGO	RAPE
	PREGNANCY TERMINATION RESULTING FROM A "CARELESS ACT"
	SEVERE RISK TO THE WOMAN'S HEALTH
	SEVERE GENETIC OR CONGENITAL FETAL ANOMALIES
	ARTIFICIAL INSEMINATION WITHOUT THE WOMAN'S CONSENT

ABORTION IN MEXICO	
STATES	**LEGAL INDICATIONS[38]**
YUCATAN	RAPE PREGNANCY TERMINATION RESULTING FROM A "CARELESS ACT" RISK TO THE WOMAN'S LIFE SEVERE GENETIC OR CONGENITAL FETAL ANOMALIES SEVERE SOCIO-ECONOMIC REASONS WHEN THE PREGNANT WOMAN HAS AT LEAST THREE CHILDREN
BAJA CALIFORNIA SUR COLIMA	RAPE PREGNANCY TERMINATION RESULTING FROM A "CARELESS ACT" RISK TO THE WOMAN'S LIFE SEVERE GENETIC OR CONGENITAL FETAL ANOMALIES SEVERE RISK TO THE WOMAN'S HEALTH ARTIFICIAL INSEMINATION WITHOUT THE WOMAN'S CONSENT
MEXICO CITY	RAPE PREGNANCY TERMINATION RESULTING FROM A "CARELESS ACT" SEVERE GENETIC OR CONGENITAL FETAL ANOMALIES SEVERE RISK TO THE WOMAN'S HEALTH ARTIFICIAL INSEMINATION WITHOUT THE WOMAN'S CONSENT AT THE WOMAN'S REQUEST DURING THE FIRST 12 WEEKS OF PREGNANCY

In this chart, we have reported the indication for severe risk to the woman's health and the indication for risk to the woman's life separately, as they appear in state Penal Codes. However, in states that include the indication for severe risk to the woman's health but not the indication for risk to the woman's life, the latter should be interpreted as part of the former to guarantee maximum protection for women's reproductive rights. This is the case of Campeche, Chihuahua, Mexico City and Hidalgo.

This chart demonstrates some of the major legal barriers to accessing abortion in Mexico. **THE STATES WITH THE MOST RESTRICTIVE ABORTION LAWS ARE GUANAJUATO AND QUERETARO, WITH LEGAL INDICATIONS FOR ABORTION ONLY IN THE CASE OF RAPE AND PREGNANCY TERMINATION RESULTING FROM A "CARELESS ACT".** There are only eight states that have more than four legal indications.[39]

B. Sanctions

Given the legal restrictions and scarce access to abortion, women frequently resort to clandestine abortions, which places them at risk of being charged and sentenced for "committing" the crime of abortion, even when they would qualify for a legal abortion under the permitted indications.

In 27 states,[40] abortion is classified as a misdemeanor, meaning that women can go through criminal proceedings without being imprisoned. According to Article 19 of the Mexican Constitution, in these cases, the woman can retain her freedom by paying bond or bail in order to continue the process outside of prison.[41] GIRE has documented cases of bail payments ranging from $1,000 to $197,000 pesos. Many women, subject to criminal proceedings for abortion, have few economic resources, making the payment of these types of bails an enormous burden.

In the remaining five states abortion is classified as a felony,[42] meaning that women subject to criminal proceeding must remain in prison during the same.[43]

The state of Tlaxcala has the lowest sanctions for abortion in the country but classifies abortion as a felony. This contradiction is not consistent with the state's criminal policy.

CRIMINAL SANCTIONS FOR ABORTION

SANCTION	STATE
PRISON SENTENCE (30)	**15 DAYS TO TWO MONTHS:** TLAXCALA
	THREE TO SIX MONTHS: MEXICO CITY[44]
	FOUR MONTHS TO ONE YEAR: JALISCO[45]
	SIX MONTHS TO ONE YEAR: AGUASCALIENTES AND NUEVO LEON
	TWO MONTHS TO TWO YEARS: BAJA CALIFORNIA SUR[46]
	SIX MONTHS TO TWO YEARS: CAMPECHE[47] AND QUINTANA ROO
	EIGHT MONTHS TO TWO YEARS: ZACATECAS
	SIX MONTHS TO THREE YEARS: CHIHUAHUA, GUANAJUATO, SINALOA AND TABASCO
	ONE TO THREE YEARS: COAHUILA, COLIMA, DURANGO, GUERRERO, HIDALGO, MICHOACAN, NAYARIT, QUERETARO, SAN LUIS POTOSI AND THE STATE OF MEXICO
	ONE TO FIVE YEARS: BAJA CALIFORNIA, MORELOS,[48] OAXACA, PUEBLA, TAMAULIPAS[49] AND YUCATAN[50]
	ONE TO SIX YEARS: SONORA
COMMUNITY SERVICE (2)	CAMPECHE[51] AND MEXICO CITY[52]
FINE[53] (11)	AGUASCALIENTES,[54] BAJA CALIFORNIA SUR, COAHUILA, COLIMA, GUANAJUATO, HIDALGO, MICHOACAN, MORELOS, NAYARIT, SAN LUIS POTOSI AND SONORA
MEDICAL OR PSYCHOLOGICAL TREATMENT (6)	CHIAPAS,[55] JALISCO,[56] MORELOS, TAMAULIPAS,[57] VERACRUZ[58] AND YUCATAN[59]

As illustrated in the above chart, abortion is considered a crime in all states, but the sanction varies by state, ranging from prison to medical or psychological treatment or community service.

Tlaxcala has the lowest prison sentence (15 days to two months) and Sonora has the highest, with penalties ranging between one and six years. Aguascalientes is a special case, because, in addition to fining the woman and sentencing her to prison, it imposes a punishment that involves reparation of damages. This is absurd considering that the only person for whom damages can be registered is the woman herself. As pointed out by the Inter-American Court of Human Rights, the embryo cannot be considered a person and as a result, there can be no reparation of damages:

"The Court concludes that the Constitutional Chamber based its decision on Article 4 of the American Convention, Article 3 of the Universal Declaration, Article 6 of the International Covenant on Civil and Political Rights, the Convention on the Rights of the Child and the 1959 Declaration on the Rights of the Child. However, it is not possible to use any of these articles or treaties to substantiate that the embryo can be considered a person in the terms of Article 4 of the Convention. Similarly, it is not possible to reach this conclusion from the preparatory work or from the systematic interpretation of the rights recognized in the American Convention or in the American Declaration."[60]

In various Mexican states, a prison sentence can be substituted by community service or "medical or psychological treatment".

Some people who promote medical or psychological treatment see it as a less severe punishment for women, and some even consider it to be a type of decriminalization of abortion. Nevertheless, this sanction is imposed for the same reason as a prison sentence and continues to be a means of criminalizing women for terminating a pregnancy. Furthermore, it treats them as if they have some type of disorder. Another problem with these types of sanctions is that they do not define the type of treatment, nor who carries it out or how long it lasts.

In the case of Jalisco, Tamaulipas and Yucatan, where the explicit objective of the treatment is to "reaffirm the value of motherhood and strengthen family", the conservative and discriminatory rationale behind the measures is made evident.

Regardless of whether the penalty for the crime of abortion is prison or another type of punishment such as psychological treatment, it is important not to lose sight of the criminalization of abortion and the negative effects of the same on the lives of women and the exercise of their human rights. In addition to the legal consequences of being subjected to criminal proceedings and put in prison, criminalization generates stigma and discrimination that can have serious impacts on women's social and family environments.

State legislation on abortion is discriminatory and violates human rights because it denies women access to gender-specific reproductive health services. This lack of access to health services places their lives, health and liberty at risk. The legislation is doubly discriminatory due to the lack of uniformity that results in differential access to abortion depending on where a woman lives. According to Article I of the Mexican Constitution, this lack of uniformity violates women's rights.

In this sense, it is worth mentioning that in July 2012, the CEDAW Committee analyzed Mexico's 7th and 8th periodic reports regarding compliance with the Convention and expressed its concern for the lack of uniformity in abortion legislation in its Final Comments:

"The Committee notes that abortion is decriminalized in Mexico City and that in the rest of the country, abortion is legal in cases of rape. It also notes inconsistencies with respect to other legal grounds for abortion in the legal frameworks of the 32 states. It is concerned that women's enjoyment of their sexual and reproductive health and rights, including access to legal abortion, have been jeopardized as a result of the amendments in local constitutions that protect life from the moment of conception, even though those amendments have not modified the already established legal grounds for abortion. It is further concerned about cases of women who have been denied access to legal abortion, even when they fulfill the restrictive legal criteria, and who have been reported to the judicial authorities by medical care providers and social workers and consequently, sentenced to long prison terms on grounds of infanticide or murder."[61]

Based on this concern, the CEDAW Committee recommended that the Mexican State:

"a) Harmonize the federal and state legislations related to abortion to eliminate the obstacles faced by women seeking legal abortion and also to extend access to legal abortion, in light of the Constitutional Human Rights Reform and the Committee's General Recommendation No. 24 (1999);
b) Inform medical care providers and social workers that the local constitutional amendments have not repealed the grounds for legal abortion and also inform them of their responsibilities; and
c) Ensure that in all states, women whose case fall under any of the legal grounds for abortion have access to safe health care services, and ensure the proper implementation of the Mexican Official Standard NOM-046-SSA2-2005, particularly access of women victims of rape to emergency contraception, abortion and treatment of sexually transmitted diseases and HIV/AIDS."[62]

These recommendations, relevant international standards and Article 4 of the Mexican Constitution, which guarantees women's reproductive autonomy, clearly establish the need and urgency for states to comply with their human rights obligations and decriminalize abortion. Otherwise, legal discrimination will persist against women who live outside of Mexico City.

Finally, it is essential to mention that, despite the existence of supposed legal indications for abortion, access to these indications in the majority of states is precarious or null, an issue that will be analyzed in the implementation section of this chapter.

1.3.3 REGULATION IN MEXICO CITY

On April 26, 2007, reforms to Mexico City's Penal Code and Health Law were published in the Official Gazette, decriminalizing abortion during the first twelve weeks of pregnancy and reducing punishments for women who terminate pregnancies after this time to three to six months in prison or 100 to 300 days of community service.

In addition to elective abortion during the first twelve weeks of pregnancy, legal indications for rape, severe congenital or genetic fetal anomalies and severe risk to the woman's health were decriminalized.[63]

The long road to this unprecedented reform began in 1931 –when the Federal Penal Code for Mexico City and Federal Territories was approved— and culminated in April 2007 when decriminalization was finally achieved. One of the most important precedents dates from the year 2000, when the Legislative Assembly approved a bill proposed by Mexico City Mayor Rosario Robles to expand legal indications for abortion and establish clear mechanisms for accessing abortion after rape or non-consensual artificial insemination.

The 2007 reforms legalized abortion in the first trimester of pregnancy, but they also established legal bases for health service provision, to ensure these services would be carried out safely and with respect for women's rights.

1.3.4 PROCEDURES AND GUIDELINES FOR TERMINATION OF PREGNANCY RESULTING FROM RAPE

Abortion when the pregnancy results from rape is legal across Mexico. In April 2006, the Official Mexican Norm 046-SSA2-2005 on Domestic and Sexual Violence and Violence against Women: Criteria for Prevention and Care (NOM 046)[64] was published, establishing rape survivors' rights to certain health services, including the right to a legal abortion. The NOM 046 obligates all national health institutions to provide this service.[65]

According to NOM 046, the termination of a pregnancy resulting from rape must be authorized by the competent authority as defined by each state's laws. In addition, some states[66] have procedures or guidelines that regulate women's access to abortion under this indication. The goal of these procedures is, in theory, to facilitate access and provide detailed instructions regarding the obligations of personnel in charge of administrating and imparting justice for rape survivors. These regulations are found in Penal Procedural Codes and/or in administrative policies.

In Mexico, it is generally the Public Prosecutor who has the authority to guarantee urgent medical care for victims of crime, take the necessary precautionary measures to restore and protect their rights, and attend to the consequences of the crime.[67] However, 2008 reforms to the criminal justice system gave more power to judges, and some states established "control judges" who can authorize these procedures.[68]

Eight states include procedures for the legal termination of pregnancy resulting from rape in their Penal Procedural Codes.[69]

Legislation in the majority of these eight states designates the Public Prosecutor as the competent authority to authorize pregnancy termination in a criminal case (rape or artificial insemination without the woman's consent). In the State of Mexico, Puebla and Zacatecas, which have adversarial criminal justice systems, the control judge is designated as the authority with this power.[70] In Quintana Roo, the Public Prosecutor can authorize a legal abortion, if criminal proceedings have not been initiated. If they have, the pre-trial judge can offer authorization.

The competent authorities have the following obligations related to protecting women's right to decide whether or not to continue a pregnancy resulting from rape:

AUTHORITIES' OBLIGATIONS IN THE CASE OF RAPE

PROVIDE ACCURATE, IMPARTIAL, OBJECTIVE AND SUFFICIENT INFORMATION REGARDING THE VICTIM'S RIGHT TO ACCESS EMERGENCY CONTRACEPTION, PREGNANCY TERMINATION UNDER SAFE AND QUALITY CONDITIONS, AND PREVENTATIVE TREATMENT FOR SEXUALLY TRANSMITTED INFECTIONS.

IF THE WOMAN NEEDS ANY OF THESE SERVICES, HER IMMEDIATE ACCESS MUST BE GUARANTEED.

Mexico City[71] establishes a maximum period of 24 hours in which the Public Prosecutor must authorize the pregnancy termination, following the woman's request, under the following conditions:

1. The woman must have formally reported the rape or non-consensual artificial insemination.
2. The woman must have formally declared the pregnancy.
3. The pregnancy must have been confirmed in a public or private health institution.
4. There must be evidence suggesting that the pregnancy is a result of rape or non-consensual artificial insemination.
5. The woman must have requested the service.

Mexico City does not impose major burdens on women, as do other states such as the State of Mexico, which requires women to confirm having received specialized information, or Hidalgo, which requires women to cover the costs of the process if they are not in a precarious economic situation.

Although Penal Codes do not explicitly require reporting a rape in order to access a legal abortion, 11 states establish this obligation within procedures and guidelines.[72] This obligation is based on the interpretation that the Public Prosecutor or judge responsible for authorizing the procedure must have some type of evidence suggesting that the crime (rape or non-consensual artificial insemination) was committed. However, given the low proportion of rapes reported, this requirement, far from contributing to legal certainty for women and public officials and guaranteeing access to this service, can instead become a barrier to access. In addition, it is worth questioning whether or not the existence of protocols and guidelines have contributed to improving women's access to termination of pregnancy resulting from rape. This issue will be analyzed in the following section on implementation of law and policy.

It is important to remember that, regardless of the existence of protocols and guidelines, all Mexican states are obligated to guarantee women access to safe abortion services, based on state Penal Codes and the NOM 046.

1.4 / IMPLEMENTATION OF THE LEGAL FRAMEWORK

The existence of legal indications for abortion does not guarantee women true access. Therefore, it is not enough to analyze abortion-related law and policy in an abstract manner, but the implementation of the same and the obstacles faced by women who decide to terminate their pregnancies must also be analyzed.

To determine the degree of implementation of these policies, GIRE analyzed public information obtained through federal and state-level remote, Infomex and alternate systems. Requests for federal information were sent to the Federal Ministry of Health (SSA), the Mexican Social Security Institute (IMSS), the Institute for Security and Social Services for State Workers (ISSSTE) and the Mexican Attorney General's Office (PGR). State-level requests were sent to state Ministries of Health, state Public Prosecutor's Offices, Ministries of Public Security, and judicial institutions. Information from cases documented by GIRE was also included.

As mentioned in the report's *Introduction*, when presenting requests and analyzing and organizing the obtained information, GIRE found serious deficiencies in access to public information related to abortion. These deficiencies directly impact women's exercise of their reproductive rights and their reproductive decisions and the development, implementation and evaluation of public policy.

1.4.1 FEDERAL LEVEL

At the federal level, information requests were sent to the SSA, IMSS and ISSSTE regarding legal abortions carried out in affiliated health institutions. In addition, GIRE sent requests to the PGR regarding the number of rapes and abortions reported under the Federal Penal Code and the number of legal abortions after rape authorized.

GIRE asked about the Federal Penal Code because of the lack of clarity among federal authorities regarding their obligation or not to apply the state laws regarding legal abortion where their facilities are located, and to find out whether they at least carry out authorizations for legal indications as defined in federal law. It is worth mentioning that, according to the Constitution and the General Health Law,[73] the provision of health services is a concurrent jurisdiction, leading us to ask the question on whether federal health institutions located in the states should provide abortions based on legal indications listed in federal or state Penal Codes.

One of the first issues we would like to point out about the information provided by the Federal Ministry of Health is that the abortions reported were not classified by legal indication.[74] The institutions report that they only record the number of abortions provided and the numbers of

abortion-related hospital admissions and discharges, making it difficult to analyze women's access to legal abortion services. It is important to remember that the crime of abortion falls under state jurisdiction, so federal public hospitals, although located in Mexican states, should provide abortion services based on each state's law and policy.

In response to the question on how many legal abortions were carried out in federal health institutions, the Ministry of Health responded that its health institutions do not have jurisdiction over the provision of legal abortion because this is the responsibility of Mexico City government hospitals.[75]

We received two responses from the ISSSTE. Its Financial Department responded that it does not have any information on the number of legal abortions due to rape, because abortion due to rape is not included in the International Statistical Classification of Diseases and Related Health Problems (ICD-10). However, it did respond that between 2007 and 2010, 261 women were discharged after abortions.[76] At the same time, ISSSTE's Medical Department reported that it did not carry out any legal abortions because it is a decentralized government agency, and that Mexico City's Ministry of Health is responsible for performing legal abortions due to rape due to reforms to Mexico City's Health Law. It is concerning to receive two very different responses from the same institution, and particularly alarming that the Medical Department considers Mexico City's Ministry of Health to be the only health institution which is obligated to provide legal abortion services, when the federal and every Mexican state's penal code includes at least the legal indication for abortion of pregnancy resulting from rape.

The IMSS responded that its information systems do not include records of external causes related to abortions registered for their patients, making it impossible to know the number of abortions carried out due to rape, or the number of rape survivors who legally terminate their pregnancies.

It appears that women do not have access to legal abortion in hospitals belonging to the Federal Ministry of Health for indications included in the Federal Penal Code nor for legal indications established at the state level. In other words, these laws are not applied, resulting in barriers for women in exercising their reproductive rights.

Regarding the information we requested from the PGR on abortion-related criminal charges and pre-trial investigations, only one 2007 case was reported in which charges were filed against a man,[77] but it appears that no women were processed for abortion under federal law.

Regarding the number of legal abortions authorized in cases of rape, the Special Prosecutor for Violent Crimes against Women and Human Trafficking responded that, after "carrying out an exhaustive search of its internal records, [it] found no precedents related to the information requested".[78] The fact that 88 pre-trial investigations were initiated between 2007 and 2012 for the crime of rape[79] begs the question as to whether none of the rape survivors became pregnant or requested a legal abortion.

1.4.2 STATE LEVEL

A. MEXICO CITY

After the decriminalization of abortion during the first trimester, Mexico City's government initiated a program to provide health services for women who wish to terminate their pregnancies. The following chart provides data from government health institutions regarding Mexico City's legal abortion program.

DATA ON LEGAL ABORTION IN MEXICO CITY APRIL 2007 TO DECEMBER 31, 2012

TOTAL: 92,363

RESIDENCE	AGE	MARITAL STATUS
MEXICO CITY: 73.2% STATE OF MEXICO: 23.5% OTHER STATES AND FOREIGNERS: 3.3%	11 TO 14 YEARS: 0.7% 15 TO 17 YEARS: 4.7% 18 TO 24 YEARS: 47.9% 25 TO 29 YEARS: 22.2% 30 TO 34 YEARS: 13.2% 35 TO 39 YEARS: 7.9% 40 TO 44 YEARS: 2.8% 45 TO 54 YEARS: 0.1% NO AGE REGISTERED: 0.5%	SINGLE: 45.5% MARRIED: 26.3% DIVORCED: 4.1% CIVIL UNION: 23.5% WIDOWED: 0.3% MISSING DATA: 0.3%
NUMBER OF CHILDREN	**EDUCATION**	**OCCUPATION**
NONE: 33.8% 1 CHILD: 26.1% 2 CHILDREN: 22.7% 3 CHILDREN 10.9% MORE THAN 3 CHILDREN: 6.5%	PRIMARY SCHOOL: 8.7% MIDDLE SCHOOL: 32.4% HIGH SCHOOL: 38.9% HIGHER EDUCATION: 17.5% TECHNICAL: 0.6% NONE: 1.8%	HOMEMAKER: 33.7% STUDENT: 30.6% EMPLOYEE: 27.3% SHOPKEEPER/MERCHANT: 5.3% DOMESTIC EMPLOYEE: 2.0% FACTORY WORKER: 0.2% PROFESSIONAL: 0.1% OTHER: 0.8%
TYPE OF ABORTION PROCEDURE	**GESTATION**	**INSURANCE**
MISOPROSTOL: 67.4 % MVA*: 29.4% D&C**: 3.2% *MVA: MANUAL VACUUM ASPIRATION **D&C: DILATION AND CURETTAGE	0 WEEKS: 0.1% 1 WEEK: 0.2 % 2 WEEKS: 0.2 % 3 WEEKS: 0.1 % 4 WEEKS: 3.5 % 5 WEEKS: 8.9 % 6 WEEKS: 15.8 % 7 WEEKS: 19.8 % 8 WEEKS: 16 % 9 WEEKS: 13.2% 10 WEEKS: 10.2 % 11 WEEKS: 10.2% 12 WEEKS: 1.8 %	NO INSURANCE (FREE SERVICES): 80.9% IMSS: 10.4% ISSSTE: 1.6% PEMEX: 0.1% OTHER: 6.9 %
RECIDIVISM	**RELIGION**	**POST-ABORTION CONTRACEPTION**
PERCENTAGE OF WOMEN WHO HAVE HAD MORE THAN ONE LEGAL ABORTION: 2.09 %	CATHOLIC: 82.9% CHRISTIAN: 2.9% OTHER: 1.7% NONE: 12.5%	CONDOM: 7.7% PILL: 14.9% IUD: 39.1% TUBAL LIGATION: 4.6% INJECTION: 4.8% OTHER: 12.1% DECLINED: 16.8%

Source: GIRE, based on data obtained through information requests.

The chart shows that between April 2007 and December 2012, 92,363 legal abortions were carried out in government health institutions free-of-charge.[80] If we add the number safe abortions carried out in private institutions, estimated to be 21,600 annually based on a recent study,[81] in the past five years, more than 200,000 women have accessed legal abortion services in Mexico City.

Based on the profile of women who had legal abortions in government health institutions, not only residents of Mexico City request this service, but also women from other states and countries where abortion is illegal or inaccessible. The majority of women who come from outside of Mexico City are from the neighboring State of Mexico, most likely due to its proximity. For most women living in other states, travelling to Mexico City for an abortion is difficult or impossible.

The Mexico City reform prioritizes sexual and reproductive health care, stating that "these services are a means for every individual to exercise their right to decide freely, responsibly, and in an informed manner regarding the number and spacing of their children".[82]

It is also worth mentioning that, as a result of the decriminalization of abortion in the first trimester and the existence of a sensible and comprehensive legal abortion program, 83.2% of the women who have accessed these services have accepted a post-abortion contraceptive method, and only 2.09% of women have undergone more than one abortion, numbers that indicate the reduction of unwanted pregnancies.

B. ACCESS TO ABORTION AFTER RAPE

Abortion is legal after rape in all states, which means that authorities are obligated to provide pregnancy termination services. For this reason, we requested information from the state Public Prosecutor's Offices and Ministries of Health on the number of authorizations of abortion after rape.

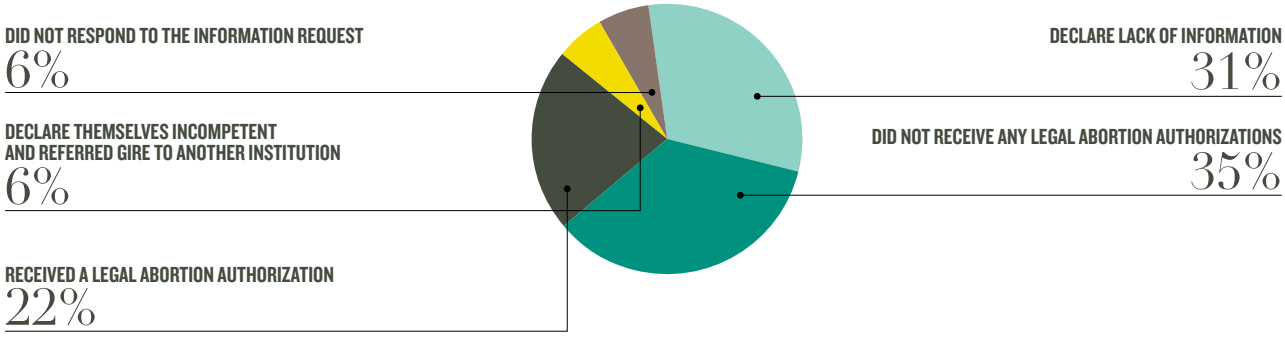
LEGAL ABORTIONS AUTHORIZED PER STATE 2007-2012

STATE	EMITTED BY STATE PUBLIC PROSECUTOR'S OFFICES	REPORTED BY STATE MINISTRIES OF HEALTH
AGUASCALIENTES	0	DECLARES LACK OF INFORMATION.
BAJA CALIFORNIA	3	2
BAJA CALIFORNIA SUR	0	1
CAMPECHE	DECLARES LACK OF INFORMATION.	0
CHIAPAS	DECLARES INCOMPETENCE IN RESOLVING THE INFORMATION REQUEST AND SUGGESTED REQUESTING INFORMATION FROM THE MINISTRY OF HEALTH.	DECLARES LACK OF INFORMATION.
CHIHUAHUA	DECLARES LACK OF INFORMATION.	0
COAHUILA	DOES NOT AUTHORIZE LEGAL ABORTIONS.	0
COLIMA	0	0
DURANGO	1	1
GUANAJUATO	0	0
GUERRERO	3	DID NOT RESPOND TO THE INFORMATION REQUEST.
HIDALGO	DID NOT RESPOND TO THE INFORMATION REQUEST.	0
JALISCO	DECLARES LACK OF INFORMATION.	DECLARES LACK OF INFORMATION.
MEXICO CITY	30	18
MICHOACAN	DECLARES LACK OF INFORMATION.	DECLARES LACK OF INFORMATION.
MORELOS	DECLARES LACK OF INFORMATION. STATES THAT LEGAL ABORTION IS NOT REGULATED IN THE STATE.	DECLARES LACK OF INFORMATION.
NAYARIT	DID NOT RESPOND TO THE INFORMATION REQUEST.	0
NUEVO LEON	DECLARES LACK OF INFORMATION.	0
OAXACA	2	DECLARES LACK OF INFORMATION.
PUEBLA	DECLARES LACK OF INFORMATION.	0
QUERETARO	0	1
QUINTANA ROO	0	DECLARES LACK OF INFORMATION.
SAN LUIS POTOSI	DECLARES LACK OF INFORMATION. CLAIMS THAT THE STATE'S PENAL CODE DOES NOT INCLUDE LEGAL ABORTION AFTER RAPE.	0
SINALOA	DECLARES LACK OF INFORMATION.	DECLARES LACK OF INFORMATION.
SONORA	DOES NOT AUTHORIZE LEGAL ABORTIONS, SINCE ABORTION IS ILLEGAL IN ALL CIRCUMSTANCES.	DID NOT RESPOND TO THE INFORMATION REQUEST.
STATE OF MEXICO	THE PUBLIC PROSECUTOR'S OFFICE CANNOT PROVIDE THIS INFORMATION BECAUSE LEGAL ABORTIONS ARE AUTHORIZED BY THE CONTROL JUDGE. SUGGESTS REQUESTING THIS INFORMATION FROM THE JUDICIAL BRANCH.	33
TABASCO	0[83]	DECLARES INCOMPETENCE, POINTS OUT THAT LEGAL ABORTION AUTHORIZATIONS ARE UNDER THE JURISDICTION OF TABASCO'S PUBLIC PROSECUTOR.
TAMAULIPAS	DECLARES LACK OF INFORMATION. POINTS OUT THAT IT IS NOT RESPONSIBLE FOR AUTHORIZING LEGAL ABORTIONS.	0
TLAXCALA	DID NOT RESPOND TO THE INFORMATION REQUEST.	3
VERACRUZ	DOES NOT AUTHORIZE LEGAL ABORTIONS.	DECLARES LACK OF INFORMATION.
YUCATAN	0	DECLARES LACK OF INFORMATION.
ZACATECAS	0	DECLARES INCOMPETENCE, THE INFORMATION REQUESTED IS AVAILABLE AT THE PUBLIC PROSECUTORS'S OFFICE; THIS ENTITY HAS NOT CARRIED OUT ANY LEGAL ABORTIONS.

Source: GIRE, based on data obtained through information requests.

The seven state Ministries of Health that received legal abortion authorizations for rape survivors were: Baja California, Baja California Sur, Mexico City, Durango, State of Mexico, Queretaro and Tlaxcala. The State of Mexico reported 33, the highest number of legal abortion authorizations received.

AUTHORIZATIONS OF LEGAL ABORTIONS RECEIVED MINISTRIES OF HEALTH 2007-2012



It is concerning that the majority of Ministries of Health that responded to GIRE's information request stated that they did not receive any requests to carry out abortions for rape survivors, in light of the high rates of rape in Mexico, as well as the difficulties in accessing emergency contraception (described in detail in the *Contraception* chapter). This leads us to believe that either legal abortions were not authorized or the Ministries of Health did not receive those women whose legal abortions were authorized.

GIRE also requested information from Public Prosecutor's Offices regarding the number of legal abortions authorized for rape survivors. We received the following: three did not respond,[84] ten declared lack of information,[85] 12 did not emit any authorizations for legal abortion,[86] two declared incompetence,[87] and only five states reported having emitted authorizations for legal abortions.[88]

It is particularly concerning that Public Prosecutor's Offices in four states (Coahuila, Sonora, Tamaulipas and Veracruz) stated that they do not have the power to authorize legal abortions after rape.

Sonora's Public Prosecutor's Office stated that it does not authorize abortion because it is illegal,[89] illustrating an obvious lack of knowledge regarding law and policy related to legal abortion of pregnancies resulting from rape, or perhaps a lack of political will to emit these authorizations despite the law.

It is important to point out that 39 legal abortions were authorized between 2007 and 2012. Mexico City had the highest number of authorizations (30), followed by Baja California (3), Guerrero (3), Oaxaca (2) and Durango (1).

Based on this information we can see that the majority of Public Prosecutor's Offices are not authorizing legal abortions after rape, whether it is because they declare themselves "incompetent" despite the fact that the law states that they are responsible, or because they do not have information, in which case we can conclude that they do not emit authorizations.

Among states that did respond, the number of legal abortion authorizations is very low, especially when compared to data regarding the number of pre-trial investigations related to rape during the same period.

Baja California, Guerrero and Tlaxcala reported only three authorizations each between 2007 and 2012.[90] In the case of Baja California, a total of 1,826 rapes were recorded but only three authorizations were reported for legal abortion after rape. This is worrisome, and does not even take into account the sub-registry of rape.

Public Prosecutor's Offices that responded to the information requests provided questionable data. For example, in Guerrero, the Public Prosecutor stated that it did not find any data related to rapes reported or pre-trial investigations initiated for cases of rape.[91] This is hard to believe, and contradicts information provided by the same institution regarding three authorizations for legal abortions after rape.

Mexico City's Public Prosecutor's Office recorded 30 authorizations between 2007 and 2012.[92] Given the legality of abortion upon request during the first trimester, we can assume that some of the legal abortions carried out during this gestational period were for women who decided to abort a pregnancy resulting from rape.

Mexico City's Ministry of Health reported having registered only 18 authorizations, which does not coincide with the 30 legal abortion authorizations reported by the Public Prosecutor. It is unclear why this data does not concur.

Despite the fact that nine states[93] have procedures and guidelines defining how to authorize abortions after rape, based on the information provided by the six states that designate the Public Prosecutor as the competent authority,[94] authorizations were only emitted in Baja California, Mexico City and Oaxaca. This calls into question as to whether or not the existence of procedures and guidelines alone can facilitate access to abortion after rape.

The obtained data reflect the fact that women have little or no access to terminate pregnancies resulting from rape. This is despite that the legal indication for abortion after rape is the only indication available in all states and should be part of comprehensive care provided to rape survivors.

It is possible that not all women who become pregnant as a result of rape decide to terminate their pregnancies, but it is difficult to believe that none of them do. In conclusion: on one hand, women are not aware that they have the right to terminate a pregnancy resulting from rape, and on the other hand, the authorities are either not aware of this legal indication or refuse to authorize these legal pregnancy terminations.

B.1 EMBLEMATIC CASES

Obstacles faced by rape survivors in accessing legal abortion are illustrated in the following cases documented by GIRE.[95] The women's names have been changed to protect their identities.

ADRIANA

Adriana,[96] a 28-year-old resident of Durango, became pregnant after being kidnapped and raped by her ex-partner *Rodrigo*. Adriana had already experienced domestic violence at the hands of *Rodrigo* before the kidnapping. After the Public Prosecutor rescued her and arrested her aggressor, *Adriana* accused *Rodrigo* of rape. Despite the obligation to do so, the Public Prosecutor's Office did not provide her with any information on emergency contraception, prophylaxis to prevent or treat sexually transmitted infections, nor did it inform her of her right to legally terminate her pregnancy.

Adriana decided to terminate the pregnancy and requested a legal abortion from the Public Prosecutor's Office. She faced various barriers to access, including a lack of objective and updated information from the medical examiner; she was asked to go through various medical tests to prove that she was pregnant; and there were many unjustified delays in the proceedings to authorize the abortion. When the Public Prosecutor finally emitted the authorization, ten days passed before the procedure could be carried out in a government health institution due to a lack of adequately trained personnel. During this time, *Adriana* received constant death threats from *Rodrigo* and the Public Prosecutor provided no protection.

Months later, after both she and her family had received various death threats, and after being pressured by *Rodrigo's* lawyer, *Adriana* retracted her accusation so that he would be set free. Instead of investigating the threats and providing *Adriana* and her family protection, the Durango Public Prosecutor's Office accused *Adriana* of false accusations and illegal abortion, demanding reparation of financial damages. In February 2013, when the Spanish version of this report was completed, *Adriana* was still in prison, suffering from serious psychological sequelae, and facing criminal proceedings, with no protection against the violence she was facing. Despite GIRE and a local organization's intervention to confront the Public Prosecutor regarding the lack of due diligence to mitigate the violence, no specialized or adequate attention was provided to the case, resulting in institutional violence and re-victimizing *Adriana*.

MÓNICA

*Mónic*a,[97] a 12-year-old indigenous girl of Mazatec origin, lives in Oaxaca. She does not speak Spanish and lives in a community far from the capital city. She became pregnant after being raped by someone she knew. When she reported the rape to the Public Prosecutor, she requested a legal abortion in accordance with state law. Despite the fact that the Public Prosecutor authorized a legal abortion, *Mónic*a faced many barriers to receiving the procedure including: lack of resources to pay for travel to the government hospital in the capital city of Oaxaca, lack of resources to cover hotel costs for her and her mother, and lack of expert interpreters available for the criminal proceedings and the medical procedure. The pregnancy termination was finally carried out when she was 12 weeks pregnant. GIRE participated in the case, providing legal assistance to the Public Prosecutor's Office regarding its obligation to guarantee *Mónic*a her reproductive rights, making sure she had support during the medical procedure and that it would be carried out by qualified personnel.

LOURDES

Lourdes,[98] 13 years old, lives in Morelos and became pregnant after being raped by a family member. *Lourdes* reported the rape to the Public Prosecutor's Office and requested a pregnancy termination despite the fact that she was never informed of this right. The Public Prosecutor did not respond to her request and, since she was still in the first trimester of pregnancy, she used private funds to travel to Mexico City to terminate her pregnancy. GIRE participated in the case by preparing and presenting a brief to Morelos' Public Prosecutor's Office requesting information regarding the lack of response to her request for a legal abortion. In response to the brief, Morelos' Public Prosecutor's Office informed GIRE that the state's criminal law does not explicitly designate the Public Prosecutor as the competent authority to authorize legal abortion after rape, adding that the victim did not request the service. It also stated that there is no state protocol describing the process that must be followed in order to terminate a pregnancy resulting from rape.

ESMERALDA

Twelve-year-old *Esmeralda*,[99] resident of Sonora, became pregnant after being raped by her stepfather. When reporting the rape to the Public Prosecutor, she also requested authorization to terminate her pregnancy and was denied this right. While her family members were looking for someone to provide them legal assistance to obtain authorization from the Public Prosecutor, *Esmeralda* had a miscarriage. After the fact, Sonora's Public Prosecutor's Office informed GIRE that because the state's criminal law does not explicitly designate the Public Prosecutor jurisdiction in authorizing legal abortion after rape, the request was referred to the control judge who never responded.

CLAUDIA

Claudia,[100] a 17-year-old adolescent from Veracruz, was raped by her stepfather. Although she was able to legally terminate the resulting pregnancy in a public hospital in Veracruz, *Claudia* faced many obstacles from judicial and legal authorities in accessing this right. In addition to the fact that she faced lack of credibility and abuse at the Public Prosecutor's Office, she was not provided information regarding her right to terminate her pregnancy nor on the prevention of sexually transmitted infections. After her stepfather was arrested, the case was passed to a judge. *Claudia* and her mother sought help from the state Women's Institute that informed them of her right to legal abortion. Claudia decided to request a legal abortion from the judge. Even though her request was presented in writing, two weeks passed and they received no response. GIRE intervened to support *Claudia* and her mother, putting pressure on the judge to respond. Acknowledging *Claudia*'s right to reproductive freedom as specified in the Mexican Constitution and international human rights law, the judge emitted the legal authorization and the pregnancy termination was carried out in a public hospital.

JIMENA

Jimena[101], 13 years old, resident of Hidalgo, became pregnant after being raped. Despite her report of the rape to the Public Prosecutor, she was not authorized the abortion because she was more than 90 days pregnant (gestational limit for legal abortion of pregnancy resulting from rape in Hidalgo). As a result, *Jimena* had to carry the pregnancy to term and gave birth to the baby. GIRE registered the case.

These cases illustrate just some of the institutional obstacles faced by women in exercising their right to terminate a pregnancy resulting from rape, particularly barriers faced when dealing with the Public Prosecutor and health institutions. The majority of them (five) are minors, victims of rape, adding to the list of paradigmatic cases such as that of Paulina.[102]

C. ACCESS TO ABORTION FOR OTHER LEGAL INDICATIONS

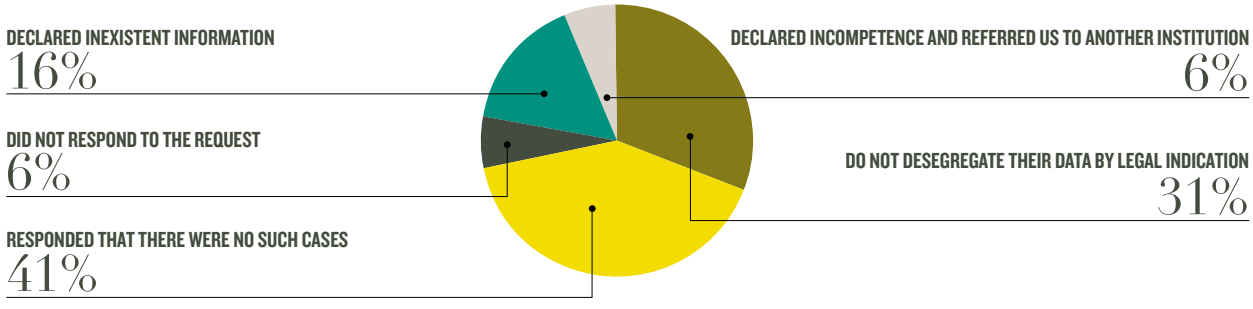
NUMBER OF LEGAL ABORTIONS FOR OTHER LEGAL INDICATIONS STATE MINISTRIES OF HEALTH 2007-2012

AGUASCALIENTES	INEXISTENT INFORMATION, BECAUSE THIS VARIABLE IS NOT INCLUDED IN THEIR STATISTICS.
BAJA CALIFORNIA	REPORTED TOTAL NUMBER OF ABORTIONS, BUT DID NOT DESEGREGATE THE INFORMATION BY LEGAL INDICATION.
BAJA CALIFORNIA SUR	DID NOT RESPOND TO THE INFORMATION REQUEST.
CAMPECHE	NO CASES REPORTED.
CHIAPAS	INEXISTENT INFORMATION.
CHIHUAHUA	REPORTED TOTAL NUMBER OF ABORTIONS, BUT DID NOT DESEGREGATE THE INFORMATION BY LEGAL INDICATION.
COAHUILA	NO CASES REPORTED.
COLIMA	NO CASES REPORTED.
DURANGO	REPORTED TOTAL NUMBER OF ABORTIONS, BUT DID NOT DESEGREGATE THE INFORMATION BY LEGAL INDICATION.
GUANAJUATO	INEXISTENT INFORMATION, BECAUSE THIS VARIABLE IS NOT INCLUDED IN THEIR STATISTICS.
GUERRERO	NO CASES REPORTED.
HIDALGO	NO CASES REPORTED.
JALISCO	INEXISTENT INFORMATION.
MEXICO CITY	NO CASES REPORTED, DESPITE THE FACT THAT THERE HAVE BEEN CASES OF LEGAL ABORTIONS CARRIED OUT DUE TO CONGENITAL FETAL ANOMALIES.
MICHOACAN	INEXISTENT INFORMATION.
MORELOS	REPORTED TOTAL NUMBER OF ABORTIONS, BUT DID NOT DESEGREGATE THE INFORMATION BY LEGAL INDICATION.
NAYARIT	NO CASES REPORTED.
NUEVO LEON	NO CASES REPORTED.
OAXACA	REPORTED TOTAL NUMBER OF ABORTIONS, BUT DID NOT DESEGREGATE THE INFORMATION BY LEGAL INDICATION.
PUEBLA	NO CASES REPORTED.
QUERETARO	NO CASES REPORTED.
QUINTANA ROO	INEXISTENT INFORMATION.
SAN LUIS POTOSI	NO CASES REPORTED.
SINALOA	NO CASES REPORTED.
SONORA	DID NOT RESPOND TO THE INFORMATION REQUEST.
STATE OF MEXICO	REPORTED TOTAL NUMBER OF ABORTIONS, BUT DID NOT DESEGREGATE THE INFORMATION BY LEGAL INDICATION.
TABASCO	REFERRED US TO TABASCO'S PUBLIC PROSECUTOR'S OFFICE FOR THIS INFORMATION.
TAMAULIPAS	NO CASES REPORTED.
TLAXCALA	REPORTED THE NUMBER OF LEGAL ABORTIONS CARRIED OUT AFTER RAPE.
VERACRUZ	INEXISTENT INFORMATION, BECAUSE THIS VARIABLE IS NOT INCLUDED IN THEIR STATISTICS.
YUCATAN	INEXISTENT INFORMATION.
ZACATECAS	REFERRED US TO ZACATECAS'S PUBLIC PROSECUTOR'S OFFICE FOR THIS INFORMATION.

Source: GIRE, based on data obtained through information requests.

Of the 32 states that received our requests for information, ten responded that they did not have the information because the variable is not included in their statistics,[103] 13 stated that there were no such cases in their states,[104] two did not respond,[105] five states declared inexistent information[106] and two referred us to their state's Public Prosecutor's Office.[107]

NUMBER OF LEGAL ABORTIONS FOR OTHER INDICATIONS MINISTRIES OF HEALTH 2007-2012



The above illustrates the statistical shortcomings in the data recorded by Ministries of Health and the deficient or complete lack of desegregation of the information, making it difficult or impossible to use that data to identify problems related to access.

The Ministries of Health do not record abortions by legal indication or by type of abortion. This makes it impossible to know, for example, how many abortions are carried out due to genetic fetal anomalies incompatible with life or how many are carried out because of risk to the woman's life or health.

D. CRIMINALIZATION OF WOMEN FOR ILLEGAL ABORTION

In addition to the risks that clandestine and unsafe abortions pose to women's lives and health, these also put women at risk of being criminally processed, even in the case of a miscarriage.

GIRE sent information requests to state judicial branches in all 32 states to learn the number of women processed and sentenced for illegal abortion.

Despite the many different systems available for requesting information, we received responses from all 32 states. We had to appeal for revisions after receiving inadequate or no information from six states. At least five of those states responded to the request claiming inexistence of classification of data related to illegal abortion. However, the majority of states do not generate statistics regarding the type of sentence, ages of

CRIMINAL PROCEEDINGS FOR ILLEGAL ABORTION LOCAL JUDICIAL BRANCHES 2007-2012

STATE	INDICTMENTS[108]	CRIMINAL PROCEEDINGS	SENTENCES[109]
AGUASCALIENTES	6	NO DATA AVAILABLE	2
BAJA CALIFORNIA	APPEALED		
BAJA CALIFORNIA SUR	NO DATA AVAILABLE	2	1
CAMPECHE	18	INEXISTENT INFORMATION	INEXISTENT INFORMATION
CHIAPAS	21	18	12
CHIHUAHUA	11	NO DATA AVAILABLE	2
COAHUILA	INEXISTENT INFORMATION		
COLIMA	APPEALED		
DURANGO	APPEALED		
GUANAJUATO	21	NO DATA AVAILABLE	21
GUERRERO	NO DATA AVAILABLE	12	2
HIDALGO	NO DATA AVAILABLE	28	15
JALISCO	NO DATA AVAILABLE	32	25
MEXICO CITY	19	NO DATA AVAILABLE	3
MICHOACAN	NO DATA AVAILABLE	25	8
MORELOS	NO DATA AVAILABLE	1	1
NAYARIT	INEXISTENT INFORMATION		
NUEVO LEON	2	7	2
OAXACA	NO DATA AVAILABLE	1	1
PUEBLA	24	NO DATA AVAILABLE	13
QUERETARO	NO DATA AVAILABLE	NO DATA AVAILABLE	1
QUINTANA ROO	INEXISTENT INFORMATION		
SAN LUIS POTOSI	APPEALED		
SINALOA	NO DATA AVAILABLE	5	INEXISTENT INFORMATION
SONORA	6	6	5
STATE OF MEXICO	APPEALED		
TABASCO	APPEALED		
TAMAULIPAS	43	NO DATA AVAILABLE	10
TLAXCALA	INEXISTENT INFORMATION		
VERACRUZ	NO DATA AVAILABLE	9	2
YUCATAN	NO DATA AVAILABLE	4	0
ZACATECAS	NO DATA AVAILABLE	1	1
TOTAL	171	151	127

Source: GIRE, based on data obtained through information requests.

those accused or sentenced, or the amount of bail required, if applicable.
The information above shows that various individuals have indeed been charged with illegal abortion in many states. Of the 22 states that responded with somewhat accurate information,[110] we received data regarding 171 indictments for illegal abortion. Of these 171 cases, the number of sentences decreases to 127, indicating the possibility that some cases were dismissed while others are still active. Based on the information received, the majority of individuals processed were released on bail, some of them after completing prison sentences that ranged from four months to six years. For others, the prison term was conditionally suspended.[111]

It is worth pointing out that statistics desegregated by sex do not exist, so there is no way of knowing if the individuals processed were men or women. Based on the minimal data that we were able to obtain regarding the ages of those convicted, the average age when sentenced was 22. In general, detentions lasted less than a year—except in one case in which the person was in prison for six years—and one individual was sentenced to medical and psychological treatment.

We also requested information from State Ministries of Public Security to investigate the number of people who are currently in prison for illegal abortion. The data received are presented in the chart below.

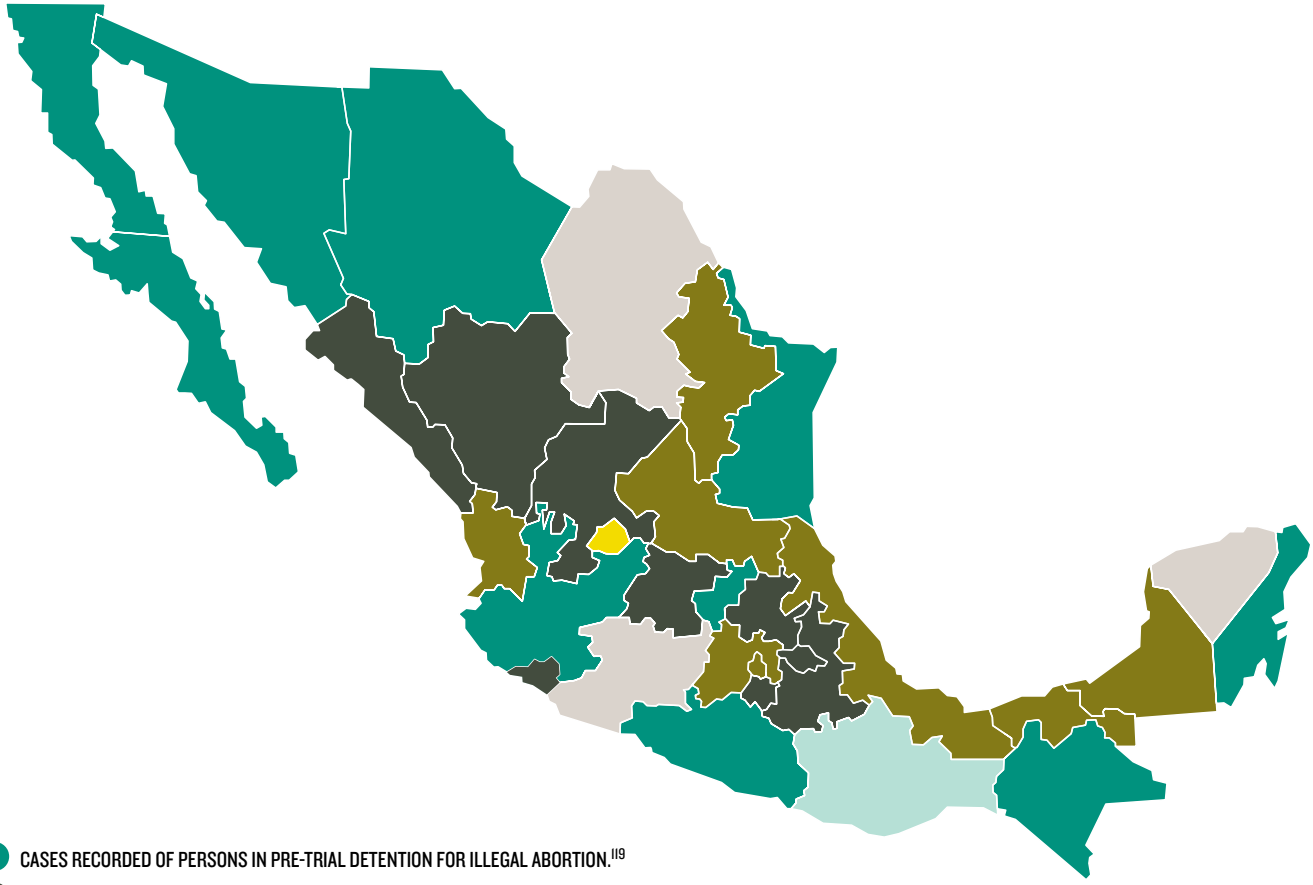
NUMBER OF INDIVIDUALS IN DETENTION
STATE MINISTRIES OF PUBLIC SECURITY 2007-2012

STATE	RESPONSE
AGUASCALIENTES	INFORMATION WITHHELD.
BAJA CALIFORNIA	1
BAJA CALIFORNIA SUR	2
CAMPECHE	REFERRED US TO THE STATE PUBLIC PROSECUTOR'S OFFICE FOR INFORMATION. THE PUBLIC PROSECUTOR'S OFFICE DID NOT RESPOND.
CHIAPAS	2[112]
CHIHUAHUA	5[113]
COAHUILA	DID NOT RESPOND TO THE INFORMATION REQUEST.
COLIMA	0
DURANGO	0
GUANAJUATO	0
GUERRERO	1[114]
HIDALGO	0
JALISCO	15
MEXICO CITY	REFERRED US TO THE SUPERIOR COURT FOR INFORMATION. THE SUPERIOR COURT RESPONDED WITH THE NUMBER OR SENTENCES IN 2010 (3) AND 2011 (2).
MICHOACAN	DID NOT RESPOND TO THE INFORMATION REQUEST.
MORELOS	0
NAYARIT	REFERRED US TO THE STATE PUBLIC PROSECUTOR'S OFFICE FOR INFORMATION. THE PUBLIC PROSECUTOR'S OFFICE REFERRED US TO THE LIAISON AND ACCESS DEPARTMENT OF THE STATE MINISTRY OF PUBLIC SECURITY.[115]
NUEVO LEON	1 AND REFERRED US TO THE STATE PUBLIC PROSECUTOR'S OFFICE FOR INFORMATION.
OAXACA	INEXISTENT INFORMATION.
PUEBLA	0
QUERETARO	2[116]
QUINTANA ROO	1[117]
SAN LUIS POTOSI	DECLARED INCOMPETENCE AND REFERRED US TO THE STATE PUBLIC PROSECUTOR'S OFFICE FOR INFORMATION.
SINALOA	0
SONORA	2[118]
STATE OF MEXICO	REFERRED US TO THE STATE PUBLIC PROSECUTOR'S OFFICE FOR INFORMATION. THE PUBLIC PROSECUTOR REFERRED US TO THE MINISTRY OF CITIZEN SECURITY.
TABASCO	DECLARED INCOMPETENCE AND REFERRED US TO THE STATE PUBLIC PROSECUTOR'S OFFICE FOR INFORMATION.
TAMAULIPAS	9
TLAXCALA	0
VERACRUZ	DECLARED INCOMPETENCE AND REFERRED US TO THE STATE'S JUDICIAL BRANCH.
YUCATAN	DECLARED INCOMPETENCE AND REFERRED US TO THE STATE'S JUDICIAL BRANCH.
ZACATECAS	0
TOTAL	41

Source: GIRE, based on data obtained through information requests

We also requested information from the Federal Ministry of Public Security, which referred us to the Federal Attorney General: as of December 14, 2012, we had received no response from the Attorney General.

NUMBER OF INDIVIDUALS IN PRE-TRIAL DETENTION FOR ILLEGAL ABORTION STATE MINISTRIES OF PUBLIC SECURITY 2007-2012



1. CASES RECORDED OF PERSONS IN PRE-TRIAL DETENTION FOR ILLEGAL ABORTION.[119]
2. NO CASES OF PRE-TRIAL DETENTION FOR ILLEGAL ABORTION.
3. REFERRED US TO STATE PUBLIC PROSECUTOR'S OFFICE OR STATE COURTS FOR INFORMATION.[120]
4. DID NOT RESPOND TO THE INFORMATION REQUEST.[121]
5. INFORMATION WITHHELD.
6. INEXISTENCE OF INFORMATION.

It is important to point out serious deficiencies in access to information provided by the state Ministries of Public Security regarding the number of persons in pre-trial detention and their crime. Despite the shortcomings of the provided information, we can observe that at least 41 people were in pre-trial detention for illegal abortion. It is unclear how many of these are women.

D.1 EMBLEMATIC CASES

Below are details regarding cases registered[122] (8) and documented[123] (18) by GIRE, who have been criminally processed for abortion between June 2011 and January 2013. The women's names have been changed to protect their identities.

The data obtained by documenting these cases shows that women are indeed criminalized for alleged illegal abortions. GIRE has identified the following patterns through the intense process of documentation, which includes interviewing the woman and reviewing legal documents related to her case:

- The majority of women have very few resources, including financial and informational resources.
- The majority of women were reported to the Public Prosecutor by hospital staff (federal and state-level nurses, physicians, and social workers), violating doctor-patient confidentiality.
- The women report having been pressured to make confessions by physicians and police, some as a condition to receive medical care, and others while still under the effects of anesthesia.
- The women were abused both physically and verbally by health personnel and Public Prosecutor staff, a form of cruel and inhuman treatment.
- There were violations of due process in the majority of cases: women were not informed of the charges against them, were not provided with legal counsel and were not told that they had the right to remain silent.

Documented Cases

Carla

In Baja California (a state that "protects life from conception") *Carla*,[124] 32 years old, was taken to a public hospital for care after hemorrhaging in the bathroom of the supermarket where she worked. Based on an anonymous report, the state Public Prosecutor initiated a pre-trial investigation against her for an illegal abortion, allegedly carried out with misoprostol pills. *Carla* was arrested and held in custody while she was in the hospital and had to pay bail in order to avoid being sent to prison. She never made any statements regarding having taken pills nor was there any evidence to that effect. A year later, after receiving support from GIRE, a judge set her free due to lack of evidence. However, the Public Prosecutor can still re-open the investigation to collect more evidence and re-initiate the criminal proceedings. GIRE paid *Carla*'s bail and participated in her legal defense to promote the definitive closure of the case, in collaboration with a criminal lawyer and a local women's rights activist.

Angela

Angela,[125] a 29-year-old indigenous woman of Otomi descent, lives in extreme poverty in the State of Mexico. She was raped various times by her ex-partner. One day, while carrying corn to the mill at work, she began to have severe abdominal pains. When she began to hemorrhage, she went to the hospital for help, where she was accused of allegedly inducing an illegal abortion. She was arrested and transferred to the Public Prosecutor's Office, where she was detained for 48 hours. A pre-trial investigation was initiated against her for an illegal abortion allegedly carried out via misoprostol pills. The Public Prosecutor set her free due to lack of evidence. However, the case is still open. GIRE actively participated in the case by providing legal assistance and is currently following up to promote its definitive closure.

REBECA

Rebeca,[126] 33 years old, was arrested during a prenatal check-up at her local IMSS clinic in Hidalgo. She was eight or nine weeks pregnant with a wanted pregnancy. Due to the fact that she had a high-risk pregnancy, she had been strictly following her prenatal protocol and even had a bracelet provided by the IMSS to guarantee her immediate access to emergency medical services if necessary. Despite all of this, she was accused of an attempted abortion. She was held in prison for 19 days in filthy conditions, which caused her health to deteriorate. When GIRE found out about her case, we paid her bail so that she would be released. Although *Rebeca* was represented by the public defense attorney assigned to her, GIRE assisted her by presenting an appeal against the formal order for her imprisonment, arguing violations of her human rights. GIRE won the appeal and is currently waiting for the judge to formally decree her freedom in compliance with the appeal.

MARÍA

María,[127] 18 years old, was accused of illegal abortion while receiving care in a state government hospital in San Luis Potosi (a state that "protects life from conception"). She was reported by a social worker. During the seven hours she spent in the hospital, *María* remained under police custody and was then transferred to a holding cell, where she was detained overnight and released the following day due to lack of evidence. The investigation remained open without her knowledge, and three years later a judge made a formal order for her arrest. She was arrested a second time and taken to the local penitentiary, where she was held for approximately 20 hours. She was subject to criminal proceedings after being accused of allegedly carrying out an abortion with misoprostol pills. *María* had to pay bail to be provisionally released from prison. GIRE took up the legal defense of her case and has been meeting with the judge every month. The criminal proceedings continue.

SOFÍA

Sofía,[128] 20 years old, was arrested by authorities after being reported by a social worker while receiving care at an IMSS hospital in Puebla (a state that "protects life from conception"). She was placed under police custody while in the hospital and later transferred to a holding cell, where she was held for more than twelve hours, accused of allegedly having provoked an illegal abortion using misoprostol pills. *Sofía* had to pay bail to be provisionally released. The local Public Prosecutor decided not to prosecute her due to lack of evidence and dismissed the case. GIRE provided legal assistance, paid for *Sofía's* legal defense (a private lawyer), and the costs of the medical and psychological tests that were required.

LAURA

In Puebla (state that "protects life from conception"), *Laura*,[129] 22 years old, was reported to the local authorities by a social worker after seeking care at the hospital for a medical emergency. She was accused of inducing an abortion with misoprostol pills. She remained under arrest and in police custody for five days while in the hospital. After being criminally processed, the judge finally released her due to lack of evidence. GIRE participated in the case, providing legal assistance and covering the costs of *Laura's* legal defense.

CLAUDIA

Claudia,[130] 16 years old, was arrested by authorities while at a state government hospital in the State of Mexico, after being reported by a physician. She was accused of allegedly inducing an abortion with misoprostol pills, put under police custody for five days while she was in the hospital, and denied communication with her family. *Claudia* was finally freed and returned to her mother's custody after GIRE presented a legal stay against the State for refusing her communication with family. We are currently waiting for confirmation of the closure of the pre-trial investigation.

Teresa

Teresa,[131] a 19-year-old resident of Mexico City, received first-aid from a group of paramedics after hemorrhaging in her home. They took her to an IMSS hospital, where she was put under police custody for nearly 48 hours after the Public Prosecutor began an investigation against her for illegal abortion. The investigation remains open despite the fact that *Teresa* was never accused before a judge. GIRE provided *Teresa* and her family legal assistance and followed up on the case with the Public Prosecutor.

GIRE registered the following cases based on a variety of sources including: newspaper articles, information provided by the authorities or local civil society organizations, and through direct contact with victims and their families. For these cases, we did not find sufficient information to carry out a complete documentation of the case.

REGISTERED CASES

NAME[132]	AGE	STATE	FACTS
Brenda	16	MORELOS	WAS REPORTED BY A PHYSICIAN WHILE RECEIVING CARE IN A STATE GOVERNMENT HOSPITAL, AND AS A RESULT, WAS ARRESTED BY AUTHORITIES. AFTER BEING ACCUSED OF AN ALLEGED ILLEGAL ABORTION INDUCED WITH MISOPROSTOL PILLS, A PRE-TRIAL INVESTIGATION WAS OPENED AGAINST HER. THE INVESTIGATION LED TO CRIMINAL PROCEEDINGS AND BRENDA WAS SENTENCED TO COMMUNITY SERVICE AND PSYCHOLOGICAL TREATMENT FOR SIX MONTHS.
Flor	27	MICHOACAN	TRAVELLED TO MEXICO CITY DURING HER FIFTH WEEK OF PREGNANCY TO GET A LEGAL ABORTION. HER BOYFRIEND REPORTED HER TO THE PUBLIC PROSECUTOR IN MICHOACAN, WHO OPENED A PRE-TRIAL INVESTIGATION AGAINST HER FOR ILLEGAL ABORTION. AFTER FLOR PROVED THAT THE ABORTION HAD BEEN CARRIED OUT LEGALLY IN MEXICO CITY, THE PUBLIC PROSECUTOR DID NOT INITIATE ANY CRIMINAL PROCEEDINGS AGAINST HER.
Roberta	21	CHIHUAHUA	WAS ARRESTED BY POLICE AFTER BEING REPORTED BY HEALTH PERSONNEL AT A FEDERAL GOVERNMENT HOSPITAL WHERE SHE SOUGHT HELP FOR A HEMORRHAGE DURING HER SEVENTH WEEK OF PREGNANCY. A PRE-TRIAL INVESTIGATION WAS INITIATED AGAINST *Roberta* FOR AN ALLEGED ILLEGAL ABORTION CARRIED OUT VIA MISOPROSTOL PILLS. ROBERTA WAS CRIMINALLY PROCESSED, AND WITH THE HELP OF A PRIVATE LAWYER, OPTED FOR "DEFERRED ADJUDICATION" (AN ALTERNATIVE MEANS OF RESOLVING THE CRIMINAL DISPUTE), ASSUMING GUILT. THE JUDGE ESTABLISHED HER OBLIGATION TO SIGN EVERY MONTH, ATTEND PSYCHOLOGICAL CARE, AND NOT TO CHANGE RESIDENCE.
Carolina	21	YUCATAN	WOMAN WITH FEW RESOURCES WHOSE BOYFRIEND GAVE HER PILLS, CLAIMING THAT THEY WERE "EMERGENCY CONTRACEPTION". THEY WERE ACTUALLY MISOPROSTOL PILLS THAT CAUSED *Carolina* TO ABORT AGAINST HER WILL. SHE SOUGHT MEDICAL CARE AT A FEDERAL HOSPITAL WHERE A SOCIAL WORKER REPORTED HER FOR AN ALLEGED ILLEGAL ABORTION. AS A RESULT, A PRE-TRIAL INVESTIGATION WAS INITIATED AND *Carolina* WAS PUT IN CUSTODY OF STATE POLICE FOR THREE DAYS. WHEN *Carolina* WAS RELEASED FROM THE HOSPITAL, SHE WAS TRANSFERRED TO PRISON, WHERE SHE REMAINED FOR AN ADDITIONAL THREE DAYS UNTIL SHE PAID BAIL. ACCORDING TO THE INFORMATION AVAILABLE, *Carolina* AND HER BOYFRIEND WERE SUBJECT TO CRIMINAL PROCEEDINGS FOR ILLEGAL ABORTION.
Sara	22	HIDALGO	WAS EIGHT WEEKS PREGNANT WHEN SHE SOUGHT CARE AT A STATE GOVERNMENT HOSPITAL AND WAS REPORTED BY TO POLICE BY THE HOSPITAL DIRECTOR FOR ALLEGEDLY INDUCING AN ABORTION WITH MISOPROSTOL PILLS AND NETRIGEN INJECTIONS. SHE WAS ARRESTED, ACCUSED OF ILLEGAL ABORTION, AND CRIMINALLY PROCESSED. *Sara* HAD TO PAY BAIL, AND CHOSE TO BE DEFENDED BY THE PUBLIC DEFENDER. SHE WAS APPARENTLY DECLARED INNOCENT IN A SENTENCE EMITTED BY A LOWER COURT.
Rosa	24	CHIHUAHUA	WAS ARRESTED IN A GOVERNMENT HOSPITAL BY POLICE AFTER BEING REPORTED BY THAT INSTITUTION'S HEALTH PERSONNEL FOR ALLEGEDLY HAVING INDUCED AN ABORTION VIA MISOPROSTOL PILLS. SHE WAS IN HER 14TH WEEK OF PREGNANCY. A PRE-TRIAL INVESTIGATION WAS INITIATED AND RESULTED IN CRIMINAL PROCEEDINGS. WITH THE HELP OF A PRIVATE LAWYER, *Rosa* OPTED FOR "DEFERRED ADJUDICATION" (AN ALTERNATIVE MEANS OF RESOLVING THE CRIMINAL DISPUTE), ASSUMING GUILT. THE JUDGE SENTENCED HER TO COMMUNITY SERVICE.
Laura	17	AGUASCALIENTES	WAS PRESSURED BY HER BOYFRIEND TO TERMINATE HER PREGNANCY WITH PILLS AND WAS REPORTED TO THE PUBLIC PROSECUTOR BY HER MOTHER.
Francisca	33	TAMAULIPAS	AUTHORITIES INITIATED A PRE-TRIAL INVESTIGATION AGAINST *Francisca* FOR ILLEGAL ABORTION. SHE WAS 12 WEEKS PREGNANT, AND WAS REPORTED BY HEALTH PERSONNEL AT A HOSPITAL.
Agustina	20	SAN LUIS POTOSI	AUTHORITIES INITIATED A PRE-TRIAL INVESTIGATION AGAINST *Agustina* FOR ILLEGAL ABORTION. SHE WAS 24 WEEKS PREGNANT, AND WAS REPORTED BY HEALTH PERSONNEL AT A STATE GOVERNMENT HOSPITAL.
Sandra	20	MICHOACAN	AUTHORITIES INITIATED A PRE-TRIAL INVESTIGATION AGAINST *Sandra* FOR ILLEGAL ABORTION. SHE WAS 21 WEEKS PREGNANT, AND WAS REPORTED BY A PHYSICIAN AT A HOSPITAL.

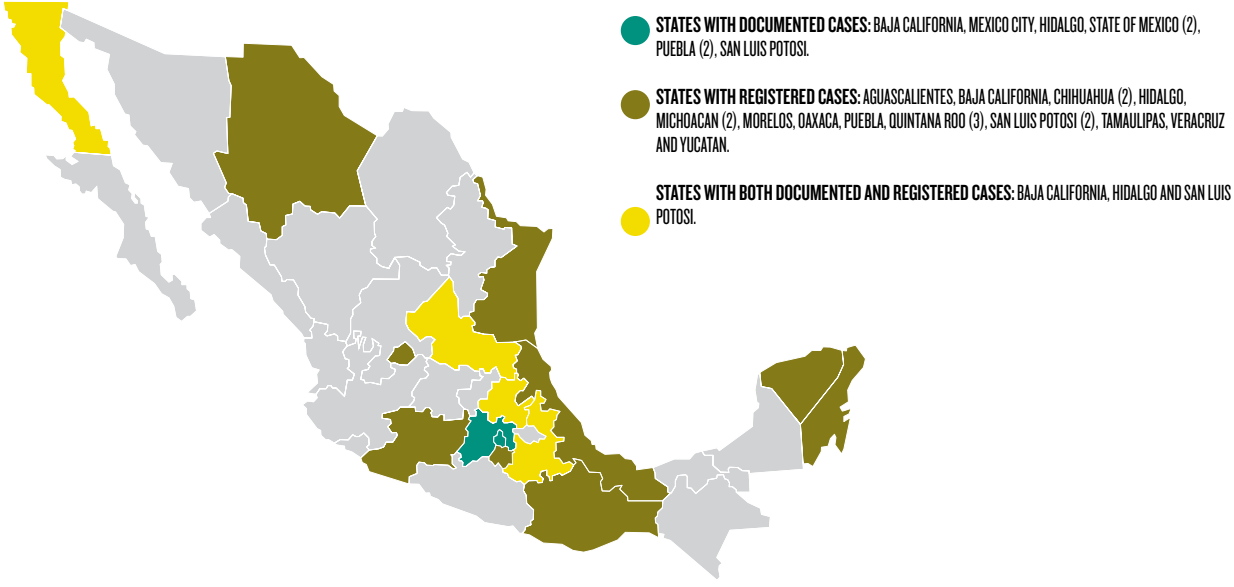
The shaded states "protect life from the moment of conception" in their constitutions.

REGISTERED CASES

NAME[132]	AGE	STATE	FACTS
Paula	18	QUINTANA ROO	AUTHORITIES INITIATED A PRE-TRIAL INVESTIGATION AGAINST *Paula* FOR ILLEGAL ABORTION. SHE WAS 20 WEEKS PREGNANT, AND WAS REPORTED BY HEALTH PERSONNEL AT A GOVERNMENT HOSPITAL AFTER SEEKING CARE FOR A HEMORRHAGE. SHE HAD ARRIVED AT THE HOSPITAL AFTER HAVING EXPELLED THE FETUS IN A BATHROOM AT THE RED CROSS WHERE SHE HAD ARRIVED HOURS EARLIER DUE TO ABDOMINAL PAIN.
Ana	21	PUEBLA	AUTHORITIES INITIATED A PRE-TRIAL INVESTIGATION AGAINST *Ana* FOR ILLEGAL ABORTION, ALLEGEDLY CARRIED OUT VIA INJECTION. SHE WAS 11 WEEKS PREGNANT AT THE TIME. SHE WAS REPORTED BY HEALTH PERSONNEL AT THE GOVERNMENT HOSPITAL WHERE SHE SOUGHT HELP FOR A HEMORRHAGE. *Ana* HAD TO PAY BAIL TO BE PROVISIONALLY RELEASED. A PRE-TRIAL INVESTIGATION WAS ALSO INITIATED AGAINST THE PHYSICIAN WHO TREATED HER. A PRIVATE LAWYER IS APPARENTLY DEFENDING THE PHYSICIAN.
Emilia	DATA NOT AVAILABLE	QUINTANA ROO	AUTHORITIES ARRESTED *Emilia* AND INITIATED A PRE-TRIAL INVESTIGATION AGAINST HER FOR ALLEGEDLY INDUCING AN ILLEGAL ABORTION VIA MISOPROSTOL PILLS. SHE WAS REPORTED BY PERSONNEL AT A FEDERAL HOSPITAL AND HAD TO PAY BAIL TO BE PROVISIONALLY RELEASED FROM PRISON.
Julieta	15	BAJA CALIFORNIA	AUTHORITIES ARRESTED *Julieta* AND INITIATED A PRE-TRIAL INVESTIGATION AGAINST HER FOR ATTEMPTING AN ABORTION BY INSERTING A METAL COAT HANGER INTO HER VAGINA. SHE WAS TEN WEEKS PREGNANT. SHE WAS REPORTED BY PERSONNEL AT THE IMSS CLINIC WHERE SHE RECEIVED MEDICAL CARE FOR A HEMORRHAGE. *Julieta* WAS FREED BUT IT IS UNCLEAR ON WHAT TERMS.
Susana	21	OAXACA	AUTHORITIES ARRESTED *Susana* AND INITIATED A PRE-TRIAL INVESTIGATION AGAINST HER FOR ALLEGEDLY INDUCING AN ABORTION AT 17 WEEKS. SHE WAS REPORTED BY PERSONNEL AT A STATE GOVERNMENT HOSPITAL AFTER RECEIVING CARE. ACCORDING TO AVAILABLE INFORMATION, THE INVESTIGATION WAS CLOSED AFTER SHE PROVED SHE HAD HAD A MISCARRIAGE.
Regina	DATA NOT AVAILABLE	QUINTANA ROO	AUTHORITIES ARRESTED *Carla* AND INITIATED A PRE-TRIAL INVESTIGATION AGAINST HER FOR ALLEGEDLY INDUCING AN ILLEGAL ABORTION AT 12 WEEKS. APPARENTLY, SHE HAD BEEN PHYSICALLY AND SEXUALLY ABUSED BY HER PARTNER. SHE WAS ACCUSED OF ALLEGEDLY INDUCING AN ABORTION VIA MISOPROSTOL PILLS. SHE HAD BEEN REPORTED BY PERSONNEL AT THE GOVERNMENT HOSPITAL WHERE SHE HAD RECEIVED CARE FOR A HEMORRHAGE CAUSED BY A MISCARRIAGE SHE HAD AT WORK A FEW HOURS EARLIER. ACCORDING TO THE AVAILABLE INFORMATION, THE INVESTIGATION WAS CLOSED BECAUSE SHE WAS ABLE TO PROVE THAT SHE HAD HAD A MISCARRIAGE.
Marcela	26	SAN LUIS POTOSI	AUTHORITIES ARRESTED *Marcela* AND INITIATED A PRE-TRIAL INVESTIGATION AGAINST HER FOR ALLEGEDLY INDUCING AN ILLEGAL ABORTION AT 12 WEEKS VIA MISOPROSTOL PILLS. SHE WAS BEEN REPORTED BY PERSONNEL AT THE STATE GOVERNMENT HOSPITAL WHERE SHE HAD RECEIVED MEDICAL CARE.
Mercedes	20	VERACRUZ	AUTHORITIES ARRESTED MERCEDES AND INITIATED A PRE-TRIAL INVESTIGATION AGAINST HER FOR ILLEGAL ABORTION. SHE WAS ACCUSED OF ALLEGEDLY INDUCING AN ABORTION VIA MISOPROSTOL PILLS AT 28 WEEKS, AFTER BEING REPORTED BY INDIVIDUALS WHO FOUND THE FETUS A FEW BLOCKS FROM MERCEDES' HOME. ACCORDING TO AVAILABLE INFORMATION, SHE WAS FREED WITHOUT HAVING TO PAY BAIL BECAUSE, IN HER STATE, CRIMINAL LEGISLATION DOES NOT CONSIDER ABORTION A CRIME THAT REQUIRES DEPRIVATION OF LIBERTY.

The shaded states "protect life from the moment of conception" in their constitutions.

CASES DOCUMENTED AND REGISTERED BY GIRE



E. Regulation of Conscientious Objection

Conscientious objection, based on the right to freedom of conscience and religion, establishes individuals' right to refuse to carry out certain activities that they consider to be against their personal beliefs (including religious beliefs).[133] However, this prerogative is not absolute and there must be guarantees that its practice does not place human rights at risk or prevent their exercise. Exercising conscientious objection cannot limit women's access to sexual and reproductive health services.

An essential part of the State's obligations is to eliminate barriers to women's effective access to reproductive health services to which they have a right, including legal abortion services. Conscientious objection by health personnel, if not adequately regulated, can become a barrier to women's access to said services.

Conscientious objection to provide reproductive health services has clear limits, and implies certain obligations for the State and responsibilities for health professionals. On one hand, health institutions cannot be objectors; only individuals have right to object. Institutions are obligated to always have "non-objecting" personnel on hand to guarantee women their right to terminate a pregnancy. Similarly, because objection is not permitted at the "institutional" level, a hospital cannot refuse to provide women with certain reproductive health services. On the other hand, objecting staff have the ethical and professional responsibility to refer women requesting the service to another adequately trained and available professional.

Individuals do not have the right to conscientious objection in cases where delaying care can be dangerous for the woman requesting the service. In these cases they must provide immediate service. Conscientious objection does not apply in medical emergencies. Finally, conscientious objection can only be invoked by personnel directly involved in the procedure, not by support or administrative personnel.

In this sense, the CEDAW Committee has voiced its concern regarding legislation that permits conscientious objection among hospital staff,[134] and laws that require medical personnel to report women who have induced an abortion.[135]

In Mexico, laws in six states[136] establish medical personnel's right to conscientious objection; the following chart describes how it is regulated in each of those states.

	AGUASCALIENTES[137]	COLIMA[138]	JALISCO[139]	MEXICO CITY[140]	QUERETARO[141]	TLAXCALA[142]
SERVICES	GENERAL	LEGAL ABORTION	GENERAL	LEGAL ABORTION	GENERAL	LEGAL ABORTION
WHO?	MEDICAL PERSONNEL	HEALTH PROVIDERS	HEALTH PROVIDERS	MEDICAL PERSONNEL	HEALTH PROVIDERS	HEALTH PROVIDERS
OBLIGATION TO REFER	NO	YES	YES	YES	NO[143]	YES
IN AN EMERGENCY	OBJECTION APPLIES	OBJECTION APPLIES	OBJECTION DOES NOT APPLY	OBJECTION DOES NOT APPLY	OBJECTION DOES NOT APPLY	OBJECTION DOES NOT APPLY
INSTITUTION'S OBLIGATION TO HAVE NON-OBJECTING PERSONNEL AVAILABLE	NO	YES	NO	YES	NO	YES

As shown in the previous chart, six states recognize medical or health personnel's right to conscientious objection. Only three of these states regulate conscientious objection specifically for legal abortion services.

Mexico City and Tlaxcala have the most protective regulation; clearly establishing the situations in which conscientious objection cannot be invoked (such as emergencies), objecting public officials' specific obligations (referral to a non-objecting professional), and institutions' obligations (to have non-objecting personnel available).

It is concerning that the 26 remaining states do not regulate conscientious objection for health personnel. It is essential to make sure that public officials' personal beliefs do not interfere with women's access to abortion services. Lack of regulation can lead to abuse and obstacles that put women's reproductive health at risk. An adequate regulation of conscientious objection provides legal certainty to both women and health providers.

F. Doctor-Patient Confidentiality vs. Obligation to Report

When discussing access to safe and legal abortion services, in addition to taking into consideration the sanctions that are imposed on women who decide to terminate their pregnancies, it is also important to be aware of obligations that the law imposes upon health providers, specifically doctor-patient confidentiality and the obligation to report.

Based on the acknowledgement and guarantee of the rights to intimacy and health, the international human rights framework establishes, as a protective mechanism, health providers' obligation to keep doctor-patient confidentiality.[144]

At the national level, the General Health Law safeguards the obligation to protect confidentiality and the Official Mexican Norm 168-SSAI-1998, establishes the obligation to manage the information contained in medical charts in a confidential manner, sharing it only upon legal or administrative order.[145]

The Federal Penal Code[146] defines the revelation of confidential information as a crime, sanctioning the disclosure of information received in the exercise of a profession, without just cause. This places women who seek medical care after an abortion at risk because having "committed" the crime of abortion could be interpreted by some as "just cause" due to the ambiguity in the law.

State Penal Codes regulate confidentiality in a similar manner, and some states, such as Baja California Sur, only establish this crime for lawyers, priests, mediators and psychiatrists, without taking physicians into consideration. Other states, such as San Luis Potosi, do not even define the crime.

In addition to the above and the sanctions that can be applied to health personnel who "commit" the crime of abortion (penalized in most criminal codes with prison and suspension of professional license from two to five years and in some cases permanently), criminal law in Mexico also punishes people who are aware that a crime has been committed but do not report it, defined as the crime of concealment. This is just another factor that seriously hinders access to safe abortion services and care for complications resulting from unsafe abortion, putting women's lives and health at risk.

In addition to defining the "crime" of concealment, the General Health Law's regulations regarding the provision of health services establish an obligation to notify the Public Prosecutor in cases involving injuries and other evidence presumably linked to a crime.[147]

We can conclude that, within the Mexican law and policy framework, there are serious contradictions between medical personnel's duty to protect doctor-patient confidentiality and their obligation to report potentially unlawful acts. These contradictions result in legal uncertainty for those who provide health services; it is unclear how authorities should act, which can result in application of the law based on personal criteria rather than legal obligations. In addition to the risk that this poses to health professionals, this legal ambiguity seriously hinders women's access to gender-specific services.

WOMEN WERE REPORTED BY HEALTH PERSONNEL IN 21 OF THE EMBLEMATIC CASES DOCUMENTED AND REGISTERED BY GIRE BETWEEN 2011 AND 2013 (DESCRIBED EARLIER IN THE CHAPTER). THESE INCLUDED PHYSICIANS, SOCIAL WORKERS AND EVEN, IN ONE CASE, THE DIRECTOR OF THE INSTITUTION. THIS INFORMATION IS PROVIDED IN THE FOLLOWING CHART.

CASES DOCUMENTED BY GIRE

	CASE	STATE	REPORTED BY
1	*Ángela*	STATE OF MEXICO	SOCIAL WORKER MUNICIPAL HOSPITAL
2	*Rebeca*	HIDALGO	PHYSICIAN IMSS
3	*María*	SAN LUIS POTOSI	SOCIAL WORKER STATE HOSPITAL
4	*Sofía*	PUEBLA	SOCIAL WORKER IMSS
5	*Laura*	PUEBLA	SOCIAL WORKER STATE HOSPITAL
6	*Claudia*	STATE OF MEXICO	PHYSICIAN IMSS

Shaded states "protect life from conception" in their constitutions.

CASES REGISTERED BY GIRE

	CASE	STATE	REPORTED BY
7	*Brenda*	MORELOS	PHYSICIAN STATE HOSPITAL
8	*Roberta*	CHIHUAHUA	HEALTH PERSONNEL IMSS
9	*Carolina*	YUCATAN	SOCIAL WORKER IMSS
10	*Sara*	HIDALGO	DIRECTOR STATE HOSPITAL
11	*Rosa*	CHIHUAHUA	HEALTH PERSONNEL STATE HOSPITAL
12	*Francisca*	TAMAULIPAS	HEALTH PERSONNEL
13	*Agustina*	SAN LUIS POTOSI	HEALTH PERSONNEL HOSPITAL
14	*Sandra*	MICHOACAN	PHYSICIAN HOSPITAL
15	*Paula*	QUINTANA ROO	HEALTH PERSONNEL HOSPITAL
16	*Ana*	PUEBLA	HEALTH PERSONNEL STATE HOSPITAL
17	*Emilia*	QUINTANA ROO	HEALTH PERSONNEL IMSS
18	*Julieta*	BAJA CALIFORNIA	HEALTH PERSONNEL IMSS
19	*Susana*	OAXACA	HEALTH PERSONNEL HOSPITAL
20	*Regina*	QUINTANA ROO	HEALTH PERSONNEL HOSPITAL
21	*Marcela*	SAN LUIS POTOSI	HEALTH PERSONNEL STATE HOSPITAL

Shaded states "protect life from conception" in their constitutions.

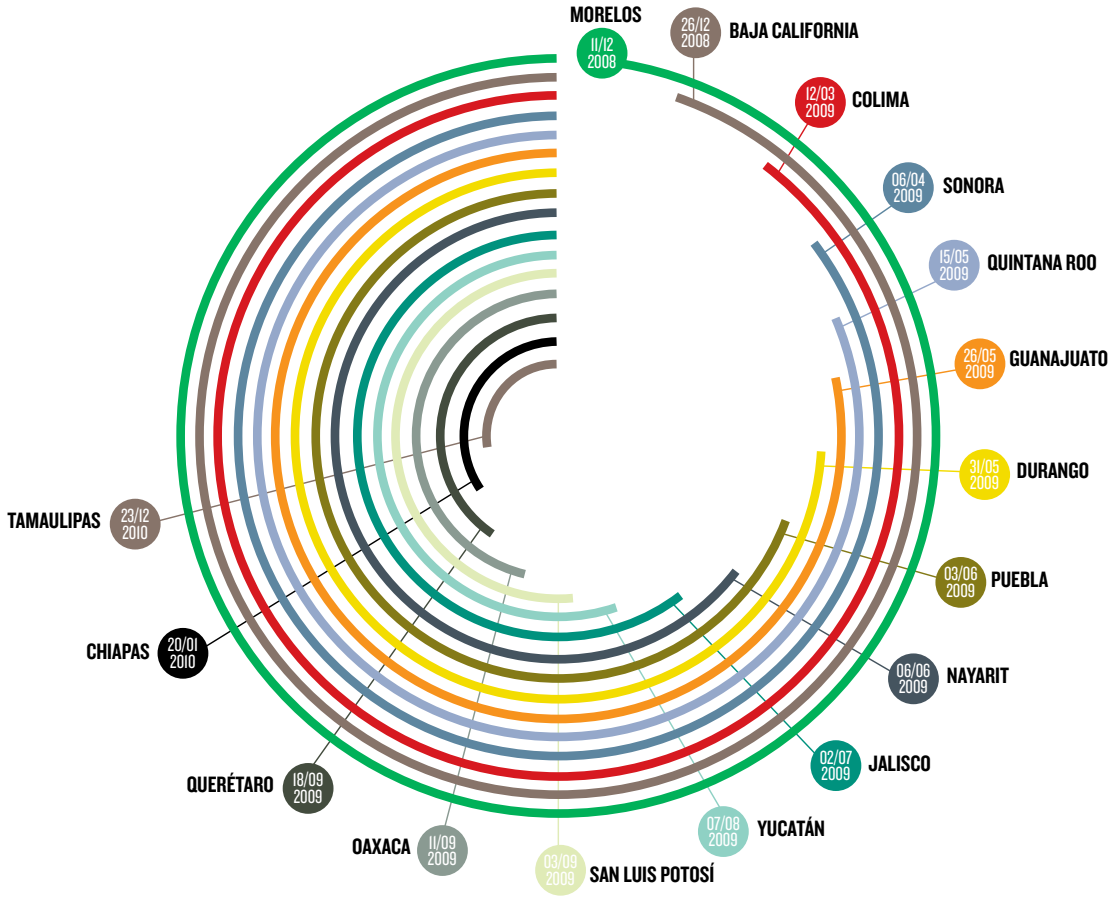
Based on the information presented in the previous charts, it is particularly important for federal and state legislative branches to harmonize their laws and policies on doctor-patient confidentiality and obligation to report with the *pro personae* principle, prioritizing the right to health, and the protection of life and intimacy of those requiring health services. Public officials in health institutions are obligated to provide medical services, not to become auxiliaries to authorities responsible for law enforcement.

In this sense, the Inter-American Court of Human Rights, in its judgment in the case *De la Cruz Flores vs. Peru* stated that "that the information a physician obtains in the exercise of his profession is privileged by professional confidentiality. For example, the International Code of Medical Ethics of the World Medical Association establishes that "a physician must keep absolutely secret everything that has been confided in him, even after the death of the patient."[148] Additionally, "The Court considers that physicians have a right and an obligation to protect the confidentiality of the information to which, as physicians, they have access."[149]

G. IMPACT OF THE REFORMS THAT PROTECT LIFE FROM CONCEPTION

Since 2008, 16 Mexican states have reformed their constitutions to protect life "from the moment of conception".[150] These reforms have the explicit intention of limiting women's reproductive rights and are a direct reaction to the decriminalization of abortion in Mexico City and the Supreme Court's confirmation of its constitutionality.

CONSTITUTIONAL REFORMS THAT PROTECT LIFE FROM CONCEPTION, 2008-2010



*CHIHUAHUA REFORMED ITS CONSTITUTION IN OCTOBER 1994. IT IS NOT INCLUDED IN THE REFORMS ABOVE FOR THE PERIOD 2008-2010.

Despite the fact that these state constitutional reforms do not annul legal indications for abortion in those states, they have generated a climate of confusion and legal uncertainty among women and legal and health personnel as to whether or not abortion continues to be legal under those circumstances. These reforms have also generated a climate of persecution against women, even in cases of miscarriage.

In order to protect prenatal life, the State must adopt measures that protect women, such as guaranteeing pregnant women adequate prenatal care and guaranteeing free and adequate amounts of folic acid and other nutritional supplements during pregnancy and the first years of life to reduce rates of maternal mortality and morbidity.[151]

As demonstrated by the cases that GIRE has documented and registered, a large number of cases of criminalization of women and obstacles to accessing legal abortion occurred in states that have reformed their constitutions to protect life from conception: 17 of 26.

In September 2011, Mexico's Supreme Court discussed two unconstitutionality claims —from San Luis Potosi and Baja California— against reforms providing absolute protection to the product of conception. The majority of court justices, seven of 11, agreed that these reforms are unconstitutional because the absolute protection of the product of conception puts women's reproductive rights at risk. These justices acknowledged the importance of the protection of prenatal life, but agreed that this protection must be compatible with women's rights. Even Justice Luna Ramos, who voted for the constitutionality of the laws, stated that the protection of life from conception cannot be absolute.[152]

In order to declare these reforms unconstitutional, eight votes were needed to reach a qualified majority.[153] Because only seven votes were achieved, the unconstitutionality claims were dismissed. This does not mean that the reforms were declared constitutional, but that a qualified majority was not achieved in order to declare unconstitutionality. However, the arguments used by the majority of the justices, the constitutional reform on human rights, and recent recommendations by the CEDAW Committee demonstrate that these reforms must be interpreted in a manner that protect women's rights. In other words, even in states with constitutional reforms in place, women must be guaranteed access to the legal indications for abortion established in state penal codes.

1.5 / CONCLUSIONS

Based on statistical data, the law and policy analysis and the responses to requests for public information presented at the federal and state level, we can conclude that Mexican authorities do not comply with their obligations to promote, protect and guarantee women's right to safe and legal abortion services.

At the law and policy level, Mexico continues to treat abortion as a criminal issue rather than as a human rights issue. Treating it as a human rights issue would imply establishing the necessary conditions to exercise this right free from discrimination; in other words, harmonizing abortion laws. Instead of acknowledging women as subjects of human rights, they are seen as potential criminals.

We must point out that important progress has been made, such as the decriminalization of abortion in Mexico City during the first trimester of pregnancy. However, in reaction to this law and the Supreme Court sentence that validated the reform, 16 states reformed their constitutions to protect abstractly prenatal life —without taking into consideration that this protection is implicit within the protection of the life and health of the pregnant woman— with the clear intention of preventing a similar decriminalization in other states. These reforms have had a negative impact on access to safe and legal abortion services in various states.

Based on the constitutional reform on human rights, resolutions by the Mexican Supreme Court and the Inter-American Court of Human Rights, and recommendations made to Mexico by international organisms such as the CEDAW Committee, both state and federal governments have the obligation to harmonize abortion legislation toward decriminalization, as was carried out in Mexico City in 2007, as a means of complying with human rights obligations specified in the Constitution.

GIRE is concerned by the lack of implementation of legal abortion indications and of NOM 046 by federal institutions and the low number of authorizations of legal abortions after rape by state Public Prosecutor's Offices.

We can conclude that current law and policy hinders access to medical services for women seeking post-abortion care. This is due to a lack of clarity regarding health personnel's obligations related to doctor-patient confidentially vs. obligation to report unlawful acts such as illegal abortion.

Another worrisome issue is the criminalization of women that is occurring in states that protect life from conception. This, in turn, has generated a context of criminal persecution and restrictions in women's access to health services, as illustrated by the cases documented and registered by GIRE.

1.6 / RECOMMENDATIONS

1.6.1 LAWS AND POLICY

- Harmonize criminal and health legislation on abortion, at the state and federal level, in accordance with the constitutional reform on human rights, to eliminate discrimination faced by women in exercising their rights due to variations in access to abortion based on residence. Taking into consideration the *pro personae* principle and the highest standards of human rights protection, states must progress towards decriminalizing abortion, at least during the first trimester of pregnancy at the woman's request. As a temporary measure, until decriminalization is achieved, states must expand legal indications for abortion to protect women's lives, bodily integrity and health.

- Reform State Penal Codes to reduce minimum penalties established for illegal abortion and eliminate penalties that involve deprivation of liberty.

- Reform Public Prosecutors' organic laws to establish their physicians' obligation to provide information on NOM 046, particularly related to legal abortion, emergency contraception and prophylaxis against HIV and other sexually transmitted infections.

- Reform state health laws to regulate reproductive health providers' right to conscientious objection in such a way that it does not hinder women's access to these services. The regulation of conscientious objection should clearly establish who can claim this right and under what circumstances. At the same time, health providers' and health institutions' obligations should be clearly established to ensure they offer reproductive health services in a timely manner.

- Reform the General Health Law to guarantee access to reproductive health services, including legal abortion and confidentiality of medical information, and establishing health personnel's obligation to keep information received while exercising their profession confidential. In addition, State Penal Codes should be modified to eliminate health personnel's obligation to report.

1.6.2 IMPLEMENTATION OF LAW AND POLICY

- Guarantee women's safe and timely access to legal abortion indications in all states. This implies strengthening sexual and reproductive health services.

- Guarantee that State Public Prosecutors authorize terminations of pregnancy resulting from rape, in compliance with their obligations, without imposing additional requirements that create barriers to rape survivors in accessing this service.

- Train state-level Public Prosecutor and health personnel regarding the rights of rape survivors and their obligation to guarantee access to safe and legal abortion.

- Train state-level legal and health personnel regarding state indications for legal abortion and emphasize that these indications are still in effect even in states that protect life from conception.

- Guarantee the interpretation of the reforms that protect life from conception in a manner that is compatible with women's rights, ensuring that they do not result in denial of legal abortion services for indications included in state legislation.

1.6.3 GENERATION OF INFORMATION AND STATISTICAL DATA

- Guarantee that state Ministries of Health desegregate abortion data by type and legal indication (risk to the woman's life, health, rape, among others).

- Guarantee that State Public Prosecutors, particularly those that are not in compliance, keep records of the number of requests for legal termination of pregnancy due to rape and the number of authorizations emitted.

- Guarantee that State Public Prosecutors and judicial branches record statistics.

NOTES

[1] Grimes, D.A. *et al*., "Unsafe abortion: the preventable pandemic" in *The Lancet*, London, vol. 368, issue 9550, November 25, 2006, pp. 1908-1919. Available at <http://bit.ly/11jllqk>. "Unsafe abortion: eight maternal deaths every hour: editorial" in *The Lancet*, London, vol. 374, issue 9698, October 17, 2009, p. 1301. Available at <http://bit.ly/VV2f3a>. Singh, S. *et al*., *Abortion Worldwide: A Decade of Uneven Progress*, New York, Guttmacher Institute, 2009. Available at <http://bit.ly/snY6RF> [accessed: October 30, 2012]. Guttmacher Institute. *Sharing Responsibility: Women, Society and Abortion Worldwide*, New York: Guttmacher Institute, 1999. Available at <http://bit.ly/vwnKdE> [accessed: October 30, 2012]. Sedgh, G. *et al*., "Induced abortion: estimated rates and trends worldwide" in *The Lancet*, vol. 370, issue 9595, October 13, 2007, pp. 338–45. "Abortion: a woman's right. Restrictive abortion laws do not prevent abortion" in The Economist, New York, October 14, 2009. Available at <http://econ.st/U7wVkp> [accessed: October 30, 2012]. *Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008*, 6th ed., Geneva, WHO, 2011. Available at <http://bit.ly/kdGgDa> [accessed: October 30, 2012].

[2] World Health Organization, *Safe Abortion: technical and policy guidance for health systems*, Second Edition, Geneva, WHO, 2012. Available at <http://bit.ly/Nnj9ZD> [accessed: October 30, 2012].

[3] CEDAW Committee, *General Comment No. 24, Article 12 of the Convention on the Elimination of All Forms of Discrimination against Women - Women and Health,* 20th Session (1999), paragraph 11. Available at <http://bit.ly/12gVp0l> [accessed: October 19, 2012].

[4] See CEDAW Committee, *Concluding comments of the Committee on the Elimination of Discrimination against Women: Chile*, 36th Session (2006), paragraph 19, [CEDAW/C/CHI/CO/4]. Available at <http://bit.ly/133m40r> [accessed: October 12, 2012]. CEDAW Committee, *Concluding comments of the Committee on the Elimination of Discrimination against Women: Honduras*, 39th Session (2007), paragraph 25, [CEDAW/C/HON/CO/6]. Available at <http://bit.ly/10RmGG5> [accessed: October 12, 2012]. Human Rights Committee, *Concluding observations of the Human Rights Committee: Honduras*, 88th Session (2006), paragraph 8, [CCPR/C/HND/CO/1]. Available at <http://bit.ly/19ppnT7> [accessed: October 12, 2012]. Committee on Economic Social and Cultural Rights, *Concluding observations of the Committee on Economic Social and Cultural Rights: Chile*, 33rd Session (2004), paragraph 25, [E/C.12/1/Add.105]. Available at <http://bit.ly/10RoUW1> [accessed: October 12, 2012].

[5] *Ibid*.

[6] Article 1- In the United Mexican States, all individuals shall be entitled to the human rights granted by this Constitution and the international treaties signed by the Mexican State, as well as to the guarantees for the protection of these rights. Such human rights shall not be restricted or suspended, except for the cases and under the conditions established by this Constitution itself. (Added by the decree published on June 10, 2011)
The provisions relating to human rights shall be interpreted according to this Constitution and the international treaties on the subject, working in favor of the protection of people at all times. (Added by the decree published on June 10, 2011)
All authorities, in their areas of competence, are obliged to promote, respect, protect and guarantee the human rights, in accordance with the principles of universality, interdependence, indivisibility and progressiveness. As a consequence, the State must prevent, investigate, penalize and redress violations to the human rights, according to the law. Available at <http://bit.ly/136JPpy> [accessed: June 25, 2013].

[7] The MARIA Abortion Fund for Social Justice was created to provide financial support to women without resources to access legal abortion services in Mexico City. Available at <http://bit.ly/aUjYnl> [accessed: October 19, 2012].

[8] Sousa, A., Rafael Lozano and Emmanuel Gakidou, "Exploring the Determinants of Unsafe Abortion: Improving the Evidence base in Mexico" in *Health Policy and Planning*, vol. 25, issue 4, 2010, p. 300-310. Available at <http://bit.ly/12kvrGi> [accessed: October 30, 2012].

[9] Juárez, Fátima and Susheela Singh, "Incidence of Induced Abortion by Age and State, Mexico, 2009: New Estimates Using a Modified Methodology" in *International Perspectives on Sexual and Reproductive Health*, Guttmacher Institute, vol. 38, no. 2, June 2012. Available at <http://bit.ly/TWmrRs> [accessed: October 17, 2012].

[10] *Ibid*.

[11] *Ibid*.

[12] *Ibid*.

[13] *Ibid*.

[14] See Table 6 in Schiavon, R., Erika Troncoso and Gerardo Polo, "Analysis of maternal and abortion-related mortality in Mexico over the last two decades, 1990-2008" in *International Journal of Gynecology and Obstetrics,* vol. 188, supplement 2, September 2012, pp. S78-S86. Available at: <http://bit.ly/12lqxIm> [accessed: October 30, 2012].

[15] Maternal Deaths (992 deaths), by cause and age group. Mexico, (2010) –Age group: 20 to 34 years. See Posadas Robledo, Javier. "Mortalidad materna avances del programa nacional de APV" in *Foro: La Protección de la Salud Materna desde una perspectiva de derechos humanos: avances y desafíos de salud materna*, Mexico, December, 2011. [Unpublished speech].

[16] Juárez, Fátima and Susheela Singh, "Incidence of Induced Abortion", *op. cit.* (see *supra*, note 9).

[17] Aguascalientes, Baja California Sur, Chiapas, Chihuahua, Guanajuato, Guerrero, Hidalgo, Jalisco, Mexico City, Michoacan, Morelos, Nuevo Leon, Oaxaca, Puebla, Queretaro, Sonora, Tamaulipas, Veracruz and Zacatecas.

[18] Data requested by the Supreme Court from the presidents of state and Mexico City's Superior Courts and Collegiate Circuit Courts (Mixed and specialized in Criminal Law), from Public Prosecutor's Offices in Mexico City and the states, from single-judge Courts and Circuit Court judges and District judges (Mixed and specialized in Criminal Law), during the analysis of the constitutionality of the decriminalization of abortion in Mexico City, to provide information regarding the number of criminal proceedings, pre-trial investigations, lawsuits against sentences related to illegal abortion and lawsuits against rulings of arrest for the crime of the abortion between 1992 and 2007. SCJN (Supreme Court), *Aborto. Acción de Inconstitucionalidad 146/2007 y su acumulada 147/2007 del Pleno de la Suprema Corte de Justicia de la Nación,* Mexico, SCJN, Programa de Equidad de Género, 2008, p. 122. Available at <http://bit.ly/Zh4YXD> [accessed: February 20, 2013].

[19] Data received through requests for information from Public Prosecutor's Office in 24 states: Aguascalientes, Campeche, Chiapas, Chihuahua, Colima, Durango, Guanajuato, Hidalgo, Jalisco, Mexico City, Michoacan, Morelos, Nayarit, Nuevo Leon, Puebla, Quintana Roo, San Luis Potosi, Sinaloa, Sonora, State of Mexico, Tamaulipas, Tlaxcala, Veracruz and Zacatecas, March, 2012.

[20] Article 73. The Congress shall have the power to:
XVI. Enact laws on nationality, legal status of foreigners, citizenship, naturalization, colonization, immigration and public health:

[21] Article 2. Will also be applied in the following cases:
I. For crimes that are initiated, or are planned or committed abroad, when they have resulted in or are committed with the goal of producing effects on Mexican territory; or for crimes initiated, planned or committed abroad, when there exists a binding treaty which includes an obligation to extradite or judge, but the allegedly responsible member of the State is not extradited to the State requiring this procedure, based on requirements established in Article 4 of this Code.
II. For crimes committed in Mexican consulates or against their personnel, as long as they have not been judged in the country in which they were committed.

[22] *American Convention on Human Rights*
Article 2. Domestic Legal Effects
Where the exercise of any of the rights or freedoms referred to in Article 1 is not already ensured by legislative or other provisions, the States Parties undertake to adopt, in accordance with their constitutional processes and the provisions of this Convention, such legislative or other measures as may be necessary to give effect to those rights or freedoms. Available at <http://bit.ly/148Upcj.>

[23] Separate Opinion of the Ad Hoc Judge Eduardo Ferrer Mac-Gregor Poisot in the Judgment of the Inter-American Court of Human Rights in the *Cabrera García and Montiel Flores vs. Mexico Case.* IAHR Court, *Cabrera García and Montiel Flores vs. Mexico Case. Preliminary Objection, Merits, Reparations and Legal Costs. Judgment of November 26, 2010.* Series C No. 220, paragraph 66. Available at <http://bit.ly/14WDTxj> [accessed: February 20, 2013].

[24] It appears that the inclusion of state-level crimes in the Federal Penal Code is due to the fact that, before Mexico City was recognized as an entity with the ability to create its own laws, the Federal Penal Code was applied as its state regulation. This is why unusual crimes, such as abortion, are included.

[25] Article 2. (see *supra*, note 21).

[26] Article 50. Federal criminal judges will have jurisdiction over:
I. Federal Offenses.
Federal Offenses are defined as the following:
c) Those committed abroad by diplomatic and official personnel representing the Mexican State and its consulates;
d) Those committed in an embassy or other foreign legation;
g) Those committed against a public servant or federal employee, during or in connection with the exercise of their functions, and those committed against the President of the Republic, secretaries of state, the Federal Attorney General, representatives and senators of the Congress, justices, magistrates and judges of the federal judicial branch, members of the Federal Judiciary Council, magistrate of the Federal Electoral Court, members of the General Council of the Federal Electoral Institute, the president of the National Human Rights Commission, directors or members of the Governing Boards or the equivalent of their decentralized agencies;
h) Those committed using the operation of a federal public service, even when that service has been decentralized or contracted out;
i) Those committed against the operation of a federal public service or against the property provided for carrying out that service, even when that service has been decentralized or contracted out.

[27] The *General Law on Victims*, published January 9, 2013, explicitly establishes rape survivors' right to access emergency contraception and treatments to prevent sexually transmitted infections, and their right to request a safe and legal abortion.

[28] WHO, "Emergency Contraception: How Effective is it?" in *Progress in Reproductive Health Research*, no. 51, 1999, p. 2. Available at <http://bit.ly/UD4ckd> [accessed: January 10, 2013].

[29] IACHR Court, *Case of Artavia Murillo et al. (In Vitro Fertilization) vs. Costa Rica. Preliminary Objection, Merits, Reparations and Costs. Judgment of November 28, 2012. Series C No. 257,* paragraph 189. Available at <http://bit.ly/17COtNC> [accessed: December 21, 2012].

[30] Baja California, Campeche, Chiapas, Chihuahua, Coahuila, Colima, Hidalgo, Oaxaca, Quintana Roo and Veracruz.

[31] Except Chiapas and Nuevo Leon.

[32] Except Guanajuato, Guerrero and Queretaro.

[33] Although the explanatory statement on the 2012 reform to Campeche's Penal Code does not refer to the fact that that the legal indication for risk to the woman's life is subsumed in the legal indication for risk to the woman's health, we can interpret, taking into consideration reforms made in Colima and Mexico City, that in Campeche, the legal indication for risk to the woman's life is included within the indication for risk to the woman's health.

[34] Baja California Sur, Coahuila, Colima, Chiapas, Guerrero, Hidalgo, Mexico City, Morelos, Oaxaca, Puebla, Quintana Roo, State of Mexico, Veracruz and Yucatan.

[35] Baja California Sur, Campeche, Chihuahua, Colima, Hidalgo, Jalisco, Mexico City, Michoacan, Nayarit, Nuevo Leon, Tamaulipas, Tlaxcala and Zacatecas.

[36] Baja California, Baja California Sur, Colima, Chihuahua, Guerrero, Hidalgo, Mexico City, Morelos, San Luis Potosi, Tabasco and Veracruz.

[37] Yucatan.

[38] Mexico City.

[39] Baja California Sur, Colima, Hidalgo, Mexico City, Morelos, Veracruz and Yucatan.

[40] Aguascalientes, Baja California, Campeche, Chiapas, Chihuahua, Coahuila, Colima, Durango, Guanajuato, Guerrero, Hidalgo, Mexico City, Michoacan, Morelos, Nayarit, Nuevo Leon, Oaxaca, Puebla, Queretaro, Quintana Roo, Sinaloa, State of Mexico, Tabasco, Tamaulipas, Veracruz, Yucatan and Zacatecas.

[41] Article 19. […]The Public Prosecution Service can request the judge preventive prison only when other precautionary measures are not enough to ensure the presence of the accused in his trial, the development of the investigation, the protection of the victim, witnesses or community, as well as when the accused is on trial or had been previously convicted for having committed an intentional crime. Also, the judge will order preventive prison, by its own motion, in the following cases: organized crime; deceitful homicide; rape; kidnapping; trafficking in persons; crimes committed using firearms, explosives or other violent instruments; and serious crimes against national security, the right to freely develop personality and public health. Available at <http://bit.ly/136JPpy> [accessed: June 26, 2013].

[42] Baja California Sur, Jalisco, San Luis Potosi, Sonora and Tlaxcala.

[43] Article 19 (see *supra*, note 41).

[44] Pregnancy termination after 12 weeks gestation, only complete abortions are penalized.

[45] This sanction is applied during the first five months of pregnancy, after this it is doubled. Medical treatment can be substituted for prison time.

[46] Can be substituted with 200 days of community service and a fine.

[47] When the abortion is carried out after 12 weeks of gestation, only complete abortions are penalized.

[48] Can be substituted with medical or psychological treatment.

[49] Can be substituted with comprehensive medical or psychological treatment.

[50] *Ibid*.

[51] When the abortion in carried out before 12 weeks of gestation.

[52] *Ibid*.

[53] A prison sentence also applies in this case.

[54] Reparation of damages.

[55] The treatment cannot exceed two years.

[56] Has the goal of reaffirming the value of motherhood and strengthening the family.

[57] *Ibid*.

[58] Treatment in liberty consists of applying education and health measures.

[59] Has the goal of reaffirming the value of motherhood and strengthening the family.

[60] IACHR Court, *Case of Artavia Murillo et al. (In Vitro Fertilization) vs. Costa Rica… op. cit*., paragraph 244 (see supra, note 29).

[61] CEDAW Committee, Concluding observations of the Committee on the Elimination of Discrimination against Women: Mexico, 52nd Session (2012), Paragraph 32, [CEDAW/C/MEX/CO/7-8]. Available at <http://bit.ly/14GJoha> [accessed: October 30, 2012].

[62] *Ibid*., paragraph 33.

[63] Bill presented by the Mayor of Mexico City to Mexico City's Legislative Assembly on August 14, 2000.

[64] Part of the friendly settlement in the Paulina case was a commitment to update the Official Mexican Norm on Domestic and Sexual Violence and Violence against Women. The modification included the obligation of health personnel to offer, either immediately or within 120 hours after a rape: emergency contraception, complete information on this method and pregnancy termination services at the victim's request and complete information regarding the same.

[65] Mexico, Ministry of Health, "Modificación a la Norma Oficial Mexicana NOM-190-SSA1-1999, Prestación de servicios de salud. Criterios para la atención médica de la violencia familiar, para quedar como NOM-046-SSA2-2005. Violencia familiar, sexual y contra las mujeres. Criterios para la prevención y atención" in *Diario Oficial de la Federación*, Mexico, April 16, 2009. Available at <http://bit.ly/TWqlJZ> [accessed: October 22, 2012].

[66] Baja California Sur, Chihuahua, Colima, Mexico City, Oaxaca, Puebla, Quintana Roo, State of Mexico, and Zacatecas.

[67] Article 20. The criminal process shall be accusatory and oral. It will be governed by the principles of publicity, contradiction, concentration, continuity and intermediation: […] C. Regarding the rights of the victim or injured party: […] III. Receive emergency medical and psychological treatment from the time the offence is committed; […] The Public Prosecutor must guarantee protection for victims, injured parties, witnesses and in general all subjects involved in the process.[…]; VI. Request preventive measures and injunctions for protection and restitution of the plaintiff's rights, […].

[68] Public Prosecutor or a judge –based on the reform of the criminal justice system, some states designated the control judge jurisdiction to authorize abortion (State of Mexico, Puebla and Zacatecas). Some states do not explicitly designate jurisdiction. In this case one must assume that it is the Ministry of Health.

[69] Baja California Sur, Colima, Mexico City, Oaxaca, Puebla, Quintana Roo, State of Mexico, and Zacatecas.

[70] After integrating the new system of oral trials into its Penal Procedural Code, the State of Mexico designates the control judge jurisdiction in authorizing this procedure. Zacatecas and Puebla also designate the control judge jurisdiction in providing this authorization.
[71] It is important to mention that Mexico City requirements do not only refer to legal termination of pregnancy due to rape, but also include cases of forced artificial insemination. Of the nine states that have procedures in place, four of these include non-consensual artificial insemination as a legal indication for abortion: Baja California Sur, Chihuahua, Colima and Mexico City.

[72] In Penal Procedural Codes: Baja California Sur, Colima, Mexico City, Oaxaca, Puebla, Quintana Roo, State of Mexico and Zacatecas. In Public Prosecutor's Office protocols: Baja California, Chihuahua, Mexico City and Oaxaca.

[73] *Mexican Constitution*, Articles 73, 122 and 124, and the General Health Law, Article 1.

[74] Federal Government, Ministry of Health, *Sistema de Acceso a la Información Pública: Infomex*, File 0001200251412. Available at <http://bit.ly/ZujAqh> [accessed: February 20, 2013].

[75] Federal Government, Ministry of Health, *Sistema de Acceso a la Información Pública: Infomex*, File 0001200094812. Available at <http://bit.ly/X1JU8S> [accessed: February 20, 2013].

[76] Federal Government, ISSSTE, *Sistema de Acceso a la Información Pública: Infomex*, File 0063700297312. Available at <http://bit.ly/Wn9gdw> [accessed: February 20, 2013].

[77] Federal Government, Federal Attorney General, *Sistema de Acceso a la Información Pública: Infomex*, File 0001700168112. Available at <http://bit.ly/157lkoY> [accessed: February 20, 2013].

[78] Federal Government, Federal Attorney General, *Sistema de Acceso a la Información Pública: Infomex*, File 0001700168212. Available at <http://bit.ly/W99Xww> [accessed: February 20, 2013].

[79] Federal Government, Federal Attorney General, *Sistema de Acceso a la Información Pública: Infomex*, File 0001700168312. Available at <http://bit.ly/XntqYe> [accessed: February 20, 2013].

[80] Mexico City, Ministry of Health, *Sistema de Acceso a la Información Pública: Infomex: [request on the Legal Abortion Program]*. Available at <http://bit.ly/1qNUVG> [accessed: February 20, 2013].

[81] Schiavon, Raffaela et al., "Characteristics of Private Abortion Services in Mexico City after Legalization" in *Reproductive Health Matters*, vol. 18, no. 36, November, 2010, p. 133. Available at <http://bit.ly/Z31x5W> [accessed: February 20, 2013].

[82] *Mexico City Health Law*, Article 52. Care for sexual and reproductive health and family planning is a priority. Services provided in these areas constitute a means for all persons to make free, responsible and well-informed decisions concerning the number and spacing of their children, with full respect for their dignity.

[83] Has not emitted any authorizations for legal abortion due to the fact that no woman requested this service. Data received in response to the information request.

[84] Hidalgo, Nayarit and Tlaxcala.

[85] Campeche, Chihuahua, Jalisco, Michoacan, Morelos, Nuevo Leon, Puebla, San Luis Potosi, Sinaloa and Tamaulipas. San Luis Potosi stated that its state Penal Code does not include legal abortion after rape.

[86] Aguascalientes, Baja California Sur, Coahuila, Colima, Guanajuato, Queretaro, Quintana Roo, Sonora, Tabasco, Veracruz, Yucatan and Zacatecas.

[87] The State of Mexico referred us to the control judge and Chiapas referred us to its Ministry of Health.

[88] Baja California (3), Durango (1), Guerrero (3), Mexico City (30) and Oaxaca (2).

[89] Sonora, Public Prosecutor's Office, *Sistema de Acceso a la Información Pública: Infomex*, File 00413712. Available at <http://bit.ly/13ny6wP> [accessed: February 20, 2013].

[90] Baja California, Public Prosecutor's Office, *Sistema de Acceso a la Información Pública: Particular,* File 120876. Available at <http://bit.ly/XnubQQ> [accessed: February 20, 2013]. Guerrero, Public Prosecutor's Office, *Sistema de Acceso a la Información Pública: Infomex*, File 00108312. Available at <http://bit.ly/YDbOWM> [accessed: February 20, 2013]. Tlaxcala, Ministry of Health, *Sistema de Acceso a la Información Pública: Infomex*, File 000106612. Available at <http://bit.ly/VyDltk> [accessed: February 20, 2013].

[91] Guerrero, Public Prosecutor's Office, *Sistema de Acceso a la Información Pública: Infomex*, File 00184312. Available at <http://bit.ly/UMCfLr> [accessed: February 20, 2013].

[92] Mexico City, Ministry of Health, *Sistema de Acceso a la Información Pública: Infomex*, File 0113000156612. Available at <http://bit.ly/YJ0abj> [accessed: February 20, 2013].

[93] Baja California Sur, Chihuahua, Colima, Mexico City, Oaxaca, Puebla, Quintana Roo, State of Mexico and Zacatecas.

[94] Baja California, Chihuahua, Colima, Mexico City, Oaxaca and Quintana Roo.

[95] GIRE's documentation of cases includes monitoring and follow-up on reproductive rights violations. During the documentation process, GIRE intervenes in cases with various actions related to the legal defense of the women involved. GIRE's main objectives in documenting and litigating cases are: to document patterns and tendencies in the violation of women's reproductive rights; to establish legal precedents for reproductive rights at the federal and state level; defend the enforceability of women's reproductive rights included in the Constitution, including those acknowledged in international human rights treaties to which Mexico is party; and, using the above, develop reports and assessments to expose these patterns and tendencies.

[96] The woman's name was changed to protect her identity.

[97] *Ibid*.

[98] *Ibid*.

[99] *Ibid*.

[100] *Ibid*.

[101] *Ibid*.

[102] See Grupo de Información en Reproducción Elegida, *Paulina: Five Years Later,* 2nd edition, Mexico, GIRE, 2009. Available at < http://bit.ly/167Q1fp > [accessed: October 30, 2012].

[103] Aguascalientes, Baja California, Chihuahua, Durango, Guanajuato, Morelos, Oaxaca, State of Mexico, Tlaxcala and Veracruz.

[104] Campeche, Coahuila, Colima, Guerrero, Hidalgo, Mexico City, Nayarit, Nuevo Leon, Puebla, Queretaro, San Luis Potosi, Sinaloa and Tamaulipas.

[105] As of December 14, 2012, Baja California Sur and Sonora.

[106] Chiapas, Jalisco, Michoacan, Quintana Roo and Yucatan.

[107] Tabasco and Zacatecas.

[108] Indictment refers to the part of the criminal process when the Public Prosecutor exercises criminal action, initiating the procedure before the legal authority.

[109] The states of Guanajuato, Guerrero, Jalisco, Nuevo Leon, Oaxaca, Puebla, Sonora and Tamaulipas did not desegregate sentences into guilty verdicts and acquittals.

[110] Aguascalientes, Baja California, Campeche, Chiapas, Chihuahua, Guanajuato, Guerrero, Hidalgo, Jalisco, Mexico City, Michoacan, Morelos, Nuevo Leon, Oaxaca, Puebla, Queretaro, Sinaloa, Sonora, Tamaulipas, Veracruz, Yucatan and Zacatecas.

[111] Baja California Sur, Judicial Branch, *Sistema de Acceso a la Información Pública: Particular,* File ITAIBCS_210-2012. Available at <http://bit.ly/WfGdZe> [accessed: February 20, 2013]. Chiapas, Judicial Branch, *Sistema de Acceso a la Información Pública: Infomex,* File 5204. Available at <http://bit.ly/WfG6Nk> [accessed: February 20, 2013]. Sonora, Judicial Branch, *Sistema de Acceso a la Información Pública: Infomex*, File 00385012. Available at <http://bit.ly/YM0rKp> [accessed: February 20, 2013].

[112] In 2007, a 45-year-old man sentenced to 23 years, 6 months and 3 days; in 2009, a 32-year-old man sentenced to six years in prison.

[113] In 2007, one person; in 2008, one person with a 30-year sentence; in 2009, one person; in 2011, one person and in 2012, one person. Cases that do not list prison time have not yet been sentenced.

[114] In 2012, one man.

[115] Nayarit, Ministry of Public Security, *Sistema de Acceso a la Información Pública: Infomex*, File 00144712. Available at <http://bit.ly/12RYVO0> [accessed: February 20, 2013].

[116] Inform that, to date, one person is incarcerated at the Social Reintegration Center in San José El Alto, Queretaro, sentenced to 32 years in prison for illegal abortion, and another person in San Juan del Río prison, sentenced to 28 years, also for illegal abortion; both are men and were also sentenced for aggravated homicide.

[117] In 2009, one person.

[118] In 2008, one man sentenced to 28 years in prison, and in 2009, one man.

[119] Colima, Durango, Guanajuato, Hidalgo, Morelos, Puebla, Sinaloa, Tlaxcala and Zacatecas.

[120] Campeche, Mexico City, Nayarit, Nuevo Leon, San Luis Potosi, State of Mexico, Tabasco and Veracruz.

[121] Coahuila and Michoacan.

[122] GIRE's documentation of cases includes monitoring and follow-up on reproductive rights violations. During the documentation process, GIRE intervenes in cases with various actions related to the legal defense of the women involved. GIRE's main objectives in documenting and litigating cases are: to document patterns and tendencies in the violation of women's reproductive rights; to establish legal precedents for reproductive rights at the federal and state level; defend the enforceability of women's reproductive rights included in the Constitution, including those acknowledged in international human rights treaties to which Mexico is party; and, using the above, develop reports and assessments to expose these patterns and tendencies.

[123] Documentation could not be completed for these cases. GIRE registered them based on various sources including newspaper articles, information provided by the authorities or members of civil society organizations in Mexico, and direct contact with victims or their families. All names were changed to maintain confidentiality.

[124] The woman's name was changed to protect her identity.

[125] *Ibid*.

[126] *Ibid*.

[127] *Ibid*.

[128] *Ibid*.

[129] *Ibid*.

[130] *Ibid*.

[131] *Ibid*.

[132] *Ibid*.

[133] *International Covenant on Civil and Political Rights.*
Article 18.3. Freedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others. Available at <http://bit.ly/16KNIh2> [accessed: July 1, 2013].

[134] CEDAW Committee, *Concluding observations of the Committee on the Elimination of Discrimination against Women: Poland*, 37th Session (2007), paragraph 25, [CEDAW/C/POL/CO/6]. Available at <http://bit.ly/18s7uC7> [accessed: October 22, 2012].

[135] CEDAW Committee, *Concluding observations of the Committee on the Elimination of Discrimination against Women: Mexico… op. cit.* (see *supra*, note 61).

[136] Aguascalientes, Colima, Jalisco, Mexico City, Queretaro and Tlaxcala.

[137] *Aguascalientes State Health Law*, Articles 139 Undecies and 139 Duodecies.

[138] *Colima State Health Law*, Article 20 bis 1.

[139] *State Health Law,* Article 18 ter.

[140] *Mexico City State Health Law*, Article 59.

[141] *Queretaro State Health Law*, Article 45.

[142] *Tlaxcala State Health Law*, Article 44 bis-A.

[143] Only includes the obligation to inform the institution providing the service.

[144] *The International Covenant on Civil and Political Rights* and *the Convention on the Elimination of All Forms of Discrimination against Women*.

[145] Ministry of Health, "Norma Oficial Mexicana NOM-004-SSA3-2012, Del expediente clínico" in *Diario Oficial de la Federación*, October 15, 2012. Available at <http://bit.ly/RAelSX> [accessed: October 22, 2012].

[146] Article 210. A penalty from 30 to 200 days of community service will be imposed upon the person who, without just cause, resulting in damages to someone and without the consent of the person to whom damage may be caused, reveals a secret or a confidential statement that he/she has received due to his/her work, employment or position.

[147] Article 19. Carrying out the following functions corresponds to responsible parties mentioned in the previous article: […] V.- Notify the Public Prosecutor and, if relevant, additional competent authorities, of cases which require medical care for people with injuries or other signs presumably linked to unlawful acts.

[148] IACHR Court, *Case of De la Cruz Flores vs. Peru, Merits, Reparations and Costs. Judgment of November 18, 2004. Series C No. 115*, paragraph 97. Available at <http://bit.ly/14lupuv> [accessed: October 22, 2012].

[149] *Ibid*.

[150] There were 17 constitutional reforms carried out after this date, however, the Congress of Campeche reformed Article Six of its Constitution on August 16, 2012 to eliminate the second paragraph that protected life from "fertilization or conception". It is worth mentioning that Chihuahua's Constitution also includes the protection of life from conception in Article Five: "All humans beings have the right to legal protection of their lives, from the moment of conception". This reform was published on October 1, 1994, before other state reforms were carried out in reaction to the decriminalization of abortion in Mexico City.

[151] Grupo de Información en Reproducción Elegida, Derechos humanos de las mujeres y protección de la vida prenatal en México, México, GIRE, 2013. Available at <http://bit.ly/XJdkcfs> [accessed: March 13, 2013].

[152] "No, in any case we need to see if Article Seven, in a certain way what it is establishing is a protection of the unborn, which states: For us, at the moment of conception. But this does not, by any means, signify that this is absolute, something for which no regulations can be established […]" Written transcript of the ordinary public session of the Mexican Supreme Court, Tuesday, September 27, 2011, pp. 60 and 61. Available at <http://bit.ly/Yd1asY> [accessed: June 8, 2012].

[153] Luis María Aguilar Morales, José Ramón Cossío Díaz, Fernando Franco González Salas, Olga Sánchez Cordero, Juan Silva Meza, Sergio Valls Hernández and Arturo Zaldívar Lelo de Larrea.

2.

CONTRACEPTION

2.1 / INTRODUCTION

Respect, protection and the guarantee of the right to contraception information and services is particularly important for women, since it is they who bear the main negative effects of an unwanted pregnancy. Lack of access to contraception information and services has a direct impact on women's right to make a free and informed decision regarding the timing and spacing of their children, which violates their rights guaranteed by Article 4 of the Mexican Constitution.

The right to contraception information and services is based on the right to life; the right to health, including sexual and reproductive health; the right to privacy; the right to equality and non-discrimination; the right to reproductive autonomy and the right to decide on the number and spacing of one's children. These rights are recognized in the Mexican Constitution and in international human rights treaties to which Mexico is party and involve States' obligation to ensure access to a wide variety of contraceptive methods that meet individuals' needs; access to information that allows informed decisions free from coercion or violence, as well as access to quality services that respect confidentiality and meet the needs of specific sectors of the population, such as adolescents.

Various international and regional human rights organisms have issued recommendations to States, designed to promote, respect, protect and ensure access to contraception information and services. At the International Conference on Population and Development, held in Cairo in 1994, the international community pledged to develop population policies with a focus on women's reproductive rights, including the right to decide the number and spacing of their children and the right to sexual and reproductive health.[1]

In its General Recommendation 19 on Violence against Women, the Committee on the Elimination of Discrimination against Women (CEDAW Committee) highlighted the need to prevent acts of coercion related to women's fertility and reproduction.[2] In its General Recommendation 24 on Women and Health, this same Committee advises States to take action to address all aspects of health care for women and girls, including access to contraception and family planning resources.[3] Both this Committee and the Committee on Human Rights have acknowledged that access to contraceptives is an important means of protecting women's lives.[4]

Another issue of concern for human rights mechanisms is adolescents' need for access to contraception, due to high pregnancy rates in that age group. In 2012, the CEDAW Committee expressed concern regarding the situation in Mexico,[5] and the Committee on the Rights of the Child has recommended that States eliminate the obligation for parental consent in accessing contraception.[6]

It is essential to analyze the fulfillment of the right to contraception information and services, both in terms of the law and policy and effective access, particularly for women and adolescents.

2.2 / SITUATION IN MEXICO

In Mexico, the right to contraception information and services is governed by law and policy related to population and health; both are based on general laws issued by Congress,[7] the General Population Law and the General Health Law concerning provision of health care services. For health regulations, each Mexican state has its own local law because it is a concurrent jurisdiction.

In addition to the above regulations, there are two Official Mexican Norms on this subject: NOM-005-SSA2-1993, Family Planning Services (NOM 005), published on January 21, 2004, and NOM-046-SSA2-2005, Domestic and Sexual Violence and Violence against Women (NOM 046), published on April 16, 2009. These laws and policies are discussed in the next section of this chapter.

According to statistical data related to the provision of contraception information and services, access remains precarious and insufficient, and the lack of access for adolescents and vulnerable populations, such as indigenous women, is a particular cause for concern. The use of these methods among women of childbearing age married or in union rose from 68.5% in 1997 to 72.5% in 2009.

This means that, as of 2009, only 12.1 million women of childbearing age married or in union used contraceptives.[8] In 2009, contraceptive coverage rose to 72.5% among women married or in union, but remained at only 58.3% among indigenous women, 63.7% among women living in rural communities and 60.5% among women with little schooling.[9]

These figures show that one of the major challenges facing Mexico is to extend coverage to marginalized or vulnerable populations.

Information from 2009 demonstrates that 97% of young women of childbearing age are aware of some contraceptive method, but only 54.9% of sexually active girls between the ages of 15 and 19 use one and 61.5% of young women in this age range report not having used contraception in their first sexual intercourse.[10]

This situation has a direct impact on adolescent pregnancy rates. According to the available information, first pregnancies occur most frequently among minors (26.8%), followed by women between the ages of 18 and 20 (14.5%), and those between the ages of 21 and 23 (20.7%).[11] In 2009, adolescents accounted for just over 27% of the sexually active unmarried population.[12]

The National Survey of Demographic Dynamics (ENADID) 2009 found that the fertility rate among women under 20 years of age reverted, *i.e.* stopped falling and rose for the first time, from 16 to 17.4 per 100,000 births between 2000 and 2008. The same trend is observed for specific fertility rates: the National Population Council (CONAPO) estimates that in 2003-2005, for every 1,000 women between the ages of 15 to 19 years, approximately 65 had given birth. This figure rose to 69.5 for the period 2006-2008.[13]

The statistics reflect an unmet need for access to quality contraception information and services tailored to each individual woman's specific needs. CONAPO recognizes that there are still inequalities in effective access to contraceptives, especially for adolescents, women with little schooling and women living in rural areas.[14]

2.3 / LEGAL AND POLICY FRAMEWORK

The regulation of the right to contraception information and services is based on Articles 4 and 73 of the Mexican Constitution[15] and on the provisions of international treaties to which Mexico is party, specifically Articles 10, 12, 14 and 16 of the Convention for the Elimination of all Forms of Discrimination against Women (CEDAW).

At the national level, law and policy applicable to this issue are the General Health Law, the General Population Law, the General Health Law's regulations concerning provision of health care services, the General Population Law's regulations, the General Law for Victims and the Official Mexican Norms NOM 005 and NOM 046, as well as state health laws.

Based on the above and the June 2011 constitutional reform on human rights, all competent authorities in the areas of health and population are obligated to comply with the highest standards of protection of women's human rights in the regulation and exercise of the right to contraception information and services.

The Constitution and other law and policy related to the subject refer to family planning rather than contraception, so it is essential to note that the concept of family planning should be interpreted in accordance with human rights regulation. This ensures that the right to contraception information and services applies to all individuals, regardless of their marital status or desire to form a family.

2.3.1 GENERAL HEALTH LAW AND ITS REGULATIONS

The underlying legislation governing the actions of federal and state authorities with regard to health is the General Health Law, which states that family planning is a basic general health service.[16]

Articles 67, 68, 69, 70 and 71 of this Law establish the family planning services and information to be provided and the agencies responsible. The following table summarizes how the law addresses the issue:

FAMILY PLANNING	
INFORMATION	INFORMATION AND EDUCATIONAL GUIDANCE FOR ADOLESCENTS.
	TIMELY, EFFICIENT AND COMPLETE CONTRACEPTION INFORMATION.
SERVICES A MEANS OF EXERCISING THE UNIVERSAL RIGHT TO DECIDE THE NUMBER AND SPACING OF CHILDREN IN A FREE, RESPONSIBLE AND INFORMED MANNER.	PROMOTION OF THE DEVELOPMENT OF EDUCATIONAL COMMUNICATION PROGRAMS
	CARE AND MONITORING OF THOSE WHO ACCEPT AND USE FAMILY PLANNING SERVICES.
	GUIDANCE FOR THE PROVISION OF FAMILY PLANNING SERVICES.
	SUPPORT AND PROMOTION OF RESEARCH IN THE FIELD.
	PARTICIPATION IN THE MECHANISM FOR DETERMINING, DEVELOPING, ACQUIRING, STORING AND DISTRIBUTING FAMILY PLANNING SUPPLIES.
NATIONAL FAMILY PLANNING PROGRAM	NATIONAL FAMILY PLANNING PROGRAM.
	MINISTRY OF HEALTH: IMPLEMENTS PROGRAM ACTIONS.

According to these regulations, family planning services are a means of exercising the universal right to decide on the number and spacing of children. These services include information and counseling on contraception, supplies and promotion.

The General Health Law provides for public sector development of family planning programs, care and monitoring of those who accept and use family planning services, as well as guidance on the provision of these services.

With regard to the National Family Planning Program, the General Health Law states that the agency in charge of its design will be CONAPO, meaning that in Mexico, public policy related to contraception information and services must consider population, development and health policies. This does not necessarily have a negative impact for women, provided that the rationale for this policy must be the protection and guarantee of their reproductive rights.

One of the challenges faced by the National Family Planning Program and other programs run by the executive branch is the lack of continuity in related public policies and actions, due to changes in federal administrations every six years, and the lack of well-defined follow-up mechanisms. This often has a negative impact on policy implementation.

The General Health Law's regulations concerning the provision of health care services[17] establish the power of the Ministry of Health to issue technical standards and provide guidance and technical support to public, social and private sector institutions in the provision of basic family planning services.

The regulation also states that social, government and private institutions have an obligation to provide free, on-site information, and orientation and promotion services for family planning, in accordance with the standards set out by the Ministry of Health.

2.3.2 GENERAL POPULATION LAW AND ITS REGULATIONS

Article 5 of the General Population Law includes the creation of CONAPO, in charge of the country's demographic planning. On April 14, 2000, the General Population Law's regulations were published in the Official Gazette of the Federation,[18] establishing a section on family planning summarized below:

FAMILY PLANNING GENERAL POPULATION LAW'S REGULATIONS	
FAMILY PLANNING	IS THE EXERCISE OF THE UNIVERSAL RIGHT TO MAKE FREE, RESPONSIBLE AND INFORMED DECISIONS REGARDING THE NUMBER AND SPACING OF ONE'S CHILDREN AND TO OBTAIN SPECIALIZED INFORMATION AND IDEAL SERVICES FOR THIS PURPOSE.
PLANNING PROGRAMS	INDICATIVE AND WITH A GENDER PERSPECTIVE.
	PROVIDE GENERAL AND INDIVIDUALIZED INFORMATION ABOUT ITS GOALS, METHODS AND CONSEQUENCES.
	ABILITY TO RESPONSIBLY EXERCISE THE RIGHT TO DECIDE THE NUMBER AND SPACING OF ONE'S CHILDREN.
	PROVIDE INFORMATION ABOUT DEMOGRAPHICS AND REPRODUCTIVE HEALTH IN CLEAR AND UNDERSTANDABLE TERMS.
	INSTRUCT ON THE LEGALLY-PERMITTED METHODS FOR MANAGING FERTILITY.
INFORMATION	GUARANTEE INDIVIDUALS' FREE DECISIONS ABOUT METHODS FOR MANAGING FERTILITY.
	DO NOT IDENTIFY FAMILY PLANNING WITH BIRTH CONTROL OR OTHER TERMS THAT IMPLY COERCIVE ACTIONS THAT PREVENT THE FREE EXERCISE OF THE RIGHT TO DECIDE THE NUMBER AND SPACING OF CHILDREN.
	PRESENT THE BENEFITS OF DECIDING IN A FREE AND RESPONSIBLE MANNER THE NUMBER AND SPACING OF CHILDREN.
	INFORMATION FOR YOUNG PEOPLE AND ADOLESCENTS.
	FREE OF CHARGE – WHEN PROVIDED BY THE PUBLIC SECTOR.
	PERMANENT PROGRAMS.
SERVICES	GUARANTEE THE RIGHT TO FREELY DECIDE REGARDING METHODS FOR MANAGING FERTILITY.
	BASED ON A GENDER PERSPECTIVE.
	PROHIBITS OBLIGATING INDIVIDUALS TO USE FERTILITY MANAGEMENT METHODS AGAINST THEIR WILL.
	INTEGRATE AND COORDINATE WITH HEALTH SERVICES, REPRODUCTIVE HEALTH, EDUCATION, SOCIAL SECURITY AND PUBLIC INFORMATION.
	FREE OF CHARGE – WHEN PROVIDED BY THE PUBLIC SECTOR.
	PERMANENT PROGRAMS.
	OFFICIAL MEXICAN NORMS.

As illustrated in the above table, in accordance with the General Population Law's regulations, family planning programs should be based on the universal right to make free, responsible and informed decisions regarding the number and spacing of children and to obtain specialized information and ideal services for this purpose. Based on the recognition of this right, programs, information, services and regulations must guarantee the exercise of this right to all individuals, including young people and adolescents.

These regulations also indicate that, based on the Federal Law on Metrology and Standardization, Official Mexican Norms shall be issued on family planning, health and reproductive health services. The following section presents an analysis of Mexican law and policy on contraception and emergency contraception, applicable throughout the country.

2.3.3 CONTRACEPTION, OFFICIAL MEXICAN NORM 005-SSA2-1993, FAMILY PLANNING SERVICES

The resolution modifying Official Mexican Norm 005-SSA2-1993 on family planning services was published in the Official Gazette of the Federation on January 21, 2004. Its contents are summarized below:

NOM 005-SSA2-1993, FAMILY PLANNING SERVICES	
PURPOSE	STANDARDIZE OPERATING CRITERIA, POLICIES AND STRATEGIES FOR THE PROVISION OF FAMILY PLANNING SERVICES IN MEXICO WITHIN A FRAMEWORK OF TOTAL FREEDOM AND RESPECT FOR INDIVIDUALS' DECISIONS AND FOLLOWING A SYSTEMATIC COUNSELING PROCESS BASED ON A HOLISTIC APPROACH TO REPRODUCTIVE HEALTH.
AREA OF APPLICATION	COMPLIANCE REQUIRED FOR ALL HEALTH INSTITUTIONS, FOR THE PROVISION OF FAMILY PLANNING SERVICES IN THE GOVERNMENT, SOCIAL AND PRIVATE SECTORS THROUGHOUT THE COUNTRY.
FAMILY PLANNING SERVICES	PROVIDE INFORMATION, ORIENTATION, COUNSELING, SELECTION, PRESCRIPTION, CONTRAINDICATIONS AND APPLICATION OF FERTILITY CONTROL METHODS.
	CONTRIBUTE TO THE REDUCTION OF UNPLANNED AND UNWANTED PREGNANCIES BY: I. PREVENTION. 2. ORIENTATION, COUNSELING. 3. GENERAL AND SPECIFIC CARE.
ACTIVITIES FOR FAMILY PLANNING SERVICES	I. PROMOTION AND DISSEMINATION. 2. INFORMATION AND EDUCATION. 3. COUNSELING. 4. SELECTION, PRESCRIPTION AND APPLICATION OF CONTRACEPTIVE METHODS. 5. IDENTIFICATION AND REFERRAL OF CASES OF INFERTILITY.

NOM 005-SSA2-1993, FAMILY PLANNING SERVICES	
QUALITY CRITERIA FOR FAMILY PLANNING SERVICES	MANNER IN WHICH INDIVIDUALS AND COUPLES SHOULD RECEIVE CARE: 1. VARIETY OF CONTRACEPTIVE METHODS AVAILABLE. 2. INFORMATION PROVIDED TO PATIENTS. 3. TECHNICAL COMPETENCE OF SERVICE PROVIDERS. 4. RELATIONSHIP BETWEEN SERVICE PROVIDERS AND PATIENTS. 5. MONITORING MECHANISMS TO PROMOTE CONTINUED USE OF CONTRACEPTIVE METHODS. 6. APPROPRIATE AND COORDINATED SET OF HEALTH SERVICES. 7. CONFIDENTIALITY AND PRIVACY IN COUNSELING.
CARE OF ADOLESCENTS	COUNSELING SHOULD PROVIDE SPECIAL CARE FOR ADOLESCENTS.

2.3.4 EMERGENCY CONTRACEPTION (HORMONAL POST-COITAL CONTRACEPTION), OFFICIAL MEXICAN NORM 046-SSA2-2005, DOMESTIC AND SEXUAL VIOLENCE AND VIOLENCE AGAINST WOMEN

In Mexico, emergency contraception has been included progressively in both general and binding policies issued by the Ministry of Health. This means that health services in all areas – federal and state, government, social and private – must comply with the guidelines established in these regulations and provide emergency contraception information and services.

Emergency contraception has been included in NOM 005 since January 21, 2004, for cases of consensual sex without contraceptive protection, forced sexual intercourse without contraceptive protection, or in the case of failure of a contraceptive method. On July 11, 2005, a dedicated emergency contraception product was included for the first time in the health sector's Essential Medicines List.

On April 16, 2009, NOM 046 was published in the Official Gazette of the Federation, replacing NOM-190-SSAI-1999, Delivery of Health Services, which also included emergency contraception for rape survivors.

NOM-046-SSA2-2005, DOMESTIC AND SEXUAL VIOLENCE AND VIOLENCE AGAINST WOMEN	
PURPOSE	ESTABLISH CRITERIA TO BE OBSERVED IN THE DETECTION, PREVENTION, CARE AND ORIENTATION PROVIDED TO HEALTH SERVICE PATIENTS IN GENERAL AND IN PARTICULAR THOSE INVOLVED IN SITUATIONS OF DOMESTIC OR SEXUAL VIOLENCE.
AREA OF APPLICATION	COMPLIANCE REQUIRED BY INSTITUTIONS IN THE NATIONAL HEALTH SYSTEM AND HEALTH SERVICE PROVIDERS IN THE PUBLIC, SOCIAL AND PRIVATE SECTORS.
EMERGENCY CONTRACEPTION IN THE EVENT OF SEXUAL ASSAULT	TO BE TREATED AS MEDICAL EMERGENCIES DEMANDING IMMEDIATE ATTENTION.
	OFFER EMERGENCY CONTRACEPTION IMMEDIATELY AND UP TO A MAXIMUM OF 120 HOURS FOLLOWING THE EVENT, INCLUDING COMPLETE INFORMATION REGARDING THE USE OF THIS METHOD, SO THAT THE INDIVIDUAL CAN MAKE A FREE AND INFORMED DECISION.

The Norm was challenged by the Governor of Jalisco through an unconstitutionality claim, alleging violations to the Mexican Constitution and arguing that the Norm had not been issued by a competent authority, since regulations relating to law enforcement and family planning correspond to state congresses and the authority to care for victims of domestic violence corresponds exclusively to the Public Prosecutor. It also argued that the Norm allows abortions to be carried out in cases not included in Jalisco state law, creating a burden for individuals by establishing an obligation to provide medical care to victims of certain crimes and encouraging discrimination against health providers who invoke conscientious objection.[19]

In May 2010, the Supreme Court validated the constitutionality of NOM 046. In its resolution, the Court established that attention to victims of crime is not the exclusive jurisdiction of the Public Prosecutor, since some issues are health-related, and, as such, fall under the responsibility of the National Health System. With regard to jurisdiction, the publication of Official Mexican Norms in matters of public health is an exclusive power of the executive branch,[20] and as such it can issue policies in this area.[21]

On January 9, 2013, the General Law for Victims was published in the Official Gazette of the Federation. Article 39 of this law recognizes rape survivors' right to access emergency contraception, and establishes that each public agency that provides services, support and care for victims must have personnel trained in treating sexual violence based on a cross-cutting gender perspective.

Public institutions belonging to the National Health System are required to provide emergency contraception to women, no later than 120 hours after a sexual assault, along with information regarding the use of this method.[22]

2.3.5 STATE REGULATION ON CONTRACEPTION

In addition to general and federal law and policy, each state has a health law, except for the State of Mexico which only has policy on this issue.[23] Most of these laws[24] expressly provide for access to contraception information and services, and are referred to as: family planning,[25] reproductive health,[26] sexual and reproductive health,[27] or sexual health, reproductive health and family planning services.[28]

The following table summarizes how states regulate contraception information and services:

CONTRACEPTION INFORMATION AND SERVICES

STATE	NAME	OBLIGATION TO PROVIDE CONTRACEPTION INFORMATION	SERVICES AS A MEANS OF EXERCISING THE RIGHT TO MAKE FREE, RESPONSIBLE AND INFORMED DECISIONS REGARDING THE NUMBER AND SPACING OF CHILDREN
AGUASCALIENTES	FAMILY PLANNING	TIMELY, EFFECTIVE AND COMPREHENSIVE, TO THE COUPLE	YES
BAJA CALIFORNIA	FAMILY PLANNING	TIMELY, EFFECTIVE AND COMPREHENSIVE, TO THE COUPLE	YES
BAJA CALIFORNIA SUR	FAMILY PLANNING	TIMELY, EFFECTIVE AND COMPREHENSIVE, TO THE COUPLE	YES
CAMPECHE	FAMILY PLANNING	TIMELY, EFFECTIVE AND COMPREHENSIVE, TO THE COUPLE	YES
CHIAPAS	FAMILY PLANNING	NO REFERENCE MADE TO CONTRACEPTION INFORMATION	NOT EXPRESSLY[29]
CHIHUAHUA	REPRODUCTIVE HEALTH	NO REFERENCE MADE TO CONTRACEPTION INFORMATION IN GENERAL[30]	YES
COAHUILA	FAMILY PLANNING	TIMELY, EFFECTIVE AND COMPREHENSIVE, TO THE COUPLE	YES
COLIMA	SEXUAL HEALTH, REPRODUCTIVE HEALTH, FAMILY PLANNING AND CONTRACEPTION	ASSUMES ROLE OF HEALTH COUNSELOR ON CONTRACEPTION	YES
DURANGO	FAMILY PLANNING	TIMELY, EFFECTIVE AND COMPREHENSIVE, TO THE COUPLE	YES
GUANAJUATO	FAMILY PLANNING	TIMELY, EFFECTIVE AND COMPREHENSIVE, TO THE COUPLE	YES
GUERRERO	FAMILY PLANNING	TIMELY, EFFECTIVE AND COMPREHENSIVE, TO THE COUPLE	YES
HIDALGO	FAMILY PLANNING	REFERS TO THE GENERAL HEALTH LAW	
JALISCO	FAMILY PLANNING	NO REFERENCE MADE TO CONTRACEPTION INFORMATION	YES
MEXICO CITY	SEXUAL AND REPRODUCTIVE HEALTH	ASSUMES ROLE OF HEALTH COUNSELOR ON CONTRACEPTION	YES
MICHOACAN	FAMILY PLANNING	REFERS TO THE GENERAL HEALTH LAW	
MORELOS	REPRODUCTIVE HEALTH	THE GENERAL PURPOSE OF REPRODUCTIVE HEALTH IS TO PROVIDE INFORMATION	YES
NAYARIT	SEXUAL HEALTH, REPRODUCTIVE HEALTH AND FAMILY PLANNING	INCLUDING FAMILY PLANNING TIMELY, EFFECTIVE AND COMPREHENSIVE, TO THE COUPLE	YES YES
NUEVO LEON	FAMILY PLANNING	NO REFERENCE MADE TO CONTRACEPTION INFORMATION	YES
OAXACA	REPRODUCTIVE HEALTH	TIMELY, EFFECTIVE AND COMPREHENSIVE, TO THE COUPLE	YES
PUEBLA	FAMILY PLANNING	TIMELY, EFFECTIVE AND COMPREHENSIVE, TO THE COUPLE	YES
QUERETARO	REPRODUCTIVE HEALTH	NO REFERENCE MADE TO CONTRACEPTION INFORMATION	YES
QUINTANA ROO	FAMILY PLANNING	TIMELY, EFFECTIVE AND COMPREHENSIVE, TO THE COUPLE	YES
SAN LUIS POTOSI	REPRODUCTIVE HEALTH	TIMELY, EFFECTIVE AND COMPREHENSIVE, TO THE COUPLE[31]	YES
SINALOA	FAMILY PLANNING	NO REFERENCE MADE TO CONTRACEPTION INFORMATION	YES
SONORA	FAMILY PLANNING	TIMELY, EFFECTIVE AND COMPREHENSIVE, TO THE COUPLE	NO
STATE OF MEXICO	NO STATE HEALTH LAW		
TABASCO	SEXUAL AND REPRODUCTIVE HEALTH	TIMELY, EFFECTIVE AND COMPREHENSIVE TO MEN AND WOMEN	YES
TAMAULIPAS	FAMILY PLANNING	NO REFERENCE MADE TO INFORMATION ON CONTRACEPTION	YES
TLAXCALA	FAMILY PLANNING	TIMELY, EFFECTIVE AND COMPREHENSIVE, TO THE COUPLE	YES
VERACRUZ	FAMILY PLANNING	NO REFERENCE MADE TO CONTRACEPTION INFORMATION	YES
YUCATAN	FAMILY PLANNING	TIMELY, EFFECTIVE AND COMPREHENSIVE, TO THE COUPLE	YES
ZACATECAS	FAMILY PLANNING	NO REFERENCE MADE TO CONTRACEPTION INFORMATION	YES

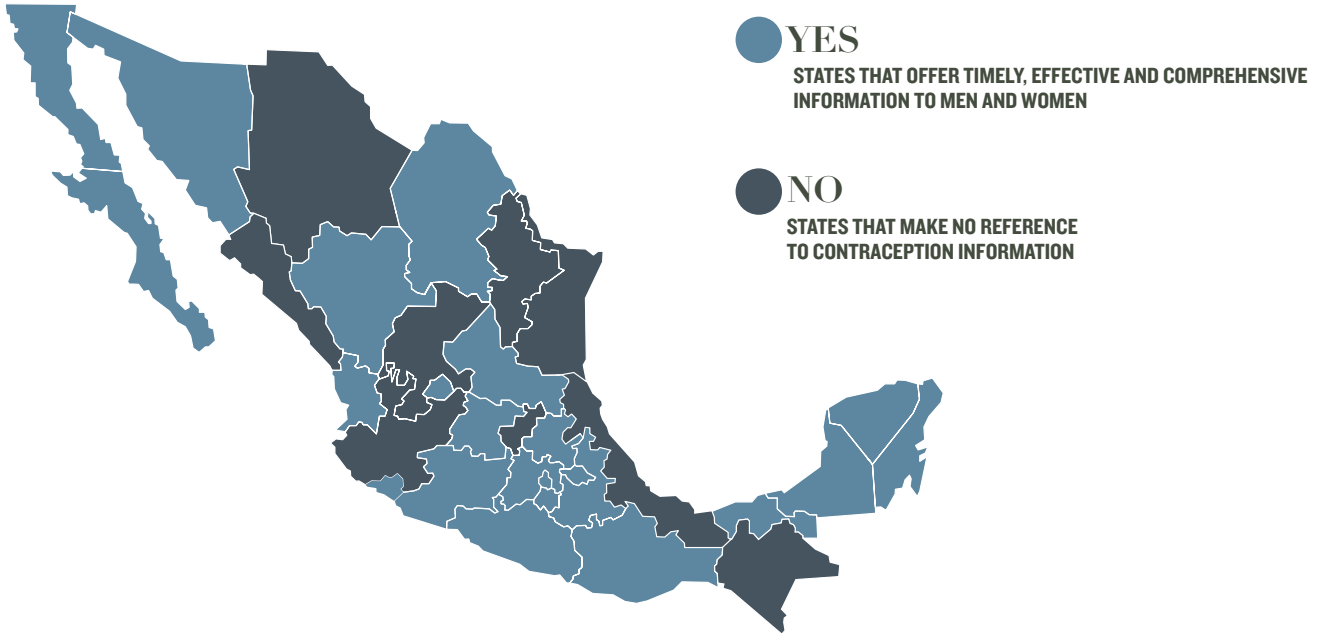
State health laws usually expressly state that family planning and/or reproductive health services are a means of exercising the right to decide the number and spacing of children. The General Health Law is the basis for state regulation; this legislation should be applied in conjunction with NOM 005, which establishes the technical specifications for the provision of such services.

Most legislation refers to the provision of contraceptive services to couples, an erroneous implementation of Article 4 of the Constitution which states that the right to make free, responsible and informed decisions about the number and spacing of children belongs to the individual, and that its exercise is not dependent on having a partner. Since this right is protected at the constitutional level, limits cannot be placed on individuals' right to contraception information and services. In accordance with the Mexican State's human rights obligations, state legislation should be modified to align with the Constitution and international treaties.

Laws and policies in at least nine states make no explicit reference to the provision of information on contraception.

Although the General Health Law, the General Population Law and Official Mexican Norms establish states' obligation to provide information on contraception, this should also be reiterated explicitly in each state's law and policy.

STATES THAT EXPRESSLY REFER TO THE PROVISION OF CONTRACEPTION INFORMATION



2.3.6 INFORMED CONSENT

In order to fully exercise the right to contraception information and services, it is important that women have accurate and objective information so they can choose the option that best suits their interests and reproductive needs. Therefore, health care providers should ensure that women offer informed consent to any reproductive health procedure, without any form of coercion, violence or discrimination. This is particularly relevant for semi-permanent contraceptive methods (such as the intrauterine device or IUD) or permanent methods (such as sterilization).

The General Health Law establishes sanctions for those who practice sterilization without the patient's consent or pressure them to accept the procedure. Apart from this specific mention, the law does not establish any other provision concerning women's right to grant informed consent and health care providers' corresponding obligations. This law regarding provision of medical care states that in order to carry out a tubal ligation or vasectomy, express written permission of those requesting the procedure must be obtained, following the provision of information regarding the intervention and its consequences. It also establishes that said operations must be carried out in accordance with relevant technical standards.

The General Population Law's regulations are more specific and state that:

> Article 20. Health, reproductive health, educational and informational services related to family planning services guarantee that individuals can make free decisions on methods to regulate their fertility.
>
> Forcing individuals to use methods of fertility regulation against their will is prohibited. When individuals choose to use a permanent contraception method, institutions or agencies providing the service must take responsibility to ensure that users receive proper guidance regarding the choice of the method, and obtain their consent with a signature or fingerprint on the corresponding official forms.

The General Health Law, the General Health Law's regulations on the provision of health care services and the General Population Law's regulations lack sufficient parameters on informed consent, and these considerable gaps must be filled. As previously pointed out, the General Health Law and its regulations regarding the provision of health care services refer to informed consent only in the case of surgical sterilization. Although the General Population Law's regulations are broader, they do not include critical issues necessary to ensure informed consent and are an integral part of international human rights standards. In the case of *A.S. vs. Hungary*, the CEDAW Committee resolved that the State violated human rights of A.S., a Hungarian woman of Roma origin, by failing to obtain her informed consent for a sterilization procedure.[32]

Legislation should make clear that the information provided on reproductive health, including contraception, must include all the alternatives, risks and benefits of the procedures, and must be accurate, objective, impartial, and free from prejudice and discrimination. It should also include the obligation to provide the information in a language appropriate to the client and in conditions free from stress and coercion.

Although some of these issues are not established in law, they are included in NOM 005. For example, NOM 005 requires that information provided to individuals must be accurate, timely and confidential, and that counseling should consist of a dialogue between the provider and the patient. Although these are fundamental aspects, content could be improved with respect to the details listed above. The current definition of informed consent in NOM 005 could also be strengthened:

> Informed consent: A voluntary decision to undergo a contraceptive procedure, with full knowledge and understanding of relevant information, free from pressure.

This definition should establish that informed consent must be based on the principles of autonomy and privacy; that it should consist of a dialogue between the health service provider and the patient; explicitly establish the characteristics of the information to be provided (accuracy, objectivity, among others) and should change the concept of pressure to that of freedom from coercion, violence and discrimination.

According to NOM 005, only the following contraceptive methods require written informed consent: bilateral tubal occlusion (provision 4.4.1.55) and vasectomy (provision 4.4.1.5). With regard to emergency contraception, NOM 046 states that health care providers must provide rape survivors complete information on the use of emergency contraception, so that they can make a free and informed decision.

Health laws in 20 Mexican states[33] include sanctions for those carrying out sterilization procedures against an individual's will, as does the General Health Law. However, they do not include specific clauses on informed consent. While NOM 005 is applicable at the state level, it is very important that state laws explicitly establish health care providers' obligation to ensure informed consent is obtained from patients for all reproductive health services, including contraceptives.

2.3.7 ACCESS FOR ADOLESCENTS

As described in the "Situation in Mexico" section of this chapter, the consequences of the lack of recognition, protection and guarantee of adolescents' right to contraception information and services in recent years is concerning. In July 2012, the CEDAW Committee made a recommendation to the Mexican State to ensure universal access to health services and information, and to education on sexual and reproductive rights in order to prevent unwanted pregnancies among adolescents.[34]

Additionally, Article 67 of the General Health Law states that family planning services should include information and educational guidance for adolescents and youth.

Health laws in 21 states[35] explicitly include adolescents in family planning services. Regulations in Tabasco deserve special mention, as they recognize the right of every individual of reproductive age to use contraceptive methods, regardless of age, explicitly stating that permission from parents or guardians is not required.[36]

As demonstrated above, state regulations regarding contraception are not fully harmonized with the highest standards of human rights protection nor with federal law, particularly in relation to informed consent and adolescents' access to contraception information and services.

Gaps in state legislation regarding adolescents' access to contraception are concerning because they can translate into denials of services and information. On the one hand, use of the concept of family planning rather than contraception *per se* represents a very limited perspective on access to these services for adolescents and youth. On the other hand, the fact that many states do not explicitly establish access to contraceptive services and information for adolescents and youth can result in barriers to access for these populations.

Tabasco is a model for state legislation because it establishes the provision of services regardless of age, and explicitly establishes that the consent of parents or guardians is unnecessary for access to services.

The General Population Law's regulations make no mention of adolescents' access to contraception information and services. NOM 005, however, establishes that adolescents deserve particular attention with regard to family planning services. The Ministry of Health has presented a new draft of the NOM-047-SSA2 2009, Health Care for the 10-19 Age Group, which establishes general criteria for access to health services (including sexual and reproductive health services) for adolescents and youth. It is important to point out that this draft, which was submitted to the Federal Regulatory Improvement Commission and has yet to be approved by the National Standardization Advisory Committee, makes counseling adolescents on sexual and reproductive health and medical examination conditional on the presence of the parent or guardian.

Civil society organizations and experts in the field demand that these services be provided directly to adolescents, and that they can request accompaniment by a trusted adult (not necessarily the parent or guardian) but their presence should not be required. Civil society organizations also demand that, when obtaining informed consent from a young person or adolescent for an invasive or risky medical procedure, in addition to the consent of the parents or guardians, the developmental capacities of the child and his or her best interest should be taken into account.

2.4 / IMPLEMENTATION OF THE LEGAL AND POLICY FRAMEWORK

To develop this report, in addition to analysis of the regulatory framework, GIRE sent requests for access to public information to federal and state health institutions, to the Attorney General's Office (PGR) and to State Public Prosecutor's Offices in order to determine the level of implementation of law and policy related to emergency contraception information and supply, as well as effective access to contraception for adolescents and the manner in which informed consent is obtained.

2.4.1 EMERGENCY CONTRACEPTION

To obtain information on emergency contraception, GIRE filed requests for access to information to the PGR and State Public Prosecutor's Offices to find out what information they provide on emergency contraception to rape survivors.

A number of State Public Prosecutor's Offices responded that they do not have this information, from which we may infer that do not provide information on contraception nor do they document the provision of such information. It is concerning that information on such an important subject is neither provided nor generated.

INFORMATION ON EMERGENCY CONTRACEPTION STATE PUBLIC PROSECUTOR'S OFFICES

STATE	INFORMATION[37]	LEAFLETS
AGUASCALIENTES	PROVIDES NO INFORMATION, AND HAS NO PRESCRIPTIONS OR MEDICATION. INDICATES THAT CASES ARE DIRECTED TO THE STATE HEALTH INSTITUTE, HEALTH CENTERS OR HIDALGO HOSPITAL.	NO
BAJA CALIFORNIA	IN MEXICALI AND TIJUANA, PUBLIC PROSECUTOR STAFF DOES NOT PROVIDE INFORMATION ON EMERGENCY CONTRACEPTION TO WOMEN WHO REPORT THIS CRIME, NOR DO THEY GIVE THEM ANY LEAFLET OR REFERENCE DOCUMENT; HOWEVER, THEY ARE DIRECTED TO THE DEPARTMENT OF ATTENTION TO VICTIMS OF CRIME. IN THE RESEARCH UNITS OF THE NEW CRIMINAL JUSTICE SYSTEM IN MEXICALI, IF A CRIME OF A SEXUAL NA TURE IS REPORTED, VICTIMS ARE SENT DIRECTLY TO THE DEPARTMENT FOR ATTENTION TO VICTIMS OF CRIME IN THE SAME INSTITUTION, WHERE, IN TURN, THEY ARE SENT TO THE GENERAL HOSPITAL SO THAT THEY CAN RECEIVE THE MEDICAL SUPPORT AND INFORMATION NECESSARY FOR PROPER CARE RELATED TO THE CRIME. THE LATTER IS THE OFFICE RESPONSIBLE FOR PROVIDING THE SPECIFIC INFORMATION AND ORIENTATION. IN TECATE, WOMEN ARE NOT GIVEN A BROCHURE OR DOCUMENT EITHER; HOWEVER THEY ARE REFERRED TO THE NEAREST HEALTH CENTER AND FAMILY PLANNING DEPARTMENT, TO RECEIVE INFORMATION ON EMERGENCY CONTRACEPTION METHODS. THE DEPUTY PUBLIC PROSECUTOR'S OFFICE, BASED IN ENSENADA, REPORTED THAT THE VICTIMS OF THIS CRIME ARE OFFERED PSYCHOLOGICAL SUPPORT IN THE DEPARTMENT FOR ATTENTION TO VICTIMS OF CRIME AND RECEIVE A GYNECOLOGICAL CHECK-UP BY AN EXPERT PHYSICIAN, WHO IN TURN DIRECTS THEM TO A MEDICAL FACILITY, IF REQUIRED. IN THE MUNICIPALITY OF PLAYAS DE ROSARITO NO INFORMATION ON CONTRACEPTION IS PROVIDED TO THE INJURED PARTY. INSTEAD, ONCE THE OFFICIAL STATEMENT HAS BEEN COMPLETED, THEY ARE GIVEN AN OFFICIAL LETTER WHICH STATES THE VICTIM'S RIGHTS AND A LEAFLET FROM THE INSTITUTION'S DEPARTMENT FOR VICTIMS OF CRIME, WHICH DETAILS THE SUPPORT PROVIDED BY THIS UNIT, ALONG WITH RELEVANT ADDRESSES, TELEPHONE NUMBERS AND OFFICE HOURS.	YES, IN SOME MUNICIPALITIES
BAJA CALIFORNIA SUR	WITHIN 72 HOURS AFTER THE COMMISSION OF THE ALLEGED CRIMINAL ACTS, THE STAFF OF THE DEPUTY PUBLIC PROSECUTOR'S OFFICE FOR THE CARE OF WOMEN AND CHILDREN FULLY INFORM THE VICTIM ABOUT THE "MORNING-AFTER PILL" (INCLUDING POTENTIAL MEDICALLY PROVEN PHYSIOLOGICAL SIDE EFFECTS) TO ALLOW HER THE OPPORTUNITY TO CONTINUE WITH HER LIFE PLAN.	NO
CAMPECHE	THERE ARE TWO DOCTORS WHO PROVIDE SOCIAL SERVICES TO VICTIMS OF SEXUAL ASSAULTS AND ARE RESPONSIBLE FOR INFORMING WOMEN WHO ARE REFERRED TO THE LEGAL MEDICINE UNIT AS A RESULT OF A SEXUAL OFFENSE (ABUSE, RAPE, STATUTORY RAPE). THIS IS BASED ON CLAUSE 6.4.2.3 OF NOM-046-2005-SSA2, DOMESTIC AND SEXUAL VIOLENCE AND VIOLENCE AGAINST WOMEN, CRITERIA AND PREVENTION, THAT STATES THAT EMERGENCY CONTRACEPTION CAN PREVENT PREGNANCY, BUT NEVER TERMINATE IT.	NO
CHIAPAS	WHEN WOMEN COME FORWARD TO REPORT THE CRIME OF RAPE WITHIN THE PERIOD OF 72 HOURS, THEY WILL BE DIRECTED TO THE HEALTH SECTOR FOR IMMEDIATE ASSESSMENT, ORIENTATION AND MEDICAL ATTENTION, IN ACCORDANCE WITH NOM 046. IT SHOULD BE NOTED TH AT, IN THIS CASE, THE WOMAN HAS AN EXCLUSIVE RIGHT TO MAKE DECISIONS IN COORDINATION WITH THE HEALTH SECTOR.	NO
CHIHUAHUA	IT IS THE RESPONSIBILITY OF THIS OFFICE TO DIRECT VICTIMS OF CRIME TO AGENCIES PROVIDING MEDICAL SERVICES, IN ORDER TO UPHOLD VICTIMS' RIGHT TO RECEIVE EMERGENCY MEDICAL ASSISTANCE, AS STATED IN ARTICLE 7, SECTION IV OF CHIHUAHUA'S STATE LAW ON CARE AND PROTECTION OF VICTIMS OF CRIME.	NO
COAHUILA	PROVIDES SOCIAL, LEGAL AND PSYCHOLOGICAL CARE AND ASSISTANCE TO VICTIMS OF RAPE, INCLUDING REFERRAL TO A MEDICAL FACILITY THAT PROVIDES EMERGENCY CARE, PREVENTION OF PREGNANCY AND SEXUALLY TRANSMITTED INFECTIONS, IN ACCORDANCE WITH THE PROVISIONS OF NOM-046 SSA2- 2005 ON CRITERIA FOR THE PREVENTION AND TREATMENT OF DOMESTIC AND SEXUAL VIOLENCE AND VIOLENCE AGAINST WOMEN.	NO
COLIMA	PEOPLE WHO COME FORWARD TO REPORT A RAPE ARE TO BE DIRECTED TO THE PHYSICIAN ON-CALL FOR PHYSICAL ASSESSMENT, AND OFFERED INFORMATION REFERRING THEM TO AN INSTITUTION SUCH AS A HEALTH CENTER, IF THEY ARE AFFILIATED TO THE IMSS, OR TO A PRIVATE DOCTOR WHO CAN RECOMMEND APPROPRIATE CONTRACEPTION AND MEDICATIONS TO PREVENT SEXUALLY TRANSMITTED INFECTIONS.	NO
DURANGO	ACCORDING TO NOM-046, BOTH PUBLIC PROSECUTOR AGENTS OF THIS UNIT AND EXPERT PHYSICIANS WILL INFORM RAPE VICTIMS OF THEIR RIGHTO EMERGENCY CONTRACEPTION, INCLUDING A BRIEF EXPLANATION OF HOW AND WHEN IT SHOULD BE TAKEN, LEAVING THE DECISION TO TAKE IT UP TO THEM. IF REQUESTED, IT WILL BE PROVIDED BY MEDICAL EXAMINER STAFF.	YES
GUANAJUATO	THE RAPE VICTIM IS PROVIDED INFORMATION ON EMERGENCY CONTRACEPTION, RECORDED IN THE PRE-TRIAL INVESTIGATION AND/OR CASE FILE, AS APPLICABLE. FURTHERMORE, THE HEAD OF THE PUBLIC PROSECUTOR'S OFFICE PROVIDES INFORMATION ON THE VICTIM'S RIGHT TO BE PROVIDED WITH THE EMERGENCY CONTRACEPTIVE PILL, FREE OF CHARGE, WITHIN 72 HOURS AFTER THE RAPE. IF THE VICTIM REQUESTS THE PILL, THE AGENT WILL INFORM THE DEPARTMENT FOR ATTENTION TO VICTIMS OF CRIME, WHICH WILL SEND A STAFF MEMBER TO THE PROSECUTOR'S OFFICES TO SUPPLY THE TABLET, AFTER OBTAINING CONSENT FROM THE VICTIM OR, IF SHE IS A MINOR, HER LEGAL REPRESENTATIVE.	NO
GUERRERO	THE SPECIAL ATTORNEY FOR THE INVESTIGATION OF SEXUAL OFFENCES AND DOMESTIC VIOLENCE PROVIDES PSYCHOLOGICAL CARE TO THE VICTIM, AND THE MORNING-AFTER PILL (EMERGENCY CONTRACEPTIVE PILL) TO AVOID AN UNWANTED PREGNANCY. SHE IS ALSO PROVIDED WITH THE INFORMATION NECESSARY TO EXERCISE HER RIGHT TO REPORT THE CRIME, AND IS PROVIDED A LEAFLET DETAILING BEHAVIORS THAT CONSTITUTE DOMESTIC VIOLENCE.	YES
HIDALGO	THE FORENSICS UNIT OF THE CRIMINAL INVESTIGATIONS DEPARTMENT AT THE HIDALGO STATE PUBLIC PROSECUTOR'S OFFICE PROVIDES VERBAL INFORMATION REGARDING: 1. WHAT IS EMERGENCY CONTRACEPTION (THE MORNING-AFTER PILL). 2. THE METHOD USED FOR EMERGENCY CONTRACEPTION (PILL TO AVOID UNWANTED PREGNANCIES). 3. WHEN TO TAKE EMERGENCY CONTRACEPTION. 4. HOW LONG EMERGENCY CONTRACEPTION IS EFFECTIVE. 5. SIDE EFFECTS OF EMERGENCY CONTRACEPTION. 6. CONTRAINDICATIONS TO THE USE OF EMERGENCY CONTRACEPTION. 7. THIS INFORMATION IS PROVIDED TO THOSE AT RISK FOR PREGNANCY, DETERMINED BY THE STAGE IN THEIR MENSTRUAL CYCLE THE DAY THE CRIME TOOK PLACE. 8. THE VICTIM OF SEXUAL ASSAULT WILL DECIDE WHETHER OR NOT TO TAKE EMERGENCY CONTRACEPTION. 9. WE WILL PROVIDE EMERGENCY CONTRACEPTION (LEVONORGESTREL 0.75 MG) IF IT IS AVAILABLE. 10. THE VICTIM IS IMMEDIATELY REFERRED TO THE HEALTH SECTOR IN ACCORDANCE WITH NOM 190 ON COMPREHENSIVE ATTENTION TO DOMESTIC VIOLENCE. 11. WE DO NOT HAVE ANY LEAFLETS TO HAND OUT.	NO

Source: Created by GIRE based on data obtained from information requests.

INFORMATION ON EMERGENCY CONTRACEPTION
STATE PUBLIC PROSECUTOR´S OFFICES

STATE	INFORMATION[37]	LEAFLETS
JALISCO	THE OFFICE FOR CRIMES AGAINST MINORS AND SEXUAL AND DOMESTIC VIOLENCE STATED: THIS OFFICE DOES NOT PROVIDE ANY INFORMATION REGARDING EMERGENCY CONTRACEPTION. THE GENERAL DIRECTORATE OF REGIONAL DELEGATIONS STATED: AMONG THE REGIONAL DELEGATIONS FOR WHICH I AM RESPONSIBLE, NO DATA WAS FOUND REGARDING THE INFORMATION PROVIDED. AS SUCH, THE PGJEJ DOES NOT PROVIDE ANY INFORMATION REGARDING CONTRACEPTION TO VICTIMS OF RAPE, NOR DOES IT HAVE OR DISTRIBUTE LEAFLETS ON THE CONTRACEPTION METHODS.	NO
MEXICO CITY	INFORMATION FOR VICTIMS, BOTH ADOLESCENTS AND ADULTS, WHO HAVE REPORTED AN ASSAULT INVOLVING VAGINAL-PENILE CONTACT, INCLUDES A REFERRAL TO THE CONDESA SPECIALTY CLINIC (VIA AN OFFICIAL LETTER FROM THE PUBLIC PROSECUTOR) WHERE THE VICTIM IS INFORMED ABOUT THE USE OF THE EMERGENCY CONTRACEPTIVE PILL, AMONG OTHER ISSUES.	YES
MICHOACAN	AFTER REPORTING A RAPE, VICTIMS OF THE CRIME ARE REFERRED TO INSTITUTIONS PROVIDING MEDICAL SERVICES, WHO OFFER EMERGENCY CONTRACEPTION IMMEDIATELY AND UP TO A MAXIMUM OF 120 HOURS AFTER THE EVENT OCCURRED, PROVIDING COMPLETE INFORMATION REGARDING THE USE OF THIS METHOD SO THAT THE INDIVIDUAL CAN MAKE A FREE AND INFORMED DECISION. INFORMATION IS ALSO PROVIDED REGARDING THE POTENTIAL RISK OF SEXUALLY TRANSMITTED INFECTIONS AND THEIR PREVENTION THROUGH CHEMOPROPHYLAXIS. BASED ON A RISK EVALUATION AND TAKING INTO ACCOUNT THE VICTIMS' RISK PERCEPTION (NOM 046), HIV / AIDS PROPHYLAXIS IS PRESCRIBED.	NO
MORELOS	THE MEDICAL EXAMINER INSTRUCTS THE VICTIM ON THE USE OF ALL AVAILABLE CONTRACEPTIVE OPTIONS. NO LEAFLETS ARE PROVIDED AND VICTIMS ARE ENCOURAGED TO ATTEND HEALTH CENTERS.	NO
NAYARIT	NO RESPONSE TO REQUEST FOR INFORMATION.	
NUEVO LEON	NO SUCH INFORMATION.	
OAXACA	PATIENTS ARE VERBALLY PROVIDED WITH THE FOLLOWING INFORMATION: - EMERGENCY CONTRACEPTION SHOULD BE USED WITHIN THE FIRST 72 HOURS AFTER THE RAPE, SO IT MUST BE ADMINISTERED AS SOON AS POSSIBLE TO ENSURE BETTER RESULTS. - THE FIRST DOSE SHOULD BE GIVEN WITHIN THE FIRST 72 HOURS AND THE SECOND DOSE TWELVE HOURS AFTER THE FIRST. - IT IS A METHOD THAT PREVENTS PREGNANCY, BUT DOES NOT TERMINATE A PREGNANCY ESTABLISHED PRIOR TO THE RAPE. - FOLLOWING ADMINISTRATION PATIENTS MAY SUFFER NAUSEA, VOMITING, BREAST TENDERNESS. THESE EFFECTS ARE TEMPORARY AND LAST ONE TO TWO DAYS. - EATING SOMETHING LIGHT BEFORE ADMINISTRATION WILL REDUCE THE ABOVE SYMPTOMS. - THE NEXT MENSTRUAL PERIOD MAY START A FEW DAYS EARLIER OR LATER THAN NORMAL. - IF THE PERIOD DOES NOT START WITHIN FOUR WEEKS A PREGNANCY TEST SHOULD BE PERFORMED.	NO
PUEBLA	THE OFFICE FOR THE COMPREHENSIVE CARE OF WOMEN ONLY PROVIDES ADVICE TO WOMEN REGARDING THEIR RIGHTS DURING THE PRE-TRIAL INVESTIGATION, INCLUDING INFORMATION ON AGENCIES RESPONSIBLE FOR PROVIDING HEALTH AND SOCIAL SERVICES AND, WHERE APPLICABLE, REFERRING VICTIMS TO THESE.	NO
QUERETARO	LEAFLETS ARE PROVIDED TO PATIENTS WHO WERE RAPED AND THEY ARE PROVIDED CARE. THEY ARE ALSO PROVIDED A LINK TO THE WEBSITE WHERE THEY CAN READ THE GUIDE ON CARE FOR RAPE SURVIVORS, WHICH EXPLAINS PROCEDURES REGARDING EMERGENCY CONTRACEPTION.[38]	YES
QUINTANA ROO	NO INFORMATION GIVEN.	
SAN LUIS POTOSI	NO RESPONSE TO REQUEST FOR INFORMATION.	
SINALOA	THE VICTIM IS INFORMED OF HER RIGHTS, AND THE PRE-TRIAL INVESTIGATION IS EXPLAINED; WITH REGARD TO CONTRACEPTION, THE MEDICAL EXAMINER IS RESPONSIBLE FOR PROVIDING INFORMATION AND GUIDANCE.	NO
SONORA	STATE PUBLIC PROSECUTOR'S MEDICAL EXAMINERS ARE INSTRUCTED TO REFER THE VICTIM TO THE HEALTH SECTOR FOR CARE AND MEDICATION OR TO INSTITUTIONS OF WHICH THE VICTIM IS A BENEFICIARY, IN THE EVENT OF A RAPE, BASED ON THE OFFICIAL MEXICAN STANDARD AND SONORA STATE LAW ON CARE FOR VICTIMS OF CRIME.	NO
STATE OF MEXICO	THROUGH ITS INSTITUTE FOR ATTENTION TO VICTIMS OF CRIME, THE STATE PUBLIC PROSECUTOR'S OFFICE, AS PART OF THE COMPREHENSIVE CARE OFFERED TO VICTIMS OF RAPE, FOCUSES PRIMARILY ON THE VICTIM'S RIGHT TO EMERGENCY CONTRACEPTION. THROUGH INTERVIEWS, IT IDENTIFIES CASES OF WOMEN OF REPRODUCTIVE AGE WHO ARE AT RISK OF FORCED PREGNANCY, AND WITHIN THE LIMIT OF 120 HOURS ACCORDING TO WORLD HEALTH ORGANIZATION GUIDELINES, REFERRING THEM TO MEDICAL INSTITUTIONS BELONGING TO THE STATE OF MEXICO'S HEALTH INSTITUTE. THESE WILL PROVIDE SPECIALIZED MEDICAL CARE AND, AFTER EVALUATING VICTIM, WILL PRESCRIBE AND SUPPLY THE NECESSARY MEDICATIONS AND INFORMATION FOR COUNSELING ON AND ADMINISTRATION OF EMERGENCY CONTRACEPTION AS WELL AS CHEMOPROPHYLAXIS TO PREVENT SEXUALLY TRANSMITTED INFECTIONS.	NO
TABASCO	THE MEDICAL EXAMINER ONLY PROVIDES GUIDANCE REGARDING THE PROBABILITY OF PREGNANCY, AND REFERS VICTIMS TO THE MINISTRY OF HEALTH, WHICH IS RESPONSIBLE FOR PROVIDING EMERGENCY CONTRACEPTION.	NO
TAMAULIPAS	NO INFORMATION GIVEN.	
TLAXCALA	NO RESPONSE TO REQUEST FOR INFORMATION.	
VERACRUZ	NO RESPONSE TO REQUEST FOR INFORMATION.	
YUCATAN	NO SUCH INFORMATION.	
ZACATECAS	PROVIDES INFORMATION TO RAPE VICTIMS REGARDING EMERGENCY CONTRACEPTION, AND PROVIDES THEM WITH THE EMERGENCY CONTRACEPTIVE PILL AND A LEAFLET WITH RELEVANT INFORMATION.	YES

Source: Created by GIRE based on data obtained from information requests.

The responses received and described in the above table demonstrate that 15 State Public Prosecutor's Offices[39] provide information regarding rape victims' right to obtain emergency contraception. In some cases, this is provided by the Office's medical unit, such as in Mexico City, Durango, Guerrero and Zacatecas.

Based on the responses obtained, State Public Prosecutor's Offices do not provide this information because they do not consider it to be within their jurisdiction. While the Public Prosecutor's Offices could argue that they are not authorized to provide emergency contraception, because NOM 046 states this is the responsibility of agencies belonging to the National Health System, it is concerning that they do not acknowledge their obligation to provide relevant information as part of comprehensive care to victims of crime.

When a woman reports a rape, the Public Prosecutor's Office must provide her information regarding the services to which she is entitled, as established in the General Law for Victims and NOM 046 (emergency contraception, pregnancy termination and prevention of sexually transmitted infections and HIV). Failure to do so jeopardizes women's effective access to these services due to lack of information, and is a clear violation of the rights of victims of crime.

The response of the Hidalgo State's Public Prosecutor's Office should be noted, since it bases its guidelines on the Official Mexican Norm 190, which was superseded by NOM 046.

Furthermore, it is especially alarming that federal authorities, in this case the Attorney General's Office, do not consider it part of their obligation to provide victims of sexual violence[40] information on their rights, particularly when this office includes a Special Prosecutor for Crimes of Violence against Women and Human Trafficking.

State Public Prosecutor's Offices are required to provide appropriate information and to refer women to health care agencies that can provide emergency contraception in a timely manner. It is essential that Public Prosecutor's Offices provide this information and that, as in Durango, Guerrero, Mexico City and Zacatecas, medical examiners administer the emergency contraception pill directly to victims of sexual violence, considering that it is only effective during the 120 hours following the rape (losing effectiveness as time passes after intercourse) and is often the only opportunity for the woman to receive care.

Regarding the provision of emergency contraception, information requests were sent to the Federal Ministry of Health, the Mexican Social Security Institute (IMSS), the Institute of Security and Social Services for State Workers (ISSSTE) and State Ministries of Health.

EMERGENCY CONTRACEPTION
FEDERAL HEALTH INSTITUTIONS

GOVERNMENT AGENCY	NUMBER OF WOMEN WHO REQUESTED EMERGENCY CONTRACEPTION				NUMBER OF WOMEN WHO RECEIVED EMERGENCY CONTRACEPTION			
	2009	2010	2011	2012	2009	2010	2011	2012
MINISTRY OF HEALTH	ND				27,175			
IMSS	ND				ND			
ISSSTE	ND				6,120	4,312	4,009	775

Source: Created by GIRE based on data obtained from information requests. ND: No data.

It is particularly striking that, at the federal level, none of the three agencies recorded the number of requests for emergency contraception. However, the Ministry of Health and the ISSSTE do record the number of women who were provided with emergency contraception. Both sets of information were requested in order to determine whether there were cases in which emergency contraception was requested but not provided.

The data listed in the previous table can lead us to assume that the ISSSTE and the Ministry of Health are complying with their obligation, stipulated in NOM 046, to provide emergency contraception to victims of sexual violence. Nevertheless, lack of information regarding the number of requests makes it impossible to determine the frequency with which it was provided and whether there were occasions in which provision of the emergency pill was refused.

Of particular concern is the lack of data from the IMSS, and it is unclear as to whether this is because they do not record the number of women who receive emergency contraception or because they do not provide the service at all.

A. STATES

EMERGENCY CONTRACEPTION
STATE HEALTH INSTITUTIONS

STATE	NUMBER OF WOMEN WHO REQUESTED EMERGENCY CONTRACEPTION				NUMBER OF WOMEN WHO RECEIVED EMERGENCY CONTRACEPTION			
	2009	2010	2011	2012	2009	2010	2011	2012
AGUASCALIENTES	ND	ND	ND	ND	ND	406	826	217
BAJA CALIFORNIA	ND	ND	ND	ND	ND	326	575	114
BAJA CALIFORNIA SUR	ND	ND	ND	ND	ND	193	393	621
CAMPECHE	"CAMPECHE'S MINISTRY OF HEALTH DOES NOT PROVIDE EMERGENCY CONTRACEPTION PILLS"							
CHIAPAS	8				8			
CHIHUAHUA	2	2	3	0	2	2	3	0
COAHUILA	ND	ND	ND	ND	611	3,077	4,687	ND
COLIMA	ND	319	261	194	ND	319	503	356
DURANGO	ND	1,196	1,066	144	ND	1,196	1,066	144
GUANAJUATO	ND	ND	ND	ND	ND	2,271	2,566	679
GUERRERO	ND	402	830	254	ND	1,284	3,280	975
HIDALGO	ND	ND	ND	ND	ND	373	1,236	ND
JALISCO			ELECTRONIC DATA UNAVAILABLE[41]					
MEXICO CITY	ND	ND	ND	ND	ND	449	662	871
MICHOACAN	REQUESTED INFORMATION UNAVAILABLE							
MORELOS	DECLARED INCOMPETENCE IN PROVIDING THE INFORMATION							
NAYARIT	ND	ND	ND	1,303	ND	ND	ND	1,303
NUEVO LEON	32	35	64	14	32	35	64	14
OAXACA	ND	ND	ND	ND	ND	1,541	1,839	517
PUEBLA	REQUESTED INFORMATION UNAVAILABLE							
QUERETARO	REQUESTED INFORMATION UNAVAILABLE							
QUINTANA ROO	ND	ND	ND	ND	200	262	190	543
SAN LUIS POTOSI	NO VICTIM OF SEXUAL VIOLENCE REQUESTED IT, AND NOR WAS IT OFFERED							
SINALOA	ND	50	50	8	ND	598		
SONORA	DID NOT RESPOND TO REQUEST FOR INFORMATION							
STATE OF MEXICO	ND	ND	1,360	1,875	ND	ND	4,341	4,719
TABASCO	DID NOT RESPOND TO REQUEST FOR INFORMATION							
TAMAULIPAS	ND	ND	ND	ND	ND	67		92
TLAXCALA	ND	946	499	203	ND	948	499	203
VERACRUZ	ND	2,824	2,553	1,115	ND	2,824	2,553	1,115
YUCATAN	NO INFORMATION AVAILABLE							
ZACATECAS	ND	ND	ND	3,881	ND	ND	ND	3,881

Source: Created by GIRE based on data obtained from information requests. ND: No data.

Of the 32 states, 30 responded to the information request. It is concerning that some states responded that the requested information is unavailable because this implies either that they do not provide emergency contraception or keep no records of its provision. At least 22 states are providing emergency contraception, although in some, such as Chihuahua, the number of women who received emergency contraception is very low in comparison with data on sexual violence. According to information from the State Public Prosecutor's Office, there were a total of 831 rapes reported between 2007 and 2012;[42] nevertheless, in 2011, the Chihuahua's Ministry of Health reported having provided emergency contraception to only three women.

Also alarming is the response from Campeche's Ministry of Health, openly declaring that it "does not provide emergency contraception pills".[43] Similarly, San Luis Potosi's Ministry of Health stated that no one requested emergency contraception and none was offered, in clear violation of NOM 046.[44]

This data demonstrates that rape survivors do not have effective access to emergency contraception information and services, in clear violation of their human rights. State Public Prosecutor's Offices and State Ministries of Health are not fully complying with their obligations to care for victims of sexual violence, as stipulated in NOM 046.

2.4.2 INFORMED CONSENT

With regard to obtaining consent for the provision of contraceptive methods, the Federal and State Ministries of Health were asked if they obtain written informed consent from patients using permanent contraceptive methods.

INFORMED CONSENT

STATE	CONSENT FORM FOR PERMANENT CONTRACEPTION METHODS	NUMBER OF PEOPLE WHO SIGNED THE FORM
AGUASCALIENTES	YES. COUNSELING AND GUIDANCE FOR INFORMED CONSENT IS BASED ON THE "WHO RECOMMENDATIONS REGARDING SELECTED PRACTICES FOR CONTRACEPTIVE USE."	PROVIDED DATA ON ACTIVE CONTRACEPTION USERS FOR THE PERIOD JAN-SEPT 2012. HOWEVER, IT DID NOT INDICATE WHETHER A CONSENT FORM WAS SIGNED.
BAJA CALIFORNIA	ND	8,741
BAJA CALIFORNIA SUR	DID NOT RESPOND TO REQUEST FOR INFORMATION	
CAMPECHE	ND	29,101
CHIAPAS	YES	463,621
CHIHUAHUA	YES	894,369
COAHUILA	YES	ND
COLIMA	YES	22,515
DURANGO	YES	48,587
GUANAJUATO	NO	1,121,177
GUERRERO	YES	30,488
HIDALGO	YES	ND
JALISCO	ELECTRONIC DATA UNAVAILABLE[45]	
MEXICO CITY	YES	REQUESTED INFORMATION UNAVAILABLE
MICHOACAN	YES	PROVIDES DATA ON ACTIVE USERS OF CONTRACEPTION FOR THE YEAR 2012: 104,467.
MORELOS	DECLARED INCOMPETENCE TO PROVIDE INFORMATION	
NAYARIT	YES	15,143
NUEVO LEON	YES	18,581
OAXACA	YES	ND
PUEBLA	YES	CONFIDENTIAL INFORMATION
QUERETARO	YES	168,259
QUINTANA ROO	YES	51,069
SAN LUIS POTOSI	YES	7,979

Source: Created by GIRE based on data obtained from information requests. ND: No data.

INFORMED CONSENT		
STATE	CONSENT FORM FOR PERMANENT CONTRACEPTION METHODS	NUMBER OF PEOPLE WHO SIGNED THE FORM
SINALOA	YES	REQUESTED INFORMATION UNAVAILABLE
SONORA	DID NOT RESPOND TO REQUEST FOR INFORMATION	
STATE OF MEXICO	YES	ND
TABASCO	YES	289,656
TAMAULIPAS	DID NOT RESPOND TO REQUEST FOR INFORMATION	
TLAXCALA	YES	46,685
VERACRUZ	YES	986,153 (2009-2012)
YUCATAN	NO INFORMATION AVAILABLE	
ZACATECAS	DID NOT RESPOND TO REQUEST FOR INFORMATION	

Source: Created by GIRE based on data obtained from information requests. ND: No data.

For the Ministries of Health that responded, we can conclude that signed informed consent is required for permanent contraceptive methods. This is a positive indicator that helps prevent coercion or lack of information in the provision of this type of contraception. However, a more careful analysis would be required to determine whether the consent obtained is truly a process of dialogue between the provider and patient or merely the procedure of obtaining a signature.

GIRE also requested information from the IMSS to learn how it implements informed consent for permanent contraceptive methods.[46] In response, the IMSS stated that the informed consent form applies to all types of contraceptive methods (both temporary and permanent), which is a violation of the applicable regulations. While it is necessary to obtain informed consent for all types of contraception, the obligation to complete a form for all methods could inhibit access to individuals who do not wish to disclose their identity. This is exacerbated in the case of adolescents seeking access to condoms or birth control pills.

Based on the data obtained, it appears that many Ministries of Health do not collect information regarding the number of women who undergo permanent contraceptive procedures; Puebla, for example, responded that this information is classified as confidential[47] without any clear basis, since its application does not require patients' personal data.

2.4.3 ACCESS FOR ADOLESCENTS

A. FEDERAL AND STATE MINISTRIES OF HEALTH

Requests for information were submitted to federal and state ministries of health concerning provision of contraception information and services to adolescents and the requirements these entail.

ACCESS FOR ADOLESCENTS		
STATE	REQUIREMENTS	PROVISION
AGUASCALIENTES	YES. THESE ACTIONS ARE CARRIED OUT IN ACCORDANCE WITH NOM-005-SSA2-1993, UPDATED IN 2004, ON FAMILY PLANNING SERVICES. THE REQUIREMENT IS A REQUEST FOR CONTRACEPTIVE SERVICES. PROVISION IS FREE OF CHARGE IN PUBLIC SECTOR FACILITIES AND USE IS BASED ON INFORMED CONSENT AND FOLLOWS WHO MEDICAL CRITERIA FOR ELIGIBILITY ENCOMPASSED IN THE OFFICIAL MEXICAN NORM 005-SSA2-1993, UPDATED IN 2004, ON FAMILY PLANNING SERVICES.	YES
BAJA CALIFORNIA	YES. ATTEND THE HEALTH CENTER, RECEIVE COUNSELING AND ORIENTATION FROM MEDICAL AND/OR NURSING STAFF AND, IN THE CASE OF PROVISION OR INSERTION OF A CONTRACEPTIVE METHOD, SIGN THE INFORMED CONSENT FORM.	UPON SIGNING A FORM
BAJA CALIFORNIA SUR	DID NOT RESPOND TO REQUEST FOR INFORMATION	
CAMPECHE	NO	YES
CHIAPAS	NO	YES
CHIHUAHUA	NO	YES
COAHUILA	NO	YES
COLIMA	NO	YES
DURANGO	NO	YES

Source: Created by GIRE based on data obtained from information requests.

ACCESS FOR ADOLESCENTS

STATE	REQUIREMENTS	PROVISION
GUANAJUATO	YES. THERE ARE NO REQUIREMENTS FOR THE PROVISION OF FAMILY PLANNING INFORMATION, INCLUDING FOR ADOLESCENTS, HOWEVER THE PROVISION OF BIRTH CONTROL METHODS REQUIRES A COUNSELING AND ORIENTATION SESSION AND AN INFORMED CONSENT FORM SIGNED BY THE PATIENT, THE PHYSICIAN WHO APPLIES THE METHOD AND A WITNESS.	YES
GUERRERO	NO	YES
HIDALGO	YES. NO DOCUMENTS ARE REQUIRED TO OBTAIN INFORMATION ON FAMILY PLANNING; IF A CONTRACEPTIVE METHOD IS REQUESTED, IT IS ESSENTIAL THAT OBSTETRIC GYNECOLOGICAL RECORDS BE PROVIDED IN ORDER TO REGISTER PATIENTS IN THE USER CONTROL ELECTRONIC CARDHOLDER PLATFORM.	YES
JALISCO	ELECTRONIC DATA UNAVAILABLE[48]	YES
MEXICO CITY	NO	YES
MICHOACAN	NO	YES
MORELOS	DECLARED INCOMPETENCE TO PROVIDE INFORMATION AND ADVISED REQUESTING THE INFORMATION FROM STATE HEALTH SERVICES	
NAYARIT	NO	YES
NUEVO LEON	NO	YES
OAXACA	YES. [PATIENTS] ARE REQUESTED TO SEEK CARE AT HEALTH CENTERS WHERE THEY ARE PROVIDED THE REQUIRED INFORMATION, OR, IF NECESSARY, THE CONTRACEPTIVE METHOD.	YES
PUEBLA	YES. NO DOCUMENT IS REQUIRED; THE PATIENT'S MEDICAL HISTORY IS CHECKED TO RULE OUT ANY PATHOLOGY THAT WOULD PREVENT THE USE OF HORMONES, IN WHICH CASE THE COPPER IUD, WHICH CONTAINS NO HORMONES, IS OFFERED. THE ONLY REQUIREMENT IS SIGNING AN INFORMED CONSENT FORM FOR THE USE OF DERMAL IMPLANTS OR INTRAUTERINE DEVICES, AS THESE METHODS ARE IMPLANTED INSIDE THE BODY.	YES
QUERETARO	YES. REQUIREMENTS ARE THAT PATIENTS FIRST ATTEND PRIMARY CARE UNITS FOR CLINICAL CARE AND ASSESSMENT AND TO ENSURE THE CONTRACEPTIVE METHOD CHOSEN MEETS THEIR NEEDS. THEY MUST SIGN THE INFORMED CONSENT FORM FOR THE USE OF A CONTRACEPTIVE METHOD, WHICH CAN BE PRESCRIBED BY THE HEALTH CARE PROVIDER.	YES
QUINTANA ROO	NO.	YES
SAN LUIS POTOSI	DID NOT RESPOND TO REQUEST FOR INFORMATION	
SINALOA	NO. EXCEPT FOR SPECIAL CASES INDICATED BY THE ELIGIBILITY CRITERIA OF VARIOUS CONTRACEPTIVE METHODS.	YES
SONORA	DID NOT RESPOND TO REQUEST FOR INFORMATION	
STATE OF MEXICO	NO	YES
TABASCO	NO. ONLY A GUIDANCE AND COUNSELING SESSION AND MEDICAL HISTORY IS REQUESTED TO DETERMINE THE APPROPRIATE METHOD, INCLUDING PERMANENT METHODS SUCH AS BILATERAL TUBAL OCCLUSION IN WOMEN OR VASECTOMY FOR MEN.	YES
TAMAULIPAS	DID NOT RESPOND TO REQUEST FOR INFORMATION	
TLAXCALA	YES. ATTEND MEDICAL CONSULTATION FOR LEGAL ADVICE. CONTRACEPTION IS PROVIDED FREE OF CHARGE ONCE INFORMATION HAS BEEN PROVIDED REGARDING BENEFITS AND SIDE EFFECTS. ATTEND THE HEALTH CENTER UPON REQUEST. PARENTAL CONSENT NOT REQUIRED. PATIENTS USING "FRIENDLY SERVICES" MUST FOLLOW THE SAME STEPS.	YES
VERACRUZ	DID NOT RESPOND TO REQUEST FOR INFORMATION	
YUCATAN	DID NOT RESPOND TO REQUEST FOR INFORMATION	
ZACATECAS	DID NOT RESPOND TO REQUEST FOR INFORMATION	

Source: Created by GIRE based on data obtained from information requests.

Of the 32 states, 23 Ministries of Health responded to the information request, indicating that they provide information and contraceptives to adolescents, stating that the only requirement is attending a medical consultation for counseling. It is striking that no Ministry of

Health referred to the need for parental consent to receive these services, although it is unclear what occurs in practice. In Baja California, Guanajuato, Puebla and Queretaro, adolescents are asked to sign an informed consent form, particularly in the case of intradermal methods such as IUDs and implants.

2.5 / CONCLUSIONS

Based on statistical data, analysis of the law and policy framework and information obtained from responses to federal and state-level requests for information, it may be concluded that Mexican authorities are far from complying with their obligations to promote, respect, protect and guarantee the right to contraception information and services. The panorama in this field is disheartening and women's lack of access to emergency contraception is of particular concern.

Applicable legislation is not fully aligned with international standards and there is a lack of coherence between the general laws, official health regulations and state regulations. A considerable portion of general and state legislation only refers to the concept of family planning, which has a connotation that links sexuality and contraceptive use to reproduction. This does not respond to the needs of many sectors of the population.

Gaps in general legislation are notable, particularly regarding informed consent and access for adolescents. Also, law and policy could be more specific regarding the type of information to be provided to the clients of health services and the conditions required for the same.

State health laws have serious shortcomings; for example, none of them explicitly deal with the issue of informed consent and few include any mention of access to contraception for adolescents.

Another important consideration is that health legislation rarely makes explicit reference to the obligation to provide accurate and objective information on contraception. While this does not exempt obligation, it is important that this obligation be made explicit in state legislation, given the general regulations on the topic.

Unfortunately, the information provided regarding access to contraceptives does not provide sufficient evidence to make a diagnosis, for example, in the case of adolescents or with regard to conditions and requirements for obtaining informed consent.

The lack of awareness or refusal of some State Public Prosecutor's Offices to provide information regarding rape survivors' right to receive emergency contraception information and supplies, as stipulated in NOM 046, is of great concern. Even in the states that did report having provided emergency contraception, the number of women who accessed this service is very low, considering of the number of rapes reported. This indicates that in many states NOM 046 is not applied and women have no access to emergency contraception information or services, which are essential to preventing unwanted pregnancy.

As noted in this chapter, it is essential that State Public Prosecutor's Offices provide detailed information about NOM 046 and either supply the pills or have an efficient system for referral to the health authorities, in compliance with the recently published General Law for Victims.

Regarding access to information, it is alarming that states have refused or failed to collect key information and data to determine the level of access and use of contraceptives. The lack of this information has a negative impact on the effectiveness of policies and programs, by making it impossible to properly evaluate them and, in turn, recommend actions to improve results.

The lack of access to contraception for women in general and adolescents and youth in particular is reflected in current statistics demonstrating a low rate of contraception use and high rates of unwanted pregnancies. This is a serious public health and human rights problem that deserves greater attention from the Mexican State.

2.6 / RECOMMENDATIONS

2.6.1 LAW AND POLICY

> Modify the General Health Law to explicitly establish health providers' obligation to obtain informed consent from patients for contraceptive services and to specify that the information provided should include all the options, risks and benefits of the procedures, and must be accurate, objective, confidential, free from prejudice or discrimination, and use a language accessible to the patient.

> Bring the General Health Law and state health laws in line with international standards and with NOM 005, particularly in the following aspects:

- Replace the term "family planning services for couples" with "contraceptive services and information."

- Ensure that the law explicitly provides for access to contraception for adolescents or indicates that access is for all individuals regardless of age.

- Ensure that the law explicitly stipulates that informed consent from parents is not required in order for adolescents to access contraception, except in the case of tubal ligation.

- Ensure that the law explicitly stipulates that health institutions must provide information and counseling on contraceptive methods, including all of the options, risks and benefits of the procedures, and must be accurate, objective, free from prejudice or discrimination, and use a language accessible to the patient.

- Ensure that the law emphasizes that contraceptive services and information must be confidential and free from any form of pressure, coercion or violence, ensuring full respect for patients' human rights.

- Ensure that the law stipulates that health providers must obtain patients' informed consent for contraceptive services and that this must involve a dialogue and exchange between the patient and the provider.

> Modify State Public Prosecutor's Offices' organic laws to include the obligation of the medical examiners in these institutions to provide information and supply emergency contraception as part of their care for victims of sexual violence.

2.6.2 IMPLEMENTATION OF LAW AND POLICY

> Ensure that State Public Prosecutor's Offices provide information on NOM 046, which establishes rape survivors' right to emergency contraception, legal abortion and prophylaxis for HIV and other sexually transmitted infections. It is essential that they provide women with accurate, objective, impartial, and timely information regarding emergency contraception.

> At the federal and state level, ensure that all individuals, particularly adolescents and indigenous women, have access to contraceptive services and information, free from discrimination. This means ensuring that health professionals do not impose requirements not stipulated by law, such as requesting consent from parents or guardians to provide adolescents access contraception.

> It is essential that the Federal Ministry of Health monitor the supply and provision of contraceptives, including emergency contraception, by State Ministries of Health and other public institutions in the National Health System.

2.6.3 GENERATION OF INFORMATION AND STATISTICAL DATA

> Register the number of requests for and provision of emergency contraception by State Public Prosecutor's Offices, State Ministries of Health, IMSS and ISSSTE in order to obtain a better sense of the demand for this service.

NOTES

[1] UNFPA, *Programme of Action of the International Conference on Population and Development, Cairo, Egypt, September 5 – 13, 1994.* Available at <http://tinyurl.com/kessgkz> [accessed: January 14, 2013].

[2] CEDAW *General Recommendation No. 19. Violence against Women* (11th session, 1992), paragraph 24. Available at <http://tinyurl.com/sputw> [accessed: November 5, 2012].

[3] CEDAW *General Recommendation No. 24. Article 12 of the Convention on the Elimination of All Forms of Discrimination against Women – Women and Health,* (20th session, 1999), paragraph 17. Available at <http://tinyurl.com/mjtbfwg> [accessed: November 5, 2012].

[4] See CEDAW, *Concluding comments of the Committee on the Elimination of Discrimination against Women: Jamaica* (36th session, 2006), paragraph 35, [CEDAW/C/JAM/CO/5]. Available at <http://tinyurl.com/mq5uw2r> [accessed: November 8, 2012]. Human Rights Committee, *Concluding observations of the Human Rights Committee: Democratic Republic of the Congo* (86th session, 2006), paragraph 14, [CCPR/C/COD/CO/3]. Available at <http://tinyurl.com/lfoesbv> [accessed: November 8, 2012].

[5] CEDAW, *Concluding Observations of the Committee on the Elimination of Discrimination against Women* (52nd session, 2012), paragraph 32, [CEDAW/C/MEX/CO/7-8]. Available at <http://tinyurl.com/ln4wepp> [accessed: October 30, 2012].

[6] Committee on the Rights of Child, *Concluding observations of the Committee on the Rights of the Child: Guatemala,* (27th session, 2001), paragraph 45, [CRC/C/15/Add.154]. Available at <http://bit.ly/1ctALxN> [accessed: November 8, 2012].

[7] *General Population Law* and *General Health Law.*

[8] Estimates based on INEGI, ENADID: *Encuesta Nacional de la Dinámica Demográfica 2009: Metodología y tabulados básicos,* Mexico, INEGI, CONAPO, 2010. Available at <http://bit.ly/Q9bIH8> [accessed: November 8, 2012].

[9] CONAPO, *Principales indicadores de salud reproductiva: ENADID 2009:* Anticoncepción en mujeres en edad fértil (MEFU). Available at <http://bit.ly/12GRPLR> [accessed: October 10, 2012].

[10] CONAPO, *Principales indicadores de salud reproductiva: ENADID 2009: Uso de anticoncepción en la primera relación sexual.* Available at <http://bit.ly/VVEJGY> [accessed: October 10, 2012].

[11] Poder Ejecutivo Federal, *Plan Nacional de Desarrollo, 2007-2012,* Mexico, Presidencia de la República, 2007, p. 221.

[12] CONAPO, *La situación actual de los jóvenes en México,* Mexico, 2010, p. 86.

[13] CONAPO, *Principales indicadores de salud reproductiva: ENADID 2009: Transiciones a la vida reproductiva y fecundidad.* Available at <http://bit.ly/10zxh7e> [accessed: October 10, 2012].

[14] CONAPO, *Nuevas estimaciones de las necesidades insatisfechas de anticonceptivos en México,* Mexico, 2012, p. 43.

[15] Article 4. "...Everyone has the right to make free, responsible and informed decisions on the number and spacing of their children."
Article 73. "Congress has the power:
XVI. - To promulgate laws on nationality, legal status of aliens, citizenship, naturalization, colonization, emigration and immigration and public health in the Republic."

[16] *General Health Law*, Articles 3 and 27.

[17] *General Health Law's Regulations on the provision of health care services,* Articles 17, 116, 117, 118, 119, and 120.

[18] *General Population Law's Regulations,* Articles 13, 14, 15, 16, 17, 18, 19, 20, 21, 22 and 23.

[19] Cossío Díaz, José Ramón, "Píldora de emergencia: las repercusiones del fallo de la Suprema Corte en el ámbito médico" in *Gaceta Médica de México,* vol. 146, no. 4, July-August 2010. Available at <http://bit.ly/X2ZBZA> [accessed: November 7, 2012].

[20] *General Health Law,* Article 13.

[21] Cossío Díaz, José Ramón, *op. cit*. (see above, note 19).

[22] *NOM-046-SSA2-2005, Domestic and Sexual Violence and Violence against Women*, provision 6.4.2.3.

[23] The State of Mexico has only the *State of Mexico Health Regulations*, the purpose of which is to "provide, in the administrative sphere, for fulfillment of the Administrative Code of the State of Mexico". Available at <http://bit.ly/10iAS4Z> [accessed: November 5, 2012].

[24] Article 3 of the *Hidalgo State Health Law* only states that family planning is a question of general health; in the case of Michoacan, Article 6 of the *State Health Law* refers to the *General Health Law.*

[25] 22 states refer to the concept of family planning (Aguascalientes, Baja California, Baja California Sur, Campeche, Chiapas, Coahuila, Durango, Guanajuato, Guerrero, Hidalgo, Jalisco, Michoacan, Nuevo Leon, Puebla, Quintana Roo, Sinaloa, Sonora, Tamaulipas, Tlaxcala, Veracruz, Yucatan and Zacatecas).

[26] Five states (Chihuahua, Morelos, Oaxaca, Queretaro and San Luis Potosi).

[27] Two states (Mexico City and Tabasco).

[28] Two states (Colima and Nayarit).

[29] *Chiapas State Health Law*, Article 14.

[30] *Chihuahua State Health Law,* Article 62.

[31] General information, not specific to contraception, according to the *San Luis Potosi State Health Law,* Article 57.

[32] CEDAW, *A.S. vs. Hungary Communication No. 4/2004,* (36th session, 2006), paragraph 31, [CEDAW/C/36/D/4/2004]. Available at <http://tinyurl.com/3xylx9k> [accessed: October 30, 2012].

[33] Aguascalientes, Baja California, Baja California Sur, Campeche, Chihuahua, Coahuila, Durango, Guanajuato, Guerrero, Morelos, Nayarit, Oaxaca, Puebla, Quintana Roo, San Luis Potosi, Tabasco, Tamaulipas, Tlaxcala, Yucatan and Zacatecas.

[34] CEDAW, *Concluding Observations of the Committee on the Elimination of Discrimination against Women* (52nd session, 2012), paragraph 31, [CEDAW/C/MEX/CO/7-8]. Available at <http://tinyurl.com/ln4wepp> [accessed: October 30, 2012].

[35] Aguascalientes, Baja California Sur, Campeche, Chiapas, Chihuahua, Coahuila, Colima, Durango, Guanajuato, Guerrero, Mexico City, Morelos, Nayarit, Oaxaca, Puebla, Quintana Roo, San Luis Potosi, Sonora, Tabasco, Tlaxcala and Zacatecas.

[36] *Tabasco State Health Law,* Article 57.

[37] The information presented is a summary of the responses provided by State Public Prosecutor's Offices and, for the most part, retain the original manner of writing.

[38] Response of Queretaro's Ministry of Health.

[39] Baja California, Baja California Sur, Campeche, Durango, Guanajuato, Guerrero, Hidalgo, Mexico City, Michoacan, Morelos, Oaxaca, Puebla, Sinaloa, State of Mexico and Zacatecas.

[40] Federal Government, Attorney General's Office, *Sistema de Acceso a la Información Pública: Infomex*, File 0001700215512. Available at <http://bit.ly/XIsgSL> [accessed: January 25, 2013].

[41] Despite the fact that the information request was made using the *Public Information Access Service (Infomex)*, the data was made available only in physical format, which would require traveling personally to the Jalisco Ministry of Health.

[42] Chihuahua, State Public Prosecutor's Office, *Sistema de Acceso a la Información Pública: Infomex,* File 067692012. Available at <http://bit.ly/WsImmU> [accessed: January 25, 2013].

[43] Campeche's Ministry of Health, *Sistema de Acceso a la Información Pública: Infomex*, File 0100041312. Available at <http://bit.ly/WzywNs> [accessed: January 25, 2013].

[44] San Luis Potosi, Health Services, *Sistema de Acceso a la Información Pública: Infomex,* File 00189112R. Available at <http://bit.ly/127B1xs> [accessed January 25, 2013].

[45] Despite the fact that the information request was made using the *Public Information Access Service (Infomex)*, the data was made available only in physical format, which would require traveling personally to the Jalisco Ministry of Health.

[46] Federal Government, Instituto Mexicano del Seguro Social, *Sistema de Acceso a la Información Pública: Infomex,* File 0064101094512. Available at <http://bit.ly/VlWs6E> [accessed: January 25, 2013].

[47] Puebla's Ministry of Health, *Sistema de Acceso a la Información Pública: Infomex,* File 00149912. Available at <http://bit.ly/VuhgOB> [accessed: January 25, 2013].

[48] Despite the fact that the information request was made using the *Public Information Access Service (Infomex)*, the data was made available only in physical format, which would require traveling personally to the Jalisco Ministry of Health.

3.

MATERNAL MORTALITY

3.1 / INTRODUCTION

Preventable maternal mortality is a violation of the human rights to life, personal integrity, health —including reproductive health—, reproductive autonomy, privacy, equality, and non-discrimination. It violates the right to decide on the number and spacing of one's children; the right not to be subjected to torture or cruel, inhuman, or degrading treatment; the right to education and information; and the right to enjoy the benefits of scientific and technological progress.

Article 12 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) expressly establishes States' obligation to adopt appropriate measures to ensure women's access to health care services, including those related to pregnancy, childbirth, and post-partum (puerperium), on a basis of equality between men and women.

Maternal mortality is defined as the death of a woman during pregnancy or childbirth or within 42 days after childbirth, from any cause related to or aggravated by the pregnancy, childbirth, or post-partum, or its management, but not from accidental causes.[1] At the international level, the most common measure used to identify and evaluate obstacles to accessing maternal health services is the Maternal Mortality Ratio (MMR)—the number of women who die during pregnancy, childbirth, or post-partum per 100,000 live births.

Since most maternal deaths occurring under the above-described circumstances are from preventable causes, maternal mortality is a human rights issue recognized by various international mechanisms. In 2009, the United Nations Human Rights Council reaffirmed that maternal death is a human rights issue and expressed its concern for the high MMR worldwide. The Council also requested that States renew their commitment to eliminate preventable maternal mortality and morbidity in compliance with their human rights obligations.[2]

In 2011, the first maternal mortality case was brought before the Committee on the Elimination of Discrimination against Women (CEDAW Committee). The Committee condemned Brazil for not having taken effective action to prevent the maternal death of a young Afro-Brazilian woman.[3]

According to the Millennium Development Goals (MDGs), a 75% reduction of the MMR should be achieved between 1990 and 2015. This represents States' commitment to reduce maternal mortality and improve health services,[4] reiterating international commitments made when ratifying the Programme of Action of the 1994[5] Cairo International Conference on Population and Development and the 1995[6] Beijing Declaration and Platform for Action.

According to the World Health Organization (WHO), 800 women die every day from causes related to pregnancy and childbirth around the world. Most maternal deaths are preventable, with a large percentage of these deaths occurring among vulnerable women —rural, indigenous, Afro-descendant, and poor women.[7] Direct causes of maternal mortality include eclampsia and preeclampsia, hemorrhage, infections, and unsafe abortion.[8] Many of these causes are associated with poor access to quality health services, which stems from the high cost of medical care, deficiencies in supplies and equipment, and a lack of trained providers. In addition, structural barriers such as laws, policies, and practices perpetuate discrimination against women in social, economic, and family spheres.[9]

The Inter-American Commission on Human Rights (IACHR) has reiterated that lack of adequate maternal health services is a violation of women's human rights, particularly women's right to personal integrity, health, and freedom from discrimination. It has also noted that States must comply with their international obligations in the area of maternal health and that "immediate priority measures" are required to address maternal mortality.[10] To that end, recommendations issued by the IACHR to the Organization of American States (OAS) Member States include timely access to effective judicial remedies for women who believe that the State has not met its obligations in this area.[11] Therefore, in addition to actions by States to prevent maternal death in the health sector, access to justice is to be promoted in cases of both maternal death and serious and disabling complications.

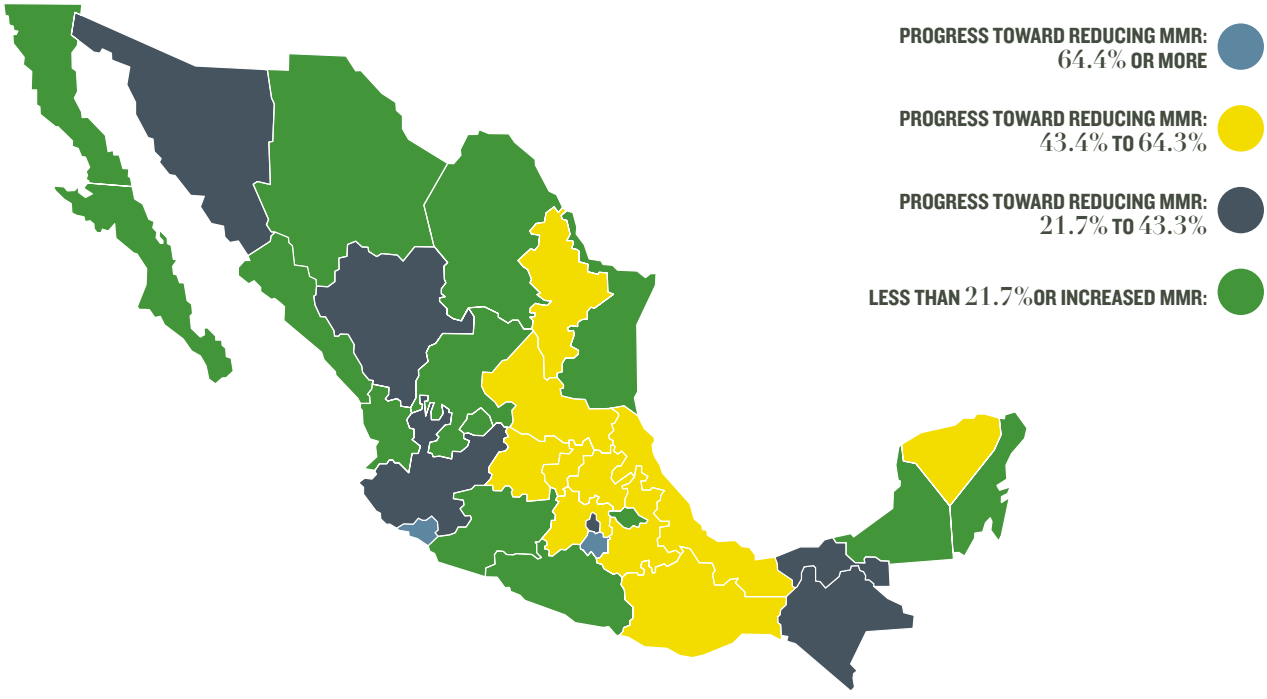
The main mechanism to ensure proper investigation and punishment of the above violations is providing effective judicial remedies and protection for victims and their families.[12] In addition, judicial inquiries to determine the States' accountability are necessary measures to identify and eradicate discriminatory practices that perpetuate maternal mortality, compensate the victims, and foster legislative and policy measures to prevent similar cases in the future.

3.2 / SITUATION IN MEXICO

Federal and state-level law and policy establish the provision of maternal health services as a priority for institutions within the Mexico's National Health System. Because of its international human rights commitments, the State is obligated to prevent maternal mortality. Nonetheless, statistical data reveal that maternal mortality has not decreased significantly in the last five years. There have been no changes in its main causes or the number of states with the highest mortality rates.[13] This situation is a reflection of structural problems in the health system that prevent women from effectively accessing maternal health services.

In Mexico, the MMR per 100,000 live births was 57.2 in 2008, 62.2 in 2009, 51.5 in 2010, and 50.7 in 2011.[14] In absolute numbers, 28,042 women died from pregnancy, abortion, childbirth, or post-partum-related complications between 1990 and 2011.[15] An analysis of progress and setbacks related to the MMR in Mexico between 1990 and 2010 reveals that in 14 states there was minimal progress or even an increase in MMR, while in the remaining 18 states the ratio decreased.[16] Of note are Colima and Morelos,[17] where the MMR decreased 64.4% or more. In accordance with the MDGs, Mexico has committed to reducing the MMR by 75% by 2015. Given the current trend, it is highly unlikely that it will reach this goal.

PERCENTAGE OF PROGRESS TOWARD MILLENNIUM DEVELOPMENT GOAL FIVE, BY STATE, FROM 1990 TO 2010



SOURCE: *Observatory of Maternal Mortality in Mexico, Percent Progress toward Goal Five of the Millennium Development Goals, by State, between 1990 and 2010.*

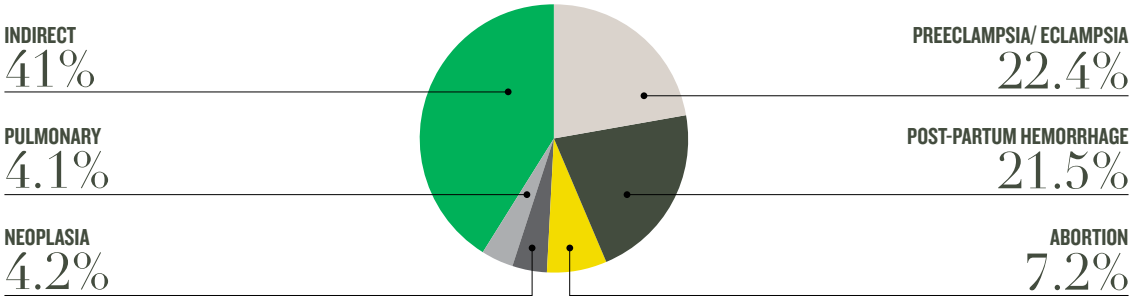
In 2010, five states had the highest maternal mortality rates among women who spoke an indigenous language. These were Oaxaca (55.9%), Guerrero (47.2%), Chihuahua (35.9%), Yucatan (25.0%), and Chiapas (24.6%).

At the national level, 8.7% of the women who died had had no access to education. In Chihuahua, Chiapas, Guerrero, Puebla, Oaxaca, Michoacan, Hidalgo, Veracruz, and Morelos, the percentage of women with little education ranges from 10 to 25%. One in three women did not have social security, and roughly 40% were affiliated to the National System for Social Protection in Health (SNPSS).[18]

In 2011, the trend remained the same. At the national level, 7.5% of the women who died had not received any formal education and 31% had only completed primary school or less; 16% spoke an indigenous language. Of a total of 68%, 20% did not have social security and 48% were affiliated to the SNPSS. [19]

The following graph shows the percentage distribution of maternal deaths by cause in Mexico, from 2010 to 2012. The data reveal that the two leading causes of maternal mortality are still preeclampsia/eclampsia and hemorrhage before, during, and after childbirth. Abortion was the third cause of death in 2010 and 2012; in 2011 the third cause was sepsis. By 2012, indirect obstetric causes were the main cause of maternal mortality nationwide.

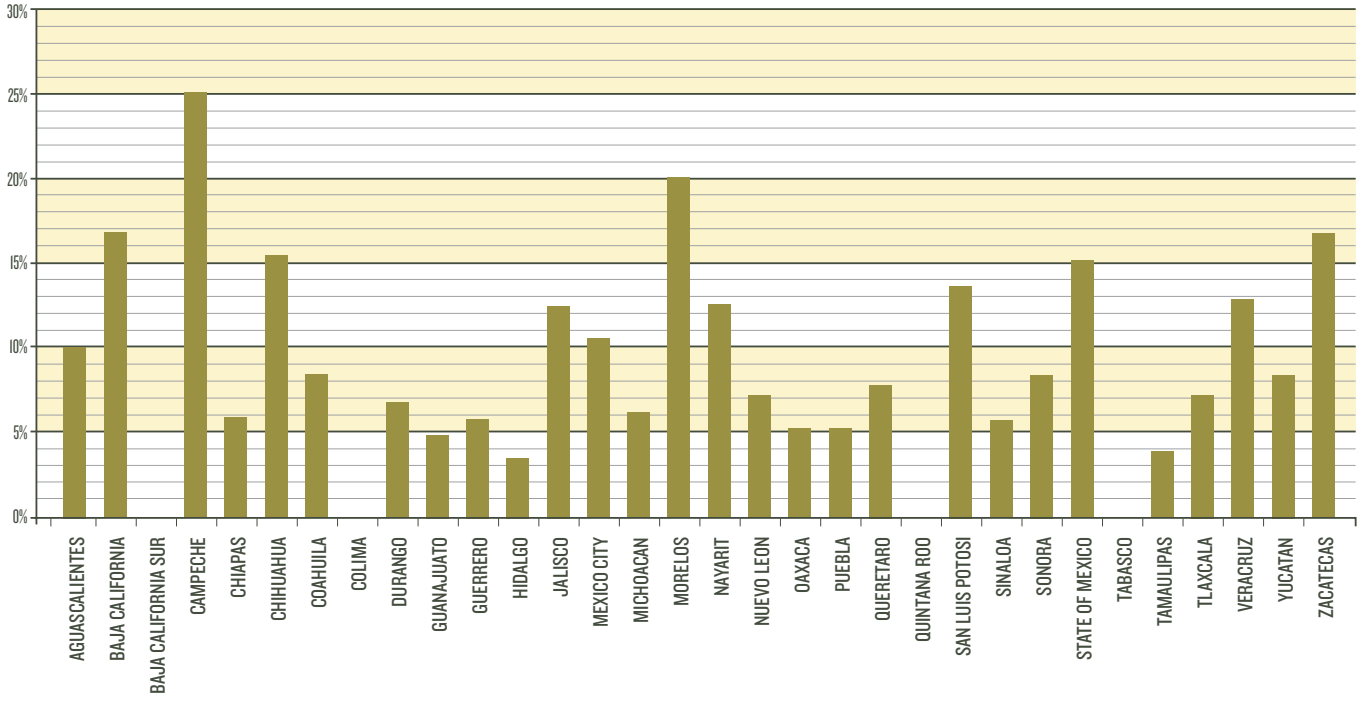
PERCENTAGE DISTRIBUTION OF MATERNAL MORTALITY CAUSES, MEXICO 2012



SOURCE: Ministry of Health, General Directorate of Epidemiology.

In 2010, abortion —the cause of an average 7% of maternal deaths in the last 20 years[20] — caused 9.3% of maternal deaths in Mexico, and between 11 and 25% in ten states (see graph below).[21] In 2011, abortion-related mortality amounted to 10% or more in eight states.[22]

PERCENTAGE DISTRIBUTION OF ABORTION-RELATED MATERNAL MORTALITY, BY STATE, MEXICO 2010



SOURCE: Observatory of Maternal Mortality in Mexico. Maternal Mortality in Mexico. Numeralia 2010.

In Mexico, many women who die from causes related to pregnancy, childbirth, and post-partum are poor and/or members of indigenous communities. Between 2004 and 2008, 33.4% of maternal deaths occurred among women who had lived in towns of less than 2,500 inhabitants, and thus were not likely to have had immediate access to hospital care.[23]

Maternal mortality among adolescents is of special concern.[24] Compared to women over 20 years of age, adolescents who initiate sex early are two to five times more likely to die of maternal causes.[25] Between 1990 and 2008, nearly one in eight maternal deaths occurred among adolescents under 19 years of age.[26] In 2009, 2010, and 2011, the percentages of maternal deaths among adolescents were 13.8%, 10%, and 9.6%, respectively.[27]

In 2010, more than 91% of the women who died of maternal causes sought hospital care and received some type of treatment before they died. This demonstrates a low quality of emergency obstetric care available in health services. In Oaxaca, Guerrero, and Chiapas, approximately one in four women died at home, and in Guerrero and San Luis Potosi, 15% died on their way to health services. These figures are evidence of the serious problems with accessing health services in marginalized communities.[28]

The Ministry of Health was the institution that recorded the highest number of maternal deaths between 2010 and 2012, with more than 400 cases each year. It is important to mention, however, that the Ministry of Health and state-level health services provide more obstetric care (deliveries and abortions) than any other institution.

The above information reflects how poorly these institutions protect maternal health. This is particularly true among vulnerable populations, particularly indigenous, adolescent and poor women.

MAIN CHARACTERISTICS OF MATERNAL DEATHS, BY CAUSE AND INSTITUTION MEXICO 2010-2012

	2010[29]			2011[30]			2012[31]		
TOTAL	992			955			949		
PERCENTAGE DISTRIBUTION FOR THREE LEADING CAUSES OF MATERNAL MORTALITY	PREECLAMPSIA-ECLAMPSIA	HEMORRHAGE DURING PREGNANCY, CHILDBIRTH, AND POST-PARTUM	ABORTION	PREECLAMPSIA-ECLAMPSIA	POST-PARTUM HEMORRHAGE	SEPSIS AND PUERPERAL INFECTION	PREECLAMPSIA-ECLAMPSIA	POST-PARTUM HEMORRAGE	ABORTION
	25%	19.6%	9.3%	24%	22.3%	7.6%	22.1%	21.2%	7.1%
DISTRIBUTION BY INSTITUTION	STATE-LEVEL HEALTH SERVICES 529 MATERNAL DEATHS			MINISTRY OF HEALTH 464 MATERNAL DEATHS			MINISTRY OF HEALTH 467 MATERNAL DEATHS		
	MEXICAN SOCIAL SECURITY INSTITUTE (IMSS) 169 MATERNAL DEATHS			NO MEDICAL CARE 200 MATERNAL DEATHS			IMSS 146 MATERNAL DEATHS		
	PRIVATE INSTITUTIONS 85 MATERNAL DEATHS			IMSS 146 MATERNAL DEATHS			PRIVATE INSTITUTIONS 88 MATERNAL DEATHS		

SOURCE: GIRE, based on data provided by the Observatory of Maternal Mortality and the Ministry of Health.

Between 2007 and 2012, the State continued to implement the program called "Arranque Parejo en la Vida" (Fair Start in Life). The program established policies that informed the provision of maternal health services in all institutions belonging to the National Health System. It also promoted the development of state-level action plans related to maternal and peri-natal health in order to identify states' needs in these areas. In addition, on May 28, 2009, the Federal Executive Branch introduced into all health institutions the Comprehensive Strategy to Accelerate the Reduction of Maternal Mortality, which includes, among other measures, free universal care for complications during pregnancy, childbirth, and post-partum, regardless of whether or not a woman has insurance (Inter-Institutional Agreement for Emergency Obstetric Care). That same year, the government launched a focused strategy to reduce maternal mortality by 7 to 14%.

Although the program proposes a series of advocacy activities in line with the national target —from improving the infrastructure of maternal health services to implementing national collaborative efforts to record maternal death statistics— the percentages of maternal mortality reduction are below percentages established for the MDGs. Since federal and state-level programs last only six years, the continuity of this program will depend on the priority that each federal government gives to maternal mortality.

Despite such programs, maternal mortality has not decreased significantly. This reveals not only a lack of effectiveness of these programs but also a poor implementation at all the three levels of government (federal, state and municipal). Not only has the government been unable to decrease maternal mortality, but it has also failed to provide victims' families with access to effective remedies to obtain compensation and justice.

The percentage of cases that are properly investigated and penalized is disturbingly low, as demonstrated in the section on implementation.

The lack of access to justice and the impunity involved in resolving cases of maternal deaths violate the human rights of women and their families. These violations are the international responsibility of the State, which has failed to diligently investigate both the irregularities in health institutions and the degree to which personnel are responsible for medical negligence.

3.3 / REGULATORY FRAMEWORK

Women's right to maternal health is based on the human rights to life, personal integrity, health, reproductive autonomy, privacy, equality, and non-discrimination. These rights are recognized in the Mexican Constitution and international treaties signed and ratified by Mexico.

3.3.1 GENERAL HEALTH LAW AND ITS REGULATIONS

The General Health Law "sets forth the bases and modalities to access health services and the harmonization of the Federation and the states in matters of general health."[32] The law's provisions also state that maternal and child healthcare[33] —a basic health service under the right to health protection— is part of general health care.[34]

Maternal health care services are described in chapter V of this law. This chapter states that maternal and child protection and maternal health promotion "span pregnancy, childbirth, post-partum, and puerperium due to the vulnerability of the woman and the fetus or child during this period,"[35] and include, among other services, "comprehensive care, including psychological care as required, for the woman during pregnancy, delivery, and post-partum."[36] In addition, the law emphasizes pregnant women's right to receive health services "with utmost respect for their human rights."[37]

The General Health Law sets out various actions aimed at identifying and eliminating risk factors for pregnant women's health and strengthening efforts to improve access to and quality of pregnancy, delivery, and post-partum care. These actions include training in obstetric care for traditional midwives,[38] participation by civil society and the private sector in Networks for Maternal Health Support,[39] "monitoring occupational activities that may threaten the physical and mental health of minors and pregnant women,"[40] and the creation of committees for maternal and child mortality prevention to "identify, systematize, and evaluate the problem and adopt beneficial measures."[41]

The General Health Law's regulations on the provision of health care services include a specific chapter on the provision of maternal and child services. The chapter states that the obligations of those responsible for an obstetrics and gynecology hospital include taking measures necessary to decrease maternal and child mortality "in compliance with recommendations to that effect by relevant national committees."[42]

3.3.2 OFFICIAL MEXICAN NORM 007-SSA2-1993, CARE OF WOMEN DURING PREGNANCY, DELIVERY AND THE POST-PARTUM PERIOD, AND OF NEWBORN CHILDREN

This Norm, adopted in 1993, defines the medical care protocol for women during pregnancy, delivery, and post-partum. The protocol seeks to ensure quality care and reduce maternal and child mortality and morbidity.

The Norm describes, in general terms, the steps for providing prenatal care and the protocol for obstetric emergencies that threaten the pregnant woman's life.[43] The purposes of the Norm are to regulate and standardize pregnancy care procedures and avoid practices that threaten pregnancy development or that do not comply with the highest quality standards.

NOM-007-SSA2-1993, Care of Women during Pregnancy, Delivery, and the Post-Partum Period, and of Newborn Children (NOM 007), states that health facilities will record the number of medical care services provided to women during pregnancy, childbirth, and post-partum. It also regulates the timely notification of maternal deaths. All related information will be collected by statistical staff with the health facility or institution and will be sent to the Ministry of Health to be entered into the National Health Information System (SINAIS).[44] The information can be consulted on the SINAIS website.[45]

The Norm is mandatory for all health personnel serving pregnant women in government, social, and private health facilities nationwide.

In addition to this Norm and to ensure its implementation, federal and state governments have implemented programs and policies to reduce maternal mortality. Some of these programs, specifically "Fair Start in Life", were mentioned in the section on the situation in Mexico. The section on implementation (see below) focuses on the analysis of accountability mechanisms and access to justice in cases of maternal death; it does not discuss existing programs.

3.4 / IMPLEMENTATION OF THE REGULATORY FRAMEWORK: ACCOUNTABILITY AND ACCESS TO JUSTICE

Monitoring and accountability are two essential aspects of the analysis of the degree of implementation of the maternal health regulatory framework.

From a human rights perspective, accountability implies developing mechanisms to identify gaps and obstacles to the implementation of regulatory frameworks and public policies. It also requires designing mechanisms that ensure access to effective remedies and compensation for victims of rights violations.

It is essential to ensure access to justice for relatives of victims of maternal mortality when their deaths are associated with a violation of their rights. Currently, victims' families have few and often ineffective judicial instruments to access justice—a situation that is exacerbated when they live in poverty.

Determining accountability for the death of these women may result in punishment for health providers. It may also result in assigning administrative accountability to the health institution for the maternal deaths or international responsibility to the State for failure to comply with its human rights obligations.[46] These cases have to be resolved by competent bodies that can investigate the facts and causes and allocate civil, administrative, criminal, and human rights accountability and comprehensive compensation for the victims.

Undoubtedly, the vast majority of preventable maternal deaths are associated with structural and institutional flaws in the health system. Therefore, it is important that accountability and access to justice are understood as opportunities to improve health systems and promote prevention; that accountability becomes a constructive process that contributes to improving the working conditions of health providers.

Monitoring and accountability mechanisms help to evaluate the effectiveness of policies and programs. This evaluation can then lead to the reforms and changes necessary to improve them.

In 2012, the CEDAW Committee recommended that Mexico "Strengthen […] its efforts to decrease the maternal mortality rate including by adopting a comprehensive safe motherhood strategy which prioritizes […] the implementation of monitoring and accountability mechanisms."[47]

3.4.1 COMMITTEES FOR THE PREVENTION OF MATERNAL AND CHILD MORTALITY

The General Health Law states that health services will promote the creation of committees for the prevention of maternal and child mortality by health institutions to determine, systematize, and evaluate the problem and adopt the necessary measures.[48] To that end, NOM 007[49] states that all secondary-level health care facilities providing obstetric care will create and operate a Committee for Maternal Mortality Studies and a Peri-Natal Mortality Studies Group.[50] The decisions made by such Committees and Groups will include prevention actions and specific measures to address the factors and causes of maternal and peri-natal death.[51]

In 1995, the Federal Ministry of Health created the National Committee for Maternal and Peri-Natal Mortality Studies (CNEMMP).[52] The objective of the Committee was to improve recording and estimation of maternal and peri-natal mortality indicators in all government and private hospitals in Mexico in order to develop strategies to reduce mortality.[53] In 2001, the Ministry published an agreement that "created the National Committee for the Fair Start in Life Program," whereby replacing the CNEMMP.[54] In 2004, it published an agreement to improve organization and coordination within and among maternal mortality committees.

CONSEQUENTLY, THE CURRENT STRUCTURE OF THE COMMITTEES IS AS FOLLOWS:

- National Committee for the Fair Start in Life Program
- Institutional Committees (central-level) in agencies that are not part of the Ministry of Health, such as IMSS and ISSSTE
- State-Level or District Committees
- Jurisdictional Committees
- State or Hospital Committees

The National Committee for the Fair Start in Life Program develops policies, guidelines, norms, procedures, strategies, and actions related to the program's operation. It also monitors and evaluates compliance with norms, procedures, and general guidelines, as well as the program's execution and results. It designs measures to improve the program's implementation; promotes, monitors, and certifies, as needed, the existence of the infrastructure and supplies at health facilities necessary to ensure the program's execution.[55] Therefore, the responsibilities of the National Committee and state-level committees are broad and promote monitoring and accountability of health facilities. This, however, begs the question as to what sort of monitoring the committees carry out for the policies, guidelines, and recommendations that they develop to improve maternal health services, and as to what happens when they determine that public officials are accountable. An analysis of the committees' specific characteristics, however, does not lead to the conclusion that they are able to identify such accountability.

The implementation of the committees has helped to decrease under-reporting and late notifications of maternal mortality, and has helped to specify its causes, and carry out clinical and epidemiological analyses. Unquestionably, all these actions have played an important role in identifying the measures necessary to improve the quality of emergency and basic obstetric care at each institution.

In addition to this complex structure, a group of civil society organizations monitors maternal mortality. The group includes Mexico's National Safe Motherhood Committee, state-level committees of Chiapas, Guerrero, Jalisco, Oaxaca, San Luis Potosi, and Veracruz, and the Observatory of Maternal Mortality in Mexico. The committees consist of civil society, government, and academic organizations, as well as international agencies concerned with maternal health.[56] The committees carry out dissemination, monitoring, and advocacy work on maternal mortality policies, whereas the Observatory is in charge of monitoring progress and setbacks related to maternal health indicators.

3.4.2 ADMINISTRATIVE COMPLAINTS AT HEALTH INSTITUTIONS

The most readily available resource for relatives of victims of maternal death is the writ of complaint. Through this mechanism, relatives can report deficiencies in medical care provided by institutions belonging to the National Health System. According to the General Health Law, these complaints "will be received and addressed in a timely and effective manner by service providers or by bodies designated by the institutions for that purpose when the complaint resolution falls within their competence."[57] Under the law, health institutions are entitled to decide on the procedures to be followed to file this type of complaint.[58]

The procedure to file complaints is important. It allows health institutions to conduct an internal investigation to determine and impose measures and administrative penalties in cases involving maternal deaths. Nonetheless, the lack of a standardized institutional procedure that regulates the mechanism to access justice in matters of health creates uncertainty among patients regarding procedures.

For this report, using a request for information, we asked the Ministry of Health to provide data on the number of complaints filed between January 2008 and August 2012 related to cases of medical negligence resulting in maternal death. The Ministry declared its incompetence in providing the information and referred the request to the National Commission of Medical Arbitration (CONAMED).[59] This demonstrates that, despite its importance, health authorities lack clarity regarding the procedure to file complaints. It also calls into question whether hospitals are formally implementing the procedure and whether federal authorities are monitoring its implementation. We requested the same information from CONAMED but received no answer.

3.4.3 ADMINISTRATIVE PROCEEDINGS AGAINST PUBLIC OFFICIALS

Omissions and deficiencies in health services that seek to adequately prevent and diagnose the causes of maternal death at public clinics and hospitals may result in administrative accountability. Public health providers at government institutions, such as those belonging to the IMSS and the ISSSTE, are subject to public accountability.[60] Therefore, they must carry out their duties in a legal, honest, impartial, and efficient manner. The Federal Law on Administrative Accountability of Public Officials states that public officials must comply with the obligations inherent in the services they provide and refrain from actions or omissions that affect or prevent their provision.[61] In addition, public officials must display good behavior and treat with respect the people with whom they come in contact during the provision of their services. They must be held accountable for their responsibilities and only use the resources allocated to achieve the intended goals.[62]

If public officials fail to comply with their obligations, they can be subject to administrative proceedings and penalties. These may include private or public warnings, layoffs, dismissal, fines, and temporary disqualification for public employment, positions, or commissions.[63] The inquiries and paperwork related to administrative proceedings, as well as their development and resolution, are the responsibility of internal controllers and officials in charge of audits, complaints, and accountability working with internal control bodies of agencies belonging to the Federal Public Administration and the Federal Attorney General's Office.[64] To initiate the proceedings, a complaint or report must be filed with a relevant area of the government agency (internal controller). The document will include the data and facts necessary to corroborate whether or not the public official is accountable. Penalties, if any, will be imposed upon completion of the investigation.

3.4.4 PECUNIARY RESPONSIBILITY OF THE STATE

In addition to penalties on public health providers, the State can also be assigned separate pecuniary responsibility.

On December 31, 2004, the Official Gazette of the Federation published the Federal Act on Responsibility for Financial Injury, which defines the bases and procedures to recognize the right to compensation for those whose property or rights are affected due to irregular administrative activities by the State.[65]

The law defines irregular administrative activities as those that affect the assets and rights of individuals that do not have a legal obligation to suffer the damage because it is not legally justified.[66] When women die because of defective and/or low-quality health services, their relatives can demand compensation from the State. This compensation, however, does not cover human rights violations. Compensation is financial and does not include actions —such as regulatory and structural changes— to avoid repetition.

3.4.5 PENAL PROCEEDINGS AT THE STATE LEVEL

As previously mentioned, most maternal deaths are associated with structural flaws in the health system and the difficult conditions in which public officials often work. In this regard, criminal punishment is inappropriate, except in extreme cases that involve malice and the evident intent to harm the woman, as is the case of forced post-partum sterilization.

GIRE submitted information requests to the 32 State Public Prosecutor's Offices to find out how many preliminary inquiries had been carried out on cases of maternal death between 2008 and 2012. We received a response from 25. Three[67] provided information on 23 inquiries that they had conducted on maternal deaths; four[68] reported that they had not carried out any preliminary inquiries on cases of medical negligence; six responded that they had recorded fewer than 15[69] preliminary inquiries related to cases of medical negligence but since the cases are classified under the general heading "medical negligence," it is not clear whether they resulted in maternal death. Twelve[70] responded that the information requested does not exist, arguing that they do not systematize or record data as required.

3.4.6 HUMAN RIGHTS COMMISSIONS

The National Human Rights Commission (CNDH) and state commissions are autonomous bodies that receive reports of human rights violations perpetrated by public officials. Since the commissions are not judicial bodies, their recommendations, although intended to protect and guarantee the human rights set forth in the Mexican Constitution and international treaties ratified by the Mexican State, are not binding because they ultimately depend on the political will of the public institution in question. Nonetheless, a diligent investigation and recommendations emphasizing public institutions' obligations can contribute to improving their administrative function.

For this report, through a request for access to information, we asked the commissions for information regarding the number of complaints filed from January 2008 to November 2012 related to human rights violations. Specifically, we requested data on women who had died due to medical negligence during pregnancy or childbirth.

The CNDH reported having issued 23 recommendations between 1994 and 2012.[71] Five state commissions responded having received one or two reports of maternal deaths during the same period,[72] and twelve claimed not having records of such complaints.[73]

3.4.7 EMBLEMATIC CASE

Karla[74], 24-years-old, was 36 weeks pregnant when she died of preventable causes. Her case clearly illustrates the health system's structural flaws related to maternal health care and obstacles to accessing justice. She did not have any complications during the first seven months of her pregnancy but during the 8th month, when she was living in Alvarado, Veracruz, she began to have warning signs and sought emergency care. She was diagnosed with a high-risk pregnancy, which could result in complications and hospital care.

On May 7, 2011, *Karla* began to feel a burning sensation in her feet. They became swollen and bruised. The following day she sought care at an IMSS Family Health Facility (UMF) in Alvarado, but her warning signs were ignored. The doctor who treated *Karla* only checked her blood pressure and the fetal heart rate. She was told that her symptoms were normal and was recommended rest and elevating her legs to deal with the swelling. On May 9, *Karla* went back to the Alvarado Health Center because her feet were still burning and swollen and was

seen by another doctor. He checked her blood pressure and the fetal heart rate; he also ordered a urine test, prescribed rest, and told her to avoid salt. *Karla* had the urine test at a private laboratory and took the results to the UMF doctor, who recommended rest and assured her that all was well.

The following day *Karla* went to see a private gynecologist because her condition did not improve. This physician also assured her that she was well and added that the urine test had only revealed a mild infection. *Karla* sought care a fourth time. She went back to the UFM because she was not feeling any better. There, however, she did not undergo any tests or physical exams. Two days later, she returned to the UFM with a fever and bruises on her feet. She was examined and eventually prescribed an antimicrobial agent, while being reassured that everything was normal. *Karla* was sent home. The following morning her condition had not improved so she went back to the Alvarado health center, where she was seen by a doctor who prescribed 500 mgs of Paracetamol every six hours, oral rehydration therapy, a blood test, and sent her home. That same day, *Karla* was taken to her private doctor, who said that a) the fetus had arrhythmia, b) the urinary tract infection persisted, and c) she had the symptoms of salmonellosis.

The following day, because of abnormal vaginal bleeding, *Karla* returned to the UMF yet again. A doctor only took her temperature and blood pressure and told her that everything looked normal. She referred *Karla* to the IMSS General Hospital in Lerdo de Tejada, Veracruz. That same day at 11:20, accompanied by her mother-in-law, she was transferred to the hospital in an ambulance; she was suffering from vaginal bleeding, abdominal pain, and vomiting. When she arrived at the emergency room, the physicians told her that she was not yet in labor because there was no dilation despite her heavy bleeding that, incidentally, nobody treated. The clinician informed her that the hospital did not have a gynecologist on-call from Monday through Friday and that because of her low platelet count, she had to be transferred to the city of Veracruz—an hour and a half away. She was transferred in an ambulance, accompanied by a nurse and the clinician. Her condition seriously deteriorated en route, and she died before reaching Veracruz.

Karla's relatives demanded justice publically and initiated legal actions with the assistance of a private lawyer. Consequently, the IMSS acknowledged its "objective institutional accountability for the lack of material and human resources at the health facilities involved, but did not find grounds for civil liability of health personnel in the provision of care to the deceased because they had provided medical care as required with the resources available at each IMSS health facility."[75] Based on this acknowledgement, dated March 12, 2012, *Karla's* husband signed an agreement with the IMSS, whereby he agreed to receive monetary compensation for damages and committed to stop any legal actions against the IMSS. As for criminal proceedings, a complaint was filed with the Public Prosecutor's Office against the physicians who treated *Karla* at the public hospitals where she sought care. To date, no information is available regarding progress made in that regard. In addition, in August 2011, a complaint was filed with the CNDH, but in December of that year the Commission reported that the investigation had been closed because the IMSS was dealing with the complaint and had granted compensation.

Given that the complaint against the IMSS was resolved through financial compensation, there is no information as to whether the IMSS implemented any measures to alleviate the lack of human and material resources to provide timely and appropriate obstetric emergency care. Nor do we know if administrative follow-up was carried out in the IMSS to ascertain whether *Karla's* death was the result of the health providers' negligence.

Of note is the failure by the State Public Prosecutor's Office to follow up on the case. Such inaction prevented the case from being brought before judicial authorities to prosecute and punish those responsible.

In this context, the actions of the CNDH are questionable. It did not carry out a proper in-depth investigation regarding the causes of this maternal death and the alleged accountability of the Veracruz health authorities. In addition, despite the way the case was resolved, the Commission failed to issue a general recommendation to ensure non-repetition. It is important to point out that the IMSS's statement —regarding the fact that the case was being dealt with, that partial accountability for the facts had been acknowledged, and that monetary compensation had been granted— was enough for the CNDH to deem the complaint resolved even though it had not investigated the characteristics of the care provided.

3.4.8 MEDICAL ARBITRATION COMMISSIONS

The CONAMED, created in 1996, and its state commissions, are public institutions that offer alternative mechanisms to resolve controversies between patients and providers. Although the General Law defines a procedure to file complaints, the Mexican State created the arbitration commissions to provide patients with a mechanism that would allow them to resolve potential conflicts derived from health service provision and "avoid overburdening jurisdictional bodies, without replacing them." Nonetheless, the capacities of these commissions are limited to reaching agreements with the parties to determine the extent of civil damages resulting from medical care provision. Hence, they do not record maternal deaths because arbitration does not require investigating the facts to assign administrative or criminal accountability to one of the parties involved.

The role of the commissions is relevant in cases of maternal death. They determine whether health institutions have incurred civil liability and the amount of financial compensation, if applicable, for victims' families. The commissions, however, do not ensure access to comprehensive justice. In fact, they may become an insurmountable obstacle to the investigation and prosecution of maternal death cases by judicial authorities. In other words, they may promote de facto impunity.

3.5 / CONCLUSIONS

Despite the many maternal health policies and programs in Mexico, maternal mortality has not significantly decreased in the country. What is more, the current trend suggests that the Mexican State will not achieve the Millennium Development Goal of reducing the MMR by 75% by 2015.

The Maternal Mortality Committees are, without a doubt, an essential mechanism to monitor maternal health policies and programs. Nonetheless, their recommendations are not binding and are not implemented.

Although the law establishes civil, administrative, and penal mechanisms that allow the relatives of victims of preventable maternal death to obtain effective remedies, this does not occur in practice. Apparently, the system of administrative complaints in hospitals is inaccessible despite being the most immediate resource for the families. Institutions belonging to the National Health System do not follow up on complaints; the regulatory framework is too lax in that it establishes that each health institution can organize their own complaint system and does not define the criteria to regulate these mechanisms. It is particularly concerning that the Federal Ministry of Health has declared itself incompetent in the matter and that the CONAMED has not provided the information requested.

With regard to administrative complaints against the IMSS and the ISSSTE, the case of *Karla*, as described above, shows that although sometimes compensation is granted (provided the relatives have legal counsel), the complaints do not translate into institutional improvements or changes —let alone the investigation and determination of potential accountability of health professionals.

It is difficult to determine the efficacy of preliminary inquiries based on the scarce information we received. Everything points to the fact, however, that cases of maternal death caused by medical negligence are not prosecuted. Criminal proceedings are not necessarily the most adequate way to deal with these cases, especially in view of the structural obstacles and deficiencies that hinder proper provision of care to pregnant women. In some cases, however, these proceedings may prove to be an alternative.

Deficiencies in monitoring and accountability mechanisms are, undoubtedly, an impediment to reducing preventable maternal mortality. It is with these mechanisms that people can access justice and identify the structural barriers facing women in accessing care during pregnancy, childbirth, and the post-partum.

3.6 / RECOMMENDATIONS

- Strengthen the civil, administrative, and penal mechanisms that provide access to justice to relatives of victims of preventable maternal death.
- Strengthen monitoring and accountability mechanisms related to maternal health policies and programs, emphasizing the identification of structural patterns and flaws.

- Ensure, through the Federal Ministry of Health, that all health institutions have accessible and effective complaint mechanisms for patients.
- Strengthen the role of the maternal mortality committees through technical, political, and financial support to enhance their efficiency.
- Ensure that institutions belonging to the National Health System effectively implement the recommendations made by maternal mortality committees and all those designed to improve maternal health services.
- Position safe motherhood as a human rights issue and develop actions to address the structural cultural, social, and economic causes associated with maternal deaths.
- The CNDH and its state commissions should address maternal mortality by preparing, disseminating, and promoting special reports; monitoring complaint filing and processing; and issuing recommendations that focus not only on compensation but also on the identification and elimination of structural flaws and health personnel deficiencies, and violations of women's rights —all determining factors in maternal deaths.

NOTES

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[10] *Ibid*, par 20.

[11] *Idem*.

[12] *Idem*.

[13] Chiapas, Mexico City, State of Mexico, and Veracruz.

[14] Observatory of Maternal Mortality in Mexico, *Mortalidad maternal en México, Numeralia 2011*, Mexico, 2012.

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[29] *Idem*.

[30] Ministry of Health, General Directorate of Epidemiology, *Informe semanal de vigilancia epidemiológica: defunciones maternas: semana epidemiológica 52, información actualizada al 28 de diciembre de 2011*. Available at <http://bit.ly/J8r073> [accessed: October 30, 2012].

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[32] *General Health Law*, Article 1.

[33] *Ibid*., Article 3, section IV.

[34] *Ibid*., Article 27, section IV.

[35] *Ibid*., Article 61.

[36] *Ibid*., Article 61, section I.

[37] *Ibid*., Article 61 bis.

[38] *Ibid*., Article 6.

[39] *Ibid*., Article 64 bis.

[40] *Ibid*., Article 65.

[41] *Ibid*., Article 62.

[42] *Reglamento de la Ley General de Salud en Materia de Prestación de Servicios de Atención Médica*, Article 99.

[43] *Official Mexican Norm 007-SSA2-1993, Atención de la mujer durante el embarazo, parto y puerperio y del recién nacido,* provision 5.1.

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[61] *Ibid*., Article 8, section I.

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[63] *Ibid*., Article 13.

[64] *Ibid*., Article 4.

[65] *Ley Federal de Responsabilidad Patrimonial del Estado,* Article 1.

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[74] The woman's name was changed to protect her identity.

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4.

OBSTETRIC VIOLENCE

4.1 / INTRODUCTION

Obstetric violence is a specific type of violation of women's reproductive rights, including the rights to equality, freedom from discrimination, information, integrity, health, and reproductive autonomy. It occurs in government and private medical practice during care related to pregnancy, childbirth, and post-partum and is the product of a multifactorial framework where institutional and gender violence meet.

> Violations of women's human and reproductive rights during institutional delivery care are numerous. They include scolding, taunts, insults, threats, humiliation, manipulation of information, denial of treatment without referring women to other providers for timely care, delaying urgent medical care, indifference to their requests or needs, failing to consult or inform them regarding medical or clinical decisions made during labor, using them as a didactic resource without respecting their human dignity, using pain as punishment during labor, and coercing them in order to obtain their "consent," as well as causing evident and deliberate harm to their health, among other even more serious and obvious violations of their human rights.[1]
> Experts have identified two forms of obstetric violence. One is physical, described as "the use of invasive practices and administration of drugs that are not justified by the health status of the woman giving birth (...) or a disregard for the timing and the possibility of natural childbirth."[2]

THE WORLD HEALTH ORGANIZATION (WHO) HAS PUBLISHED A SERIES OF GUIDELINES REGARDING PRACTICES THAT IT HAS CLASSIFIED AS:

1. Practices which are demonstrably useful and should be encouraged;
2. Practices which are clearly harmful or ineffective and should be eliminated;
3. Practices for which insufficient evidence exists to support a clear recommendation and which should be used with caution while further research clarifies the issue; and
4. Practices that are frequently used inappropriately.[3]

Among the practices to avoid as recommended by the WHO is to limit unnecessary medical interventions, that is, routine episiotomy, shaving, fetal monitoring, and enema. It also encourages limiting the use of oxytocin, analgesia, and anesthesia; and keeping the Caesarean rate to no more than 10 to 15% of all births.[4]

The second type of obstetric violence is psychological violence. This includes "dehumanized and rude treatment, discrimination, and humiliation when the woman seeks advice or requires care or during obstetric service provision. It also includes failure to provide information about how the labor is progressing."[5] In recent years, an alternate model of "humanized childbirth" has become more popular. This model:

> Seeks to explicitly and directly take into account the opinions, needs, and emotional perceptions of women and their families during pregnancy, childbirth, and postpartum care. Its main objective is to make the experience special and pleasant, one that occurs in dignified conditions, where the woman is the subject and protagonist of her own labor, and her or her partner's right to freely decide where and with whom to give birth is recognized.[6]

In addition to the WHO recommendations, there is an ample international legal framework underlying protection against reproductive health-related violence. Article I of the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women ("Convention of Belem do Para") states that violence against women shall be understood as "any act or conduct, based on gender, which causes death or physical, sexual or psychological harm or suffering to women, whether in the public or the private sphere." The Convention imposes positive obligations on the States to eradicate all forms of violence against women and establishes that special consideration is to be given to women subjected to violence while pregnant (Article 9). Internationally, violence against women is recognized as a form of discrimination that hinders their enjoyment of human rights and fundamental freedoms on a basis of equality with men. Specifically, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) establishes that the States are to adopt appropriate measures to eliminate discrimination against women in the context of access to medical services, guaranteeing women appropriate services relating to pregnancy, birth, and the post-partum.[7]

Consequently, in the reproductive health sphere, actions or behaviors that cause death, harm or physical, sexual, or psychological suffering to women because of their gender are forms of violence and discrimination against women.

Acts or omissions that violate women's reproductive rights can be acts of torture or cruel, inhuman, or degrading treatment, if they cause physical or mental pain or suffering and are committed in order to destroy their personality or physical or mental abilities or to achieve any other end. In that regard, the Committee against Torture has pointed out that the situations in which women are at risk of torture or ill treatment "include deprivation of liberty, [and] medical treatment, particularly involving reproductive decisions (...)".[8]

Extreme cases of obstetric violence reveal the use of abusive strategies, such as obtaining women's authorization to perform sterilization or insert an IUD during labor—when women are vulnerable and not in optimum circumstances to grant informed consent.[9]

Particularly, indigenous women have been the victims of this ongoing practice.[10] Due to cultural and sociological factors that associate the bodies of poor indigenous women with a public health threat, sterilization and fertility control among these women are associated with the benefits of social programs.

> Although sterilization is not itself 'oppressive' and many women choose to undergo the procedure, it is unethical to coerce women into agreeing to sterilization by threatening them with the loss of social benefits. In addition, the imposition of contraceptive methods and non-consensual sterilization clearly reveals the existence of hierarchical social values related to motherhood and women's bodies, and the intersections of multiple axes of oppression revolving around motherhood.[11]

Sterilization without women's informed consent is an act of torture and/or cruel, inhumane and degrading treatment. It violates women's right to health and proper medical care, equality, freedom from discrimination, and dignity—all of them recognized in the Mexican Constitution and international treaties signed by Mexico.

At the international level, cases of forced sterilization of women with HIV, such as *F.C. v Chile*,[12] and of indigenous women, such as *María Mamérita Mestanza Chávez v Peru*,[13] have been brought to the Inter-American Commission on Human Rights (IACHR). In cases such as these, States failed to protect women against violence and discrimination and did not enforce their right to decide on the number and spacing of their children. Further, in the case of *A.S. v Hungary*[14], the Committee on the Elimination of Discrimination against Women (the CEDAW Committee) declared that the Hungarian State had failed to guarantee the right to information to A. S., a woman of Roma descent, who was sterilized without consent.

4.2 / SITUATION IN MEXICO

According to the 2010 Population and Household Census, seven in ten Mexican women over the age of 15 have had at least one live birth.[15] This means that, in Mexico, 71.6% of women of reproductive age have needed medical care during pregnancy, childbirth, or post-partum.

Data on the number of deliveries and Caesareans attended in 2009 confirms what has been documented for several years: a disproportionate increase in Caesarean births. According to the National Institute of Statistics and Geography (INEGI), Caesarean deliveries accounted for 38.1% of all births.[16]

Worldwide, according to the 2012 National Health and Nutrition Survey, Mexico ranks fourth (after China, Brazil, and the United States) in the use of non-medically indicated Caesarean deliveries. The survey also shows a 50.3% increase in the Caesarean rate in the last 12 years —a 33.7% increase in the public sector and a 60.4% increase in the private sector.[17]

Of the rest of the births, 59.7% were "eutocic" deliveries (or normal deliveries, that is, when the process ends without a medical (surgical) intervention)[18] and 2% were "dystocic" births (or deliveries with complications requiring specialized medical care). For 0.2% of the births, the type of delivery was unspecified.[19]

PERCENTAGE DISTRIBUTION OF BIRTHS BY TYPE OF DELIVERY / MEXICO 2009

60% EUTOCIC DELIVERIES

38% CAESAREAN DELIVERIES

2% DYSTOCIC BIRTHS

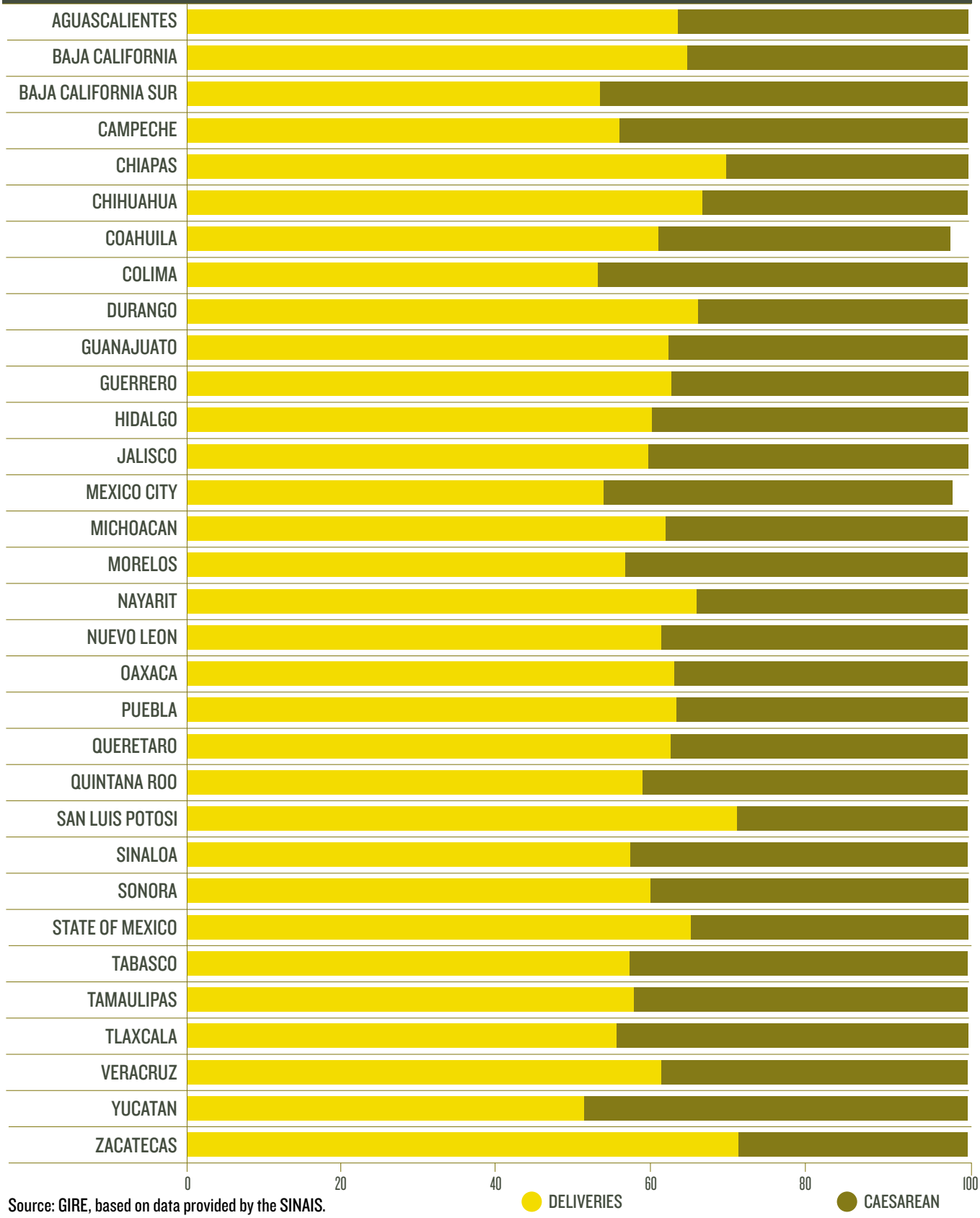
Source: INEGI.

DECREASED PREVALENCE OF CAESAREAN DELIVERIES[20]

As previously mentioned, the maximum rate of Caesareans recommended by the WHO is 15% of all births.[21] In Mexico, the rate doubles this level, revealing that providers overuse the procedure.

The Caesarean delivery rate is the clearest indicator of a series of harmful practices carried out during pregnancy, childbirth, and post-partum care.

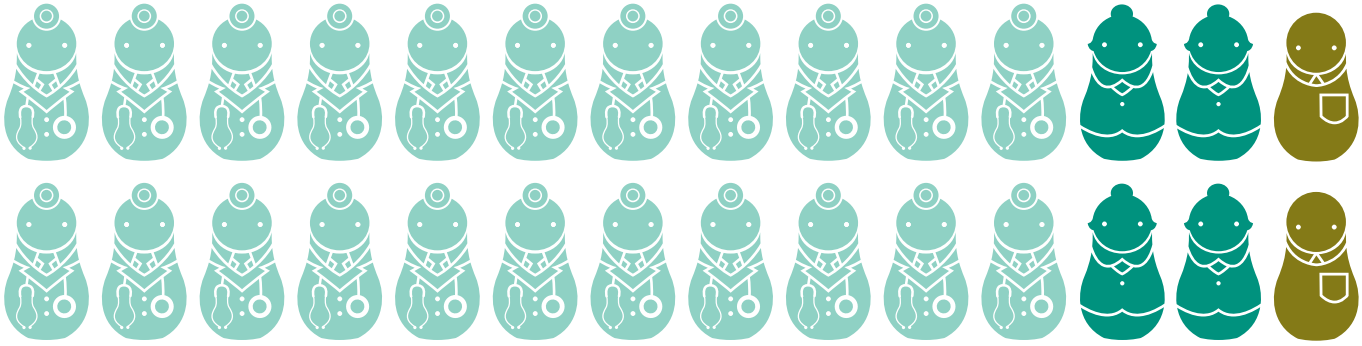
TYPE OF DELIVERY BY STATE / MEXICO 2010



Source: GIRE, based on data provided by the SINAIS.

At the national level, in 2010, 97 out of 100 pregnant women were attended by a doctor, whereas 2% received care from a midwife. For the remaining 1%, there was no information regarding birth attendants.[22]

BIRTH ATTENDANTS / MEXICO 2010

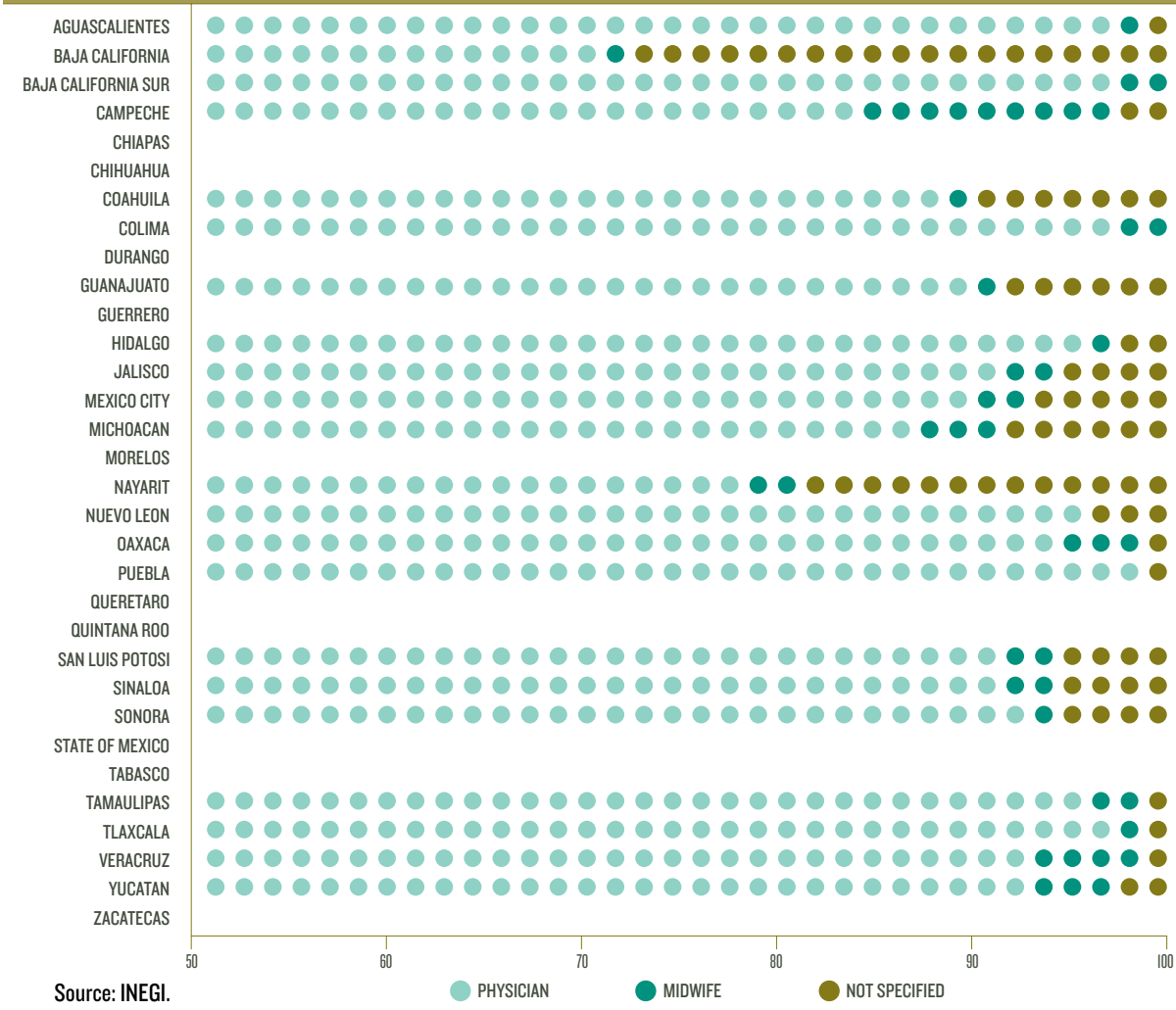


Source: INEGI.

PHYSICIAN MIDWIFE N/S

At the state level, the above percentages are similar. Nonetheless, in Baja California and Nayarit, the percentage of deliveries attended by physicians is lower.

BIRTH ATTENDANTS BY STATE / MEXICO 2010



Source: INEGI.

No existing quantitative research or report allows us to determine the magnitude of the problem of obstetric violence. Several academic studies with qualitative approaches, however, have identified an interesting but worrisome pattern. In principle, "obstetric violence continues to go unrecognized in policies related to quality health services and in the discussion about obstetrics/gynecology training and practice."[23]

Research centered on women's testimonies shows specific forms of ill treatment and abuse, which Castro and Erviti[24] have identified as the basic forms in the continuum of reproductive right violations during institutional care for childbirth and Caesarean delivery. Since they do not manifest themselves in visible harm to women's physical health, these forms have been made invisible and have been naturalized by health institutions and staff and by the women themselves and their families. Although the scope of this report does not include a study of these forms of obstetric violence, it is important to note that women's testimonies point to the following revealing conclusion:

> Obstetric violence has been naturalized by medical and obstetric personnel and by society as a whole, including the women who suffer this violence. Most of the women that were interviewed said that they preferred to forget childbirth-related discomfort and ill treatment (often deemed God's will) and focus on the joy of having a newborn to avoid worsening their emotional condition.[25]

Studies that analyze health providers' perceptions of reproduction, motherhood, and women are consistent with the previous quote. They also report that "there is a complex web of beliefs, myths, and social devices in participants' discursive constructions, which allows for doubting the credibility of some women while at the same time holding them accountable for the outcome of their pregnancy."[26]

4.3 / LEGAL AND POLICY FRAMEWORK

4.3.1 OBSTETRIC VIOLENCE

In Mexico, the various types of violence against women are identified in the General Law on Women's Access to a Life Free of Violence and its state versions (hereinafter called the general law and access laws), which regulate public policy on the matter. The general law does not include obstetric violence and at the state level, only the access laws in Chiapas,[27] Guanajuato,[28] Durango,[29] and Veracruz[30] have defined it.

The Mexico City law defines a type of violence against reproductive rights. Although it does not expressly define obstetric violence, it refers to "all acts or omissions that restrict or violate women's rights [...] concerning [...] prenatal care and emergency obstetric care services."[31]

The Guanajuato Access Law defines obstetric violence as "[...] medical negligence and all intentional acts or omissions by health personnel that harm, hurt or denigrate women during pregnancy and childbirth."[32]

The definitions in the access laws of Durango, Chiapas, and Veracruz are more specific regarding acts and omissions that constitute obstetric violence. They include the following:

1. Failing to provide timely and efficient obstetric emergency care.
2. Forcing birthing women to deliver in the supine position with their legs raised, in settings where they can deliver in more upright positions.
3. Hindering early infant-mother bonding without medical justification, denying the mother the chance to hold and breastfeed her baby immediately after birth.
4. Altering a natural low-risk delivery process by using labor augmentation techniques without women's expressed, voluntary, and informed consent.
5. Performing a Caesarean without women's expressed, voluntary, and informed consent when conditions allow for a natural delivery.

Consistent with the nature and focus of this regulatory framework, the access laws of the above three states define the health provider as the perpetrator of obstetric violence, irrespective of his or her title. This means that the perpetrator can be any person that provides or participates in the provision of public, social, or private health services.

A. DEFINITION OF THE CRIME OF OBSTETRIC VIOLENCE

The Penal Code of Veracruz defines the crime of obstetric violence. This definition was developed in the context of a series of proposed changes to the code in an attempt to promote women's effective access to a life free from violence, as stated in the justification section of the bill to reform Article 363 of the code.

> [...] a review of the Access Law will reveal legal provisions that define various types and forms of violence against women. It cannot be ignored that the Law on Access to a Life Free of Violence also stipulates that measures necessary to punish such acts of violence must be adopted, thus creating the need to define as crimes some of these types and forms of violence in the Penal Code [...][33]

The reformed Article 363 establishes that health providers commit the crime of obstetric violence when they:

> I. Fail to provide care or timely and efficient care to women during pregnancy, delivery, post-partum, and obstetric emergencies;
> II. Alter a natural low-risk delivery process by using labor augmentation techniques without women's expressed, voluntary, and informed consent;
> III. Perform a Caesarean without women's expressed, voluntary, and informed consent when conditions allow for a natural delivery;
> IV. Harass or pressure, psychologically or rudely, a birthing woman to stop her exercising her free choice regarding childbirth;
> V. Hinder infant-mother bonding without medical justification by denying the mother the chance to hold and breastfeed her baby immediately after birth; and
> VI. Force birthing women to deliver in the supine position (on their backs) and with their legs raised or in ways that differ from their obstetric customs and traditions, in settings where they can deliver in more upright positions.

The law, in sections I, II, III, and IV, prescribes three to six years imprisonment and fines of the equivalent of up to 300 days of the offender's salary. For those guilty under sections IV and V, the law prescribes six months to three years imprisonment and fines of the equivalent of up to 200 days of their salary. In addition, if the perpetrator of the crime is a government official, the penalty will be dismissal from office or disqualification (for up to two years) from holding another government job or office or accepting a public assignment.

If the definition in the Veracruz Access Law is compared to those in the relevant sections of the Veracruz Penal Code, no differences or further descriptions are found regarding conducts against women's dignity in the context of obstetric violence. The exception is section IV of Article 363 of the code.

Interestingly, in Puebla and Oaxaca, two reform bills have been submitted regarding the definition of the crime of obstetric violence.[34] Both of them, however, have yet to be approved.

In addition, although some conducts, especially forced sterilization, should be defined as crimes in the penal code, one cannot help but wonder if use of the penal law as a coercive mechanism is the correct response to eradicate violence of this kind. Modern penal law theories, such as the *ultima ratio* principle and the minimum penal law,[35] maintain that criminalizing a conduct should be the last resort when trying to obtain respect and guarantees for human rights and the social order. Therefore, before criminalizing a specific conduct, administrative and public policy measures should be developed to reinforce the regulatory and human rights-based framework. Consequently, non-compliance or human rights violations would be penalized using administrative or civil remedies.

In this regard, penal action should be used to penalize only specific acts of obstetric violence, such as forced sterilization. For other types of conducts, rather than using penal formulas —that would only "strengthen" the State's tendency toward criminalization instead of ending a structural problem—,alternate mechanisms or solutions should be found that include administrative and public policy measures. Penal remedies are not ideal to prevent obstetric violence practices because they predispose physicians and do not promote a change in mindset or in public policies regarding humanized childbirth.

4.3.2 OFFICIAL MEXICAN NORM 007-SSA2-1993, CARE OF WOMEN DURING PREGNANCY, DELIVERY AND THE POST-PARTUM PERIOD, AND OF NEWBORTH CHILDREN

On January 6, 2005, the Official Gazette of the Federation published a resolution that modified the Official Mexican Norm 007-SSA2-1993 (NOM 007) that seeks to decrease obstetric damage and health risks for women and their children during pregnancy, delivery, and post-partum. The Norm empha-

sizes risk prevention during pregnancy and the reduction of routine practices that increase risk or are unnecessary. Further, it highlights the need to improve quality of care and promote a warm doctor-patient relationship during pregnancy, delivery, and post-partum care.

NOM-007-SSA2-1993, CARE OF WOMEN DURING PREGNANCY, DELIVERY, AND THE POST-PARTUM PERIOD, AND OF NEWBORN CHILDREN	
OBJECTIVE	Establish criteria to provide care for women and monitor their health during pregnancy, childbirth, and post-partum, as well as criteria for the newborn's care.
SCOPE OF IMPLEMENTATION	The norm is compulsory for all health personnel at public, social, and private health facilities nationwide that provide care to pregnant, birthing, and post-partum women, as well as to the newborn.
CRITERIA FOR DELIVERY CARE PROVISION	**Among other measures, the norm recommends the following:**
	> Encourage women to alternate between lying on their side and walking to improve labor and maternal-fetal status. Women's decisions as to what positions to adopt will be respected, unless medically contraindicated.
	> Avoid using routine analgesia, sedatives, and anesthesia during normal labor. In exceptional cases, they can be used based on provider criteria and after having informed and obtained authorization from the birthing woman.
	> Avoid routine use of normal labor induction/conduction and artificial rupture of membranes to accelerate labor. Use of these procedures requires medical justification in writing and will be performed under strict supervision by physicians with in-depth knowledge of obstetric physiology. Further, the relevant institutional norm will always be followed.
	> Develop indication guidelines for Caesarean delivery. The recommended rate is 15% of all births at secondary care hospitals and 20% at tertiary hospitals. Medical facilities will comply with these recommendations.
	> Use of enemas and shaving of pubic hair during labor will take place only when medically indicated and with the woman's consent.
	> Episiotomies will be performed only by qualified medical personnel trained in proper repair techniques. When an episiotomy is indicated, the woman will be informed and the procedure will be recorded in writing.

As the above table shows, NOM 007 establishes health provider obligations concerning pregnancy, delivery, and post-partum care to prevent obstetric violence against women. It is, therefore, essential to create awareness among medical personnel that they are legally bound to comply with the official Mexican norms related to their professional practice. Currently, NOM 007 is under review. Hence, the moment is ideal to incorporate the highest WHO standards, particularly the inclusion and recognition of midwives as birth attendants, which would enable them to provide vital services during childbirth.[36]

4.3.3 FORCED STERILIZATION

The General Health Law and some state health laws forbid forced sterilization. In addition, the Federal Penal Code and some state-level penal codes define forced sterilization as a crime.

The General Health Law establishes that "Those who perform sterilization without the patient's consent or through coercion will be penalized as per the provisions in this Law, irrespective of their criminal liability."[37] The penalties can include: 1) reprimand and warning; 2) fines; 3) temporary or permanent (partial or total) closure; and 4) up to 36 hours imprisonment. In addition, a fine of 6,000 to 12,000 times the minimum wage will be imposed. In 10 states, the state laws include similar provisions.

The Federal Penal Code defines the crime of "non-consensual sterilization" in the chapter on crimes against reproductive rights and imposes between four and seven years of imprisonment and a fine of up to 70 days of salary, compensation for damages, as well as layoff or disqualification from holding another job for a term equal to that of imprisonment or permanent disqualification. The definition of the crime of forced sterilization in eight state-level penal codes is similar to that in the federal code.

FORCED STERILIZATION

STATE	STATE HEALTH LAW	STATE PENAL CODE (DEFINITION OF THE CRIME)
AGUASCALIENTES	**ARTICLE 75** Those who perform sterilization, insert contraceptive methods, or induce abortion without the patient's consent or through coercion will be penalized as per the provisions in this Law, irrespective of their criminal liability.	
BAJA CALIFORNIA	**ARTICLE 26** Those who perform sterilization without the patient's consent or through coercion will be penalized as per the provisions in this Law, irrespective of their criminal or civil liability.	
BAJA CALIFORNIA SUR	**ARTICLE 69** Those who perform sterilization without the patient's consent or through coercion will be penalized as per the provisions in this Law, irrespective of their criminal liability.	
CAMPECHE	**ARTICLE 64** Those who perform sterilization without the patient's consent or through coercion will be penalized as per the provisions in this General Law, irrespective of their criminal liability.	
CHIAPAS		**ARTICLE 186 BIS** Those who perform sterilization by any means and without the person's consent. The penalty for this crime will be four to seven years imprisonment and a fine of 40 to 120 times the minimum wage plus compensation for damages.
CHIHUAHUA	**ARTICLE 62** Those who perform sterilization without the patient's consent or through coercion will be penalized as per the provisions in this Law, irrespective of their criminal liability.	
COAHUILA	**ARTICLE 62** Those who perform sterilization without the patient's consent or through coercion will be penalized as per the provisions in this Law, irrespective of their criminal liability.	

FORCED STERILIZATION

STATE	STATE HEALTH LAW	STATE PENAL CODE (DEFINITION OF THE CRIME)
DURANGO	**ARTICLE 88** Those who perform sterilization without the patient's consent or through coercion will be penalized as per the provisions in the General Health Law, irrespective of their criminal liability.	**ARTICLE 236** A penalty of 2 to 6 years imprisonment, a fine of 144 to 432 times the minimum wage, and disqualification from holding another job for one to three years will be imposed to the medical professional who […] IV. Performs sterilization to render the patient infertile without the patient's consent or through coercion.
GUANAJUATO	**ARTICLE 68** Those who perform sterilization or insert mechanical contraceptive devices without the patient's consent or through coercion will be penalized as per the provisions in this Law, irrespective of their criminal liability.	
GUERRERO	**ARTICLE 71** Those who perform sterilization without the patient's consent or through coercion will be penalized as per the provisions in this Law, irrespective of their criminal liability.	**ARTICLE 147 B** Those who perform non-consensual surgical procedures on a person to render this person infertile will commit the crime of forced sterilization. The penalty for this crime will be four to seven years imprisonment and a fine of 40 to 120 times the minimum wage plus compensation for damages.
MEXICO CITY		**ARTICLE 151 BIS** The penalty for those who perform sterilization on a person over 18 years of age without the person's consent will be four to seven years imprisonment.
MORELOS	**ARTICLE 74** In the sphere of reproductive health services, those who perform sterilization or provide a family planning method without the patient's consent or through coercion will be penalized as per the provisions in this Law, irrespective of their criminal liability.	
NAYARIT	**ARTICLE 62** Those who provide a patient with sterilization or any other contraceptive method without his or her consent or through coercion will be penalized as per the provisions in this Law, irrespective of their criminal liability.	
OAXACA	**ARTICLE 62** Those who provide sterilization or any other contraceptive method without the patient's consent or through coercion will be penalized as per the provisions in this Law, irrespective of their criminal liability.	

FORCED STERILIZATION

STATE	STATE HEALTH LAW	STATE PENAL CODE (DEFINITION OF THE CRIME)
PUEBLA	**ARTICLE 62** Those who perform sterilization without the patient's consent or through coercion will be penalized as per the provisions in this Law, irrespective of their criminal liability.	**ARTICLE 343 TER** The penalty for those who perform irreversible sterilization on a person over 18 years of age without the person's previous informed consent will be 10 to 15 years imprisonment. If sterilization is reversible, the term of the penalty will be reduced by a third.
QUINTANA ROO	**ARTICLE 62** Those who perform sterilization without the patient's consent or through coercion will be penalized as per the provisions in this Law, irrespective of their criminal liability.	**ARTICLE 113 QUATER** Those who perform non-consensual surgical procedures on a person to render this person infertile will commit the crime of forced sterilization. The penalty for this crime will be four to seven years imprisonment and a fine of 40 to 120 days plus compensation for damages.
SAN LUIS POTOSI	**ARTICLE 57** Those who perform sterilization on a patient without his or her consent or through coercion will be penalized as per the provisions in this Law, irrespective of their criminal liability.	**ARTICLE 158.** Those who perform non-consensual surgical procedures on a person to render this person infertile will commit the crime of forced sterilization. The penalty for this crime will be two to six years imprisonment and a fine of 40 to 120 times the minimum wage plus compensation for damages.
TABASCO	**ARTICLE 66** Those who perform sterilization without the patient's consent or through coercion will be penalized as per the provisions in this Law, irrespective of their criminal liability.	
TLAXCALA	**ARTICLE 105** Those who perform sterilization without the patient's consent or through coercion will be penalized as per the provisions in this General Health Law, irrespective of their criminal liability.	
VERACRUZ		**ARTICLE 160 BIS** Those who perform or prescribe non-consensual surgical procedures or otherwise on a person to render this person infertile will commit the crime of forced sterilization. The penalty for this crime will be three to 10 years imprisonment and a fine of up to 300 times a day's wage plus compensation for damages. Compensation will consist, if applicable, of restructuring, reopening, and rechanneling the vas deferens or of any other surgical procedure that restores the reproductive function and, if required, psychological treatment at the expense of the perpetrator. In addition to the above penalties, the perpetrator will be disqualified, if applicable, from practicing for a period equal to the term of imprisonment. If the perpetrator is a government official,

FORCED STERILIZATION		
STATE	**STATE HEALTH LAW**	**STATE PENAL CODE (DEFINITION OF THE CRIME)**
		the penalty will also be dismissal and disqualification from public employment, positions, or commissions for up to 10 years.
YUCATAN	**ARTICLE 68** Those who perform sterilization without the patient's consent or through coercion will be penalized as per the provisions in this Law, irrespective of their criminal liability.	
ZACATECAS	**ARTICLE 41** Those who perform sterilization without the patient's consent or through coercion will be penalized as per the civil and penal legislation.	

As demonstrated by the table, the health laws in the aforementioned states establish that forced sterilization of women is punishable by an administrative penalty and, since it is a crime, by any other applicable criminal penalties. In all states, except Baja California, which includes civil responsibility, the wording of the laws and that of the General Health Law are identical. Nonetheless, it is alarming that almost half of the states fail to explicitly forbid forced sterilization.

Of concern is the fact that forced sterilization is not regarded as a crime in the penal codes of most states in Mexico, even though it is a serious violation of personal integrity, reproductive autonomy, and health.

4.4 / IMPLEMENTATION OF THE LEGAL AND POLICY FRAMEWORK

For this report, requests for access to public information were submitted to federal and state health institutions and the national and state human rights commissions. The information was needed to determine the degree of implementation of law and policy related to care during pregnancy and delivery, and obstetric violence. In addition, in that regard, the National Commission of Medical Arbitration (CONAMED) was asked to report how many complaints had been filed and how many penalties had been imposed. In the case of Veracruz, a specific request for information was submitted to the state Ministry of Health and Public Prosecutor's Office to find out how many health providers had been reported in connection with the crime of obstetric violence.[38]

4.4.1 CARE DURING DELIVERY

To obtain national data regarding delivery care, requests for information were submitted to the Ministry of Health, the Mexican Social Security Institute, and the Institute for Social Security and Services for State Workers (SSA, IMSS, and ISSSTE, respectively). The information revealed that SSA hospitals, which serve individuals not affiliated with the IMSS and had the greatest number of deliveries in 2009, 2010, and 2011,[39] had the lowest rate of Caesarean deliveries (25.6% on average). In contrast, IMSS[40] and ISSSTE hospitals performed a higher number of Caesareans —an average 51 and 40%, respectively— despite having served half the population in the same period.

NUMBER OF DELIVERIES AND CAESAREANS / 2009-2011

State	2009			2010			2011		
	Deliveries	Caesareans	Total	Deliveries	Caesareans	Total	Deliveries	Caesareans	Total
SSA	993,655	339,919	1,333,574	1,011,243	349,855	1,361,098	1,040,481	356,825	1,397,306
	74.5%	25.5%	100%	74.3%	25.7%	100%	74.5%	25.5%	100%
IMSS	233,215	243,252	476,467	219,348	237,885	457,233	224,485	238,166	462,651
	49%	51%	100%	48%	52%	100%	49%	51%	100%
ISSSTE	38,450	25,422	63,872	41,020	28,135	69,155	39,671	27,016	66,687
	60.2%	39.8%	100%	59.3%	40.7%	100%	59.5%	40.5%	100%

Source: GIRE, based on data obtained through information requests.

The fact that the institutions did not provide information regarding the medical justification for Caesarean deliveries raises concern. The IMSS, which performs the highest number of Caesareans, does not follow even its own recommendations. It has developed two sets of guidelines, one for labor monitoring and management and another for Caesarean delivery, where it states that the high prevalence of this practice is regarded as a public health problem.

> A considerable increase in unnecessary Caesareans has been identified recently. This practice is unsafe and entails inherent surgical and anesthesia-related risks. Such an increase is associated with higher maternal morbidity and mortality because it increases the risk of placenta previa and placenta accreta, resulting in a higher likelihood of obstetric hemorrhage and, consequently, maternal death.[41]

Regarding the information provided to women on different delivery options and their risks and advantages, only the IMSS and the ISSSTE replied, but did not provide details. The IMSS reported providing women with verbal information about evident obstetric risk factors pertaining to each type of delivery, and the ISSSTE replied that the information provided depends on each case and on the clinician. None of them mentioned the WHO recommendations or NOM 007, which reflects an alarming failure to comply with relevant national and international norms.

A. CARE DURING DELIVERY: SITUATION IN THE STATES

Federal and the state ministries of health received the same information requests. The information requested included the type of information provided to pregnant women about different delivery options, their risks and advantages; number of women who delivered at their facilities each year by age group; percentage of births by vaginal delivery and Caesarean delivery; and medical justification for Caesarean deliveries. As was the case with other information requests submitted for the purposes of this report, not all states replied. In the cases in which they did provide information, its content and detail varied. Because the replies are biased and heterogeneous, representative conclusions for all the states are hard to reach.

Based on the data received, we can identify indicators of a persistent high prevalence of Caesarean delivery with no downward trend. In fact, in two states (Aguascalientes and Chiapas) the prevalence doubled in a year. Since only Colima was able to reduce this practice between 2010 and 2011, the factors that caused this reduction warrant careful study.

NUMBER OF DELIVERIES AND CAESAREANS / 2009-2011

	DELIVERIES			CAESAREANS		
ENTIDAD	2009	2010	2011	2009	2010	2011
AGUASCALIENTES	8,690	9,192	9,489	5,161	5,236	10,806
BAJA CALIFORNIA	23,288	23,306	23,233	5,794	5,478	6,264
BAJA CALIFORNIA SUR	Did not reply to the information request					
CAMPECHE	Officials replied that they would only provide information in person at their local offices					
CHIAPAS	39,366	41,217	44,487	13,707	14,628	28,546
CHIHUAHUA	22,279	19,675	23,621	6,008	5,552	6,721
COAHUILA	55,284	54,209	56,071	24,079	24,159	25,199
COLIMA	8,134	7,848	7,350	3,412	3,355	2,841
DURANGO	12,079	11,344	12,058	4,407	4,637	4,486
GUANAJUATO	ND	ND	ND	20,805	20,570	22,172
GUERRERO	42,351	41,793	45,246	13,454	13,611	13,010
HIDALGO	26,255	25,844	26,514	9,611	9,877	10,989
JALISCO	Did not reply to the information request					
MEXICO CITY	Did not reply to the information request					
MICHOACAN	Did not reply to the information request					
MORELOS	The state Ministry of Health declared itself incompetent to reply to the information request and referred it to another agency— Morelos Health Services					
NAYARIT	Did not reply to the information request					
NUEVO LEON	46,152	79,722	85,537	38,996	40,926	44,504
OAXACA	21,232	22,969	23,167	11,524	11,763	13,372
PUEBLA	49,228	47,777	49,726	16,590	16,282	16,374
QUERETARO	38,298	39,154	41,379	17,682	18,358	19,064
QUINTANA ROO	ND	ND	7,641	ND	ND	4,364
SAN LUIS POTOSI	Did not reply to the information request					
SINALOA	ND	ND	ND	26,058	26,138	27,121
SONORA	Did not reply to the information request					
STATE OF MEXICO	114,364	116,670	121,414	35,028	37,655	38,616
TABASCO	37,374	36,727	ND	13,309	14,084	ND
TAMAULIPAS	Did not reply to the information request					
TLAXCALA	8,421	8,617	9,072	6,130	6,297	6,306
VERACRUZ	Did not reply to the information request					
YUCATAN	Did not reply to the information request					
ZACATECAS	18,231	18,755	19,771	5,145	5,072	5,238

Source: GIRE, based on data obtained through information requests sent to state ministries of health. ND: No Data.

Regarding the information provided to women about different delivery options and their risks and advantages, the 20 states that replied said that the information is provided by a physician or via materials or workshops for pregnant women. In all cases, however, the decision to deliver vaginally or by Caesarean is made by health personnel; women —merely informed of the providers' decisions— grant their consent verbally.

The innovations and good practices that emerged from an analysis of the replies include the following:

> In Chiapas, health facilities serving indigenous communities provide obstetric care according to local customs and traditions. This includes accompaniment and use of upright birthing positions.

> In Colima, health facilities provide counseling on conventional and upright birthing practices and Caesarean delivery.

> In Guerrero, eight community hospitals are implementing humanized childbirth. They offer pregnant women the possibility to choose freely how to give birth to strengthen their protagonist role during labor, avoid intervening in the natural process of childbirth, and respect their privacy and individual needs.

The table shows that there have been changes in some state-level health services. These, however, are small and are not in any way representative of the national situation.

4.4.2 OBSTETRIC VIOLENCE

To document cases and prevalence of obstetric violence in health services, information requests were submitted to the SSA, state ministries of health, the IMSS, the ISSSTE, and the CONAMED. GIRE sought information on the number of complaints against health providers at obstetrics/gynecology services for ill treatment and/or medical negligence, as well as the penalties imposed. In addition, information requests were sent to the National Human Rights Commission (CNDH) and state commissions to find out about the number of complaints and recommendations offered, accepted, and adopted regarding ill treatment and medical negligence in the context of obstetrics/gynecology services.

The Federal Ministry of Health and the IMSS replied that they did not have the statistical data requested, nor did they have information about the number of complaints. The ISSSTE informed that between 2009 and 2012 it had received 122 complaints from women for ill treatment and/or medical negligence during obstetric/gynecological care. Of great concern is the fact that neither the IMSS nor the SSA are producing such information, which is essential to determine if quality care is being provided to pregnant women in accordance with NOM 007.

In addition, the CONAMED informed that between 2009 and 2011 it had completed 17 inquiries regarding complaints concerning obstetric/gynecological care that clearly revealed malpractice and/or ill treatment of women. The CNDH received 122 complaints of ill treatment and/or medical negligence occurring during the provision of pregnancy, childbirth, and post-partum care, between 2009 and 2012. In response to the complaints, it issued only four recommendations of which three were accepted and two were partially adopted. The number of recommendations issued and adopted is very low, compared to the large number of complaints.

COMPLAINTS FILED WITH THE CNDH

INSTITUTION ALLEGEDLY RESPONSIBLE	NUMBER OF COMPLAINTS
IMSS	92
ISSSTE	13
MINISTRY OF NATIONAL DEFENSE	3
MINISTRY OF THE NAVY	3
SSA	3
NO INSTITUTION NAMED	2
SOCIAL SECURITY INSTITUTE FOR THE MEXICAN ARMED FORCES	1
NATIONAL INSTITUTE OF PERINATOLOGY	1
PEMEX	1
MEXICO CITY'S MINISTRY OF HEALTH	1
HIDALGO'S MINISTRY OF HEALTH	1
STATE OF MEXICO'S MINISTRY OF HEALTH	1

Source: GIRE, based on data obtained through information requests.

RECOMMENDATIONS ISSUED BY THE CNDH		
RECOMMENDATION	**OFFERED TO**	**DEGREE OF COMPLIANCE**
30/2010 JUNE 2, 2010	PEMEX	NOT ACCEPTED
06/2011 FEBRUARY 22, 2011	GOVERNOR OF HIDALGO	PARTIALLY ADOPTED
37/2011 JUNE 24, 2011	IMSS	PARTIALLY ADOPTED
14/2012 APRIL 23, 2012	ISSSTE	ACCEPTED; IN PERIOD TO PROVE COMPLIANCE

Source: GIRE, based on data obtained through information requests.

Despite the scarce information received, it was possible to determine that there were few complaints of obstetric violence and that most had been filed subsequent to tragic events, like the death of the woman or the fetus. The small number of complaints reveals that physical and psychological ill treatment, humiliation, failure to provide information, and disrespect for women's decisions are not considered grounds to file complaints. Obstetric violence, as the information shows, is unrecognized. Only in extreme cases do the subtle and naturalized forms of ill treatment and abuse become visible.

In addition, a series of institutional mechanisms hinders patients' right to complain about abuse and thus contributes to perpetuating an environment that promotes the violation of their rights. The first of such mechanisms is the anonymity with which physicians interact with the patients. In many cases, the woman does not know the name of those who treated her, making it incredibly difficult to identify who ultimately mistreated her. Another mechanism, associated with the previous one, is the frequent health staff rotation, which often makes it very difficult for women to find those who provide them care. Other less accidental mechanisms are the warnings that women often receive including threats that if they do complain, they may receive worse care in the future, the next time they need medical care.[42]

Another disquieting fact is that of the complaints received by the CNDH, only three led to a recommendation that the relevant institution accepted. This begs the question as to what happened to the other —more than 100— complaints and whether they were followed up or if an agreement was reached. Regrettably, the CNDH did not provide such information.

As shown in the table of complaints submitted to the CNDH, the IMSS received a large number of complaints for actions regarded as obstetric violence. This figure, however, may only be the tip of the iceberg if, as previously mentioned, we consider that the vast majority of acts of obstetric violence are not likely to be reported or identified as such.

In addition, it is worrisome that the most important health institutions in the country do not record or follow up on complaints. To adequately comply with law and policy, they would have to properly follow up and assess each complaint. Although reports themselves cannot change reality, they do help to visualize and appreciate the magnitude of the problem in order to implement specific measures that can change the patterns of obstetric violence.

A. OBSTETRIC VIOLENCE: SITUATION IN THE STATES

The situation in the Mexican states does not differ greatly from that in federal government institutions. We found inconsistencies in the replies that we received from state ministries of health and human rights commissions. Once again, the lack of transparency and clarity of the information is one of the most relevant deficiencies because improving public policies and care provided by health services requires information to properly assess the problem.

The data obtained, presented in the following table, reveals that only 17 health institutions replied to the information requests. Of these, six reported not having information or that the reply fell outside their area of competence.

As for the human rights commissions, 21 replied. Only one, the Mexico City Human Rights Commission (CDHDF), provided details regarding the content of two recommendations that had been issued and accepted.

Recommendation 02/2009, issued by the CDHDF,[43] addresses seven complaints filed between 2007 and 2008, which refer to the cases of 11 women who received care at hospitals belonging to Mexico City's Ministry of Health. Of these cases, seven had fatal consequences —either the woman or the baby died, or both— due to medical negligence, insufficient material resources, lack of medical personnel, and omissions in the information provided to women to obtain their informed consent. Although the details in this recommendation may not be representative of the situation in all states, it was included here, given the little information provided by the state commissions and because, once again, it shows that cases of obstetric violence become visible only when they have very serious consequences.

NUMBER OF COMPLAINTS OF OBSTETRIC VIOLENCE / 2009-2012

	INFORMATION PROVIDED BY STATE MINISTRIES OF HEALTH / 2009-2012	INFORMATION PROVIDED BY STATE HUMAN RIGHTS COMMISSIONS / 2009-2012			
STATE	NUMBER OF COMPLAINTS	NUMBER OF COMPLAINTS	NUMBER OF RECOMMENDATIONS ISSUED	NUMBER OF RECOMMENDATIONS ACCEPTED	NUMBER OF RECOMMENDATIONS ADOPTED
AGUASCALIENTES	77	2	ND	ND	ND
BAJA CALIFORNIA	6	DID NOT REPLY TO THE INFORMATION REQUEST			
BAJA CALIFORNIA SUR	NO INFORMATION	3	0	0	0
CAMPECHE	DID NOT REPLY TO THE INFORMATION REQUEST	DID NOT REPLY TO THE INFORMATION REQUEST			
CHIAPAS	13	6	2	2	1 (PARTIALLY)
CHIHUAHUA	DECLARED ITSELF INCOMPETENT TO REPLY TO THE INFORMATION REQUEST AND REFERRED GIRE TO CONAMED	33	3	ND	ND
COAHUILA	16	DID NOT REPLY TO THE INFORMATION REQUEST			
COLIMA	NO INFORMATION	DID NOT REPLY TO THE INFORMATION REQUEST			
DURANGO	0	DID NOT REPLY TO THE INFORMATION REQUEST			
GUANAJUATO	DID NOT REPLY TO THE INFORMATION REQUEST	23	4	4	3 (PARTIALLY)
GUERRERO	0	--	15	3	2
HIDALGO	NO INFORMATION	21	3	2	1 (PARTIALLY)
JALISCO	DID NOT REPLY TO THE INFORMATION REQUEST	--	8	6	2
MEXICO CITY	DID NOT REPLY TO THE INFORMATION REQUEST	11	2	2 (PARTIALLY)	0
MICHOACAN	15	19	12	ND	7
MORELOS	DID NOT REPLY TO THE INFORMATION REQUEST	ND	6	6	4
NAYARIT	DID NOT REPLY TO THE INFORMATION REQUEST	DID NOT REPLY TO THE INFORMATION REQUEST			
NUEVO LEON	56	10	1	1	1
OAXACA	IT HAD INFORMATION ABOUT TWO CASES THAT WERE SUBMITTED TO THE LOCAL HUMAN RIGHTS COMMISSION	5	1	1	1 (PARTIALLY)
PUEBLA	15	6	0	0	0
QUERETARO	NO INFORMATION	DID NOT REPLY TO THE INFORMATION REQUEST			
QUINTANA ROO	2	ND	3	3	1 (PARTIALLY)
SAN LUIS POTOSI	DID NOT REPLY TO THE INFORMATION REQUEST	DID NOT REPLY TO THE INFORMATION REQUEST			
SINALOA	DID NOT REPLY TO THE INFORMATION REQUEST (IT IS OUTSIDE THE SCOPE OF ITS COMPETENCE)	ND	6	ND	ND
SONORA	DID NOT REPLY TO THE INFORMATION REQUEST	ND	0	ND	ND
STATE OF MEXICO	THE INFORMATION REQUEST SHOULD BE SUBMITTED TO THE LOCAL CONAMED	20	0	0	0
TABASCO	7	ND	7	7	2 4 (IN THE PROCESS OF BEING ADOPTED)
TAMAULIPAS	DID NOT REPLY TO THE INFORMATION REQUEST	DID NOT REPLY TO THE INFORMATION REQUEST			
TLAXCALA	162	2	0	0	0
VERACRUZ	8	ND	12	12	12
YUCATAN	DID NOT REPLY TO THE INFORMATION REQUEST	DID NOT REPLY TO THE INFORMATION REQUEST			
ZACATECAS	0	ND	4	4	4

Source: GIRE, based on data obtained through information requests. ND: No Data.

B. SANCTIONS

At the federal and the state level, information was requested regarding the penalties imposed as the result of complaints submitted to public health institutions. In all the cases, the ministries of health and the CONAMED argued that the implementation of measures in that regard fell outside their area of competence. Based on the data obtained we can conclude that no individual was penalized for having committed acts of obstetric violence.

Of note is the case of Veracruz, which is the only state that defines obstetric violence as a crime. A request was sent to the Health Service Directorate of Legal Affairs and the state Public Prosecutor's Office to obtain information regarding the number of complaints of obstetric violence committed by health providers and the number of providers that had been laid off as a result of the complaints.

The reply to the information request was that since March 2012 (when the reform went into effect) there had been no record of layoffs. This shows that the definition of the crime of obstetric violence poses challenges in terms of its prosecution and that—at least in Veracruz—penalties are not being enforced.

4.5 / CONCLUSIONS

Obstetric violence is a violation of several human rights and is part of a structural, national, and state problem. Obstetric violence is associated with a lack of respect for patient's autonomy and their right to information; deficiencies related to care and women's access to quality reproductive health services; and flaws in the social health system in the provision of care for women during pregnancy, childbirth, and post-partum. In addition, obstetric violence is the result of budgetary gaps, resource mismanagement, insufficient clinics and health centers, a shortage of beds at hospitals, and a lack of information regarding women's reproductive rights, among others. The problem worsens among indigenous and marginalized women, girls, and adolescents, who are more likely to suffer rights violations because of their age, ethnicity, and socioeconomic status.

Based on statistical data, policy analysis, and replies to information requests submitted to federal and state-level institutions, we can conclude that obstetric violence is still a problem. It has been made invisible and is rarely addressed by Mexican authorities.

As previously mentioned, visibility of obstetric violence does not depend as much on legal complaints as it does on in-depth and systematized monitoring of health care services. Although, as discussed in this report, there are cases that should be considered in the penal system, administrative and public policy measures should be implemented to reinforce the regulatory and human rights framework before defining obstetric violence. Where appropriate, cases of non-compliance or violations of human rights should be punished with administrative or civil penalties, and reformulating the proposed definition of the crime should be considered to avoid "strengthening" the State's tendency toward criminalization. The exception would be in cases of more serious violations, such as forced sterilization, that should be defined in the criminal law.

In terms of legislation, significant gaps need to be addressed. For example, in almost half of the state laws, forced sterilization is not explicitly prohibited and no appropriate penalties are established. Most state penal codes have yet to define forced sterilization, which is an essential step to correctly impose penalties. NOM 007, which includes important elements regarding how to treat pregnant women to prevent obstetric violence, has not been fully implemented or monitored, and information provided by public institutions reveals that only extreme cases of obstetric violence are reported, of which a vast majority goes unpunished. Administrative penalties —an alternative to criminal procedures— are apparently not used to punish obstetric violence.

Statistics illustrate the continuous overuse of Caesareans. The percentage of Caesarean deliveries is alarming and is twice or three times as high as the percentage recommended by the WHO. This suggests that many of these procedures are unnecessary and that they are performed to serve the interests of the physician or health institution at the expense of pregnant women's health. This situation has often been underreported; even in the cases where administrative penalties have been issued in that regard, as is the case of the IMSS, they are not enforced.

At the federal and state level, there are very large information gaps in terms of complaints regarding acts that could be considered obstetric violence. This situation, therefore, poses obstacles to fully assessing the problem of obstetric violence in Mexico.

4.6 / RECOMMENDATIONS

4.6.1 LAW AND POLICY

> Include the definition of the crime of forced sterilization in state penal codes and establish appropriate penalties in state health laws.

> Establish monitoring mechanisms and administrative penalties that promote the visibility and punishment for obstetric violence.

4.6.2 IMPLEMENTATION OF LAW AND POLICY

> The SSA and the state ministries of health should ensure the adequate implementation of NOM 007 by disseminating its content and monitoring its application and compliance by all health professionals.

> National Health System institutions should take measures to implement —within their sphere of action— the humanized childbirth model and incorporate nurses and midwives into the process.

> Commit to decreasing the number of Caesareans in all states and institutions of the federal system to meet the standards recommended by the WHO.

> Increase the visibility of the problem of obstetric violence and create awareness among health personnel about humanized birth.

> Strengthen complaint systems and organize information campaigns for women inside hospitals and health institutions to enable users to complain about acts of obstetric violence.

> Human rights commissions should include obstetric violence in their catalogues of human rights violations.

NOTES

[1] Villanueva-Egan, Luis Alberto, "El maltrato en las salas de parto: reflexiones de un gineco-obstetra," in *Revista CONAMED*, vol. 15, no. 3, July-September 2010, p. 148. Available at <http://bit.ly/hF16fY> [accessed: November 15, 2012].

[2] Medina, Graciela, "Violencia obstétrica," in *Revista de Derecho y Familia de las Personas,* Buenos Aires, no. 4, December 2009. Available at <http://bit.ly/UjH62l> [accessed: November 5, 2012].

[3] WHO, *Care in Normal Birth: A Practical Guide. Report of the Technical Working Group,* Geneva, 1996. Available at <http://bit.ly/Y3UKMC> [accessed: November 10, 2012].

[4] WHO, "Appropriate technology for birth," in *The Lancet*, UK, vol. 326, no. 8452, August 24, 1985, pp. 436-437.

[5] Medina, Graciela, "Violencia obstétrica," *op. cit.* (see *supra* note 2).

[6] Nueve Lunas, *Atención humanizada del parto y nacimiento. Carpeta Informativa*, Mexico, 2011. Available at <http://bit.ly/MN9YQa> [accessed: November 9, 2012].

[7] CEDAW Committee, *Concluding observation 24. Article 12: Women and Health,* 20th session (1999), par 2. Available at <http://bit.ly/19gdNGE > [accessed: November 9, 2012].

[8] Committee against Torture, *Concluding observation 2. Implementation of Article 2 by States Parties, 39th session* (2007), par 22. Available at < http://bit.ly/13WysyD > [accessed: November 9, 2012].

[9] Castro, Roberto and Joaquina Erviti, "La violación de derechos reproductivos durante la atención institucional del parto: un estudio introductorio," in López, Paz, Blanca Rico, Ana Langer, and Guadalupe Espinosa, *Género y Política en Salud,* Mexico, Ministry of Health, 2003, p. 259.

[10] See National Human Rights Commission (CNDH), *Recomendación General N° 4. Derivada de las prácticas administrativas que constituyen violaciones a los Derechos Humanos de los miembros de las comunidades indígenas respecto de la obtención de consentimiento libre e informado para la adopción de métodos de planificación familiar,* Mexico, December 16, 2002. Available at <http://bit.ly/UVEhmv> [accessed: November 15, 2012].

[11] Erviti, Joaquina, "Construcción de los objetos profesionales, orden corporal y desigualdad social. Una reflexión en torno a las interacciones médicos-usuarias de servicios ginecológicos," in Castro, Roberto and Alejandra López Gómez (eds.), *Poder médico y ciudadanía: el conflicto social de los profesionales de la salud con los derechos reproductivos en América Latina,* Montevideo, University of the Republic, 2010, p. 107.

[12] See Center for Reproductive Rights, "Francisca's story: Forcibly sterilized because of her HIV status," date not specified. Available at <http://bit.ly/12uLpgb> [accessed: November 15, 2012].

[13] IACHR, *María Mamérita Mestanza Chávez v Peru. Case 12.191. Report 71/03. Friendly Settlement,* October 10, 2003. Available at < http://bit.ly/14JZqw1> [accessed: November 15, 2012].

[14] CEDAW Committee, *A.S. v Hungary*: *Communication No. 4/2004,* 36th session (2006). Available at <http://bit.ly/19qWPZE > [accessed: November 15, 2012].

[15] INEGI, "Estadísticas a propósito del Día de la Madre. Datos Nacionales," Mexico, May 10, 2012. Available at <http://bit.ly/V2qcYW> [accessed: November 20, 2012].

[16] *Idem*.

[17] National Public Health Institute (INSP), "Elevada recurrencia a las cesáreas: revertir la tendencia y mejorar la calidad en el parto," in *Encuesta Nacional de Salud y Nutrición 2012*, Mexico, 2012. Available at <http://bit.ly/TSk1H4> [accessed: December 13, 2012].

[18] Public health institutions do not differentiate between medical interventions carried out at deliveries. In other words, they do not know the percentage of natural births occurring without any intervention (that is, when the process unfolds naturally and without interfering with the woman's decision, under the supervision of a physician, who intervenes if needed). Moreover, they do not know how often medical interventions —such as use of oxytocin to augment labor, administration of an epidural, or use of an episiotomy— are performed.

[19] INEGI, "Estadísticas a propósito del Día de la Madre...," *op. cit.* (see *supra* note 15).

[20] The percentages were obtained from data disaggregated by state, which were published in *Boletín de Información Estadística*, National Health Information System (SINAIS). See SINAIS, Boletín de Información Estadística. Volumen III: Servicios otorgados y Programas sustantivos, Mexico, Ministry of Health, no. 30, 2010. Available at <http://bit.ly/V2qCOQ> [accessed: December 14, 2012].

[21] WHO, Care in Normal Birth..., *op. cit.* (see *supra* note 3).

[22] INEGI, "Estadísticas a propósito del Día de la Madre...," *op. cit*. (see *supra* note 15).

[23] Almaguer, José Alejandro, Hernán José García, and Vicente Vargas Vite, "La violencia obstétrica: una forma de patriarcado en las instituciones de salud," in *Género y salud en cifras*, Mexico, vol. 8, no. 3, September-December 2010, pp. 3-20.

[24] Castro, Roberto and Joaquina Erviti, "La violación de derechos reproductivos...," op. cit. (see supra note 9), p. 261.

[25] Almaguer, José Alejandro et al., "La violencia obstétrica…," *op. cit.* (see *supra* note 23), p. 6.

[26] Erviti, Joaquina, "Construcción de los objetos profesionales...," *op. cit.* (see *supra* note 11), p. 109.

[27] "Ley de Acceso a una Vida Libre de Violencia para las Mujeres en el Estado de Chiapas," in *The Official Gazette of Chiapas*, no. 152, March 23, 2009. Available at <http://bit.ly/Zc1CZK> [accessed: November 20, 2012].

[28] "Ley de Acceso de las Mujeres a una Vida Libre de Violencia para el Estado de Guanajuato," in *The Official Gazette of Guanajuato*, year 97, vol. 148, no. 189, November 26, 2010, (see the fourth section). Available at <http://bit.ly/TVFpaK> [accessed: November 20, 2012].

[29] "Ley de las Mujeres para una Vida sin Violencia del Estado de Durango," December 30, 2007. Available at <http://bit.ly/XErUmu> [accessed: January 7, 2013].

[30] "Ley Número 235 de Acceso de las Mujeres a una Vida Libre de Violencia para el Estado de Veracruz de Ignacio de la Llave," in *The Official Gazette of Veracruz*, ext 65, February 28, 2008. Available at <http://bit.ly/VKZW1A> [accessed: November 20, 2012].

[31] "Ley de Acceso de las Mujeres a una Vida Libre de Violencia del Distrito Federal," in *The Official Gazette of the Federal District*, 17th era, no. 263, January 29, 2008. Available at <http://bit.ly/VL0uV5> [accessed: November 20, 2012].

[32] *Ley de Acceso a las Mujeres a una vida libre de violencia para el estado de Guanajuato*, Article 5, section VIII.

[33] *Legislative Gazette of the Veracruz Congress*, year 2, no. 94, December 4, 2008, p. 7. Available at <http://bit.ly/Tq7Qin> [accessed: November 20, 2012].

[34] In Puebla, the bill was proposed by Congresswoman Myriam Galindo Petriz (National Action Party or PAN) on May 31, 2012. The Oaxaca bill was submitted by Governor Gabino Cué in August 2011.

[35] Baratta, A., *Criminología y sistema penal*, Buenos Aires, B de F, 2004. Ferrajoli, Luigi, "El derecho penal mínimo", in Ferrajoli *et al*., *Prevención y teoría de la pena*, Santiago de Chile, Jurídica Conosur, 1995.

[36] The Official Mexican Norm Draft known as "PROY-NOM-007-SSA2-2010. Para la atención de la mujer durante el embarazo, parto y puerperio, y del recién nacido" was published in *The Official Gazette of the Federation* on November 5, 2012.

[37] *Ley General de Salud*, Article 67.

[38] Since no information requests about non-consensual sterilization were sent, the subject will not be discussed in this section.

[39] Information was requested for the January-July 2012 period but no institution had provided any data as of December 14, 2012.

[40] According to the reply provided by the IMSS, it classified Caesareans as dystocic births.

[41] General Health Council, *Guía de práctica clínica. Realización de operación cesárea. Evidencias y recomendaciones. Catálogo maestro de Guías de Práctica Clínica: IMSS-048-08,* Mexico, Ministry of Health, 2009, p. 7. Available at <http://bit.ly/12uUSUY> [accessed: November 20, 2012].

[42] Castro and Erviti, "La violación de derechos reproductivos...", *op. cit.* (see *supra* note 9), pp. 270-271.

[43] CDHDF, *Recomendación 02/2009. Negligencia médica y deficiencias en la disponibilidad de personal y de recursos materiales en la atención a la salud materno-infantil,* Mexico, March 30, 2009. Available at <http:/bit.ly/V2yHTU> [accessed: November 21, 2012].

5.

WORK AND FAMILY LIFE

5.1 / INTRODUCTION

The protection of motherhood is a fundamental right that States should respect, protect and guarantee. Article 4 of the Mexican Constitution consecrates the protection of free and voluntary motherhood by protecting the right to "decide in a free, responsible and informed manner on the number and spacing of one's children."

This implies the State's obligation to establish conditions and adopt necessary measures so that women can carry their pregnancies to term satisfactorily and exercise their maternity under conditions of equality, free from discrimination and with full respect for their human rights.

These protections and guarantees include, but are not limited to, the work environment and social security. According to the Mexican Constitution (Article 123), working women are entitled to maternity leave and social benefits, as well as breastfeeding breaks during the workday and the right to avoid tasks that present a risk to their health during pregnancy.

International human rights law also includes maternity protection. This protection is found, for example, in the Universal Declaration of Human Rights, that establishes "Motherhood and childhood are entitled to special care and assistance"[1] and in the International Covenant on Economic, Social and Cultural Rights which states: "Special protection should be accorded to mothers during a reasonable period before and after childbirth", as well as paid leave or adequate social security benefits during said time.[2]

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) establishes a broad conception of maternity protection as a social function related to family development. In this sense, it obligates States to adopt the necessary measures to ensure equal opportunities between men and women, guaranteeing their rights in the workplace, such as: prohibiting women's dismissal due to pregnancy, motherhood, or civil status; establishing employers' obligations to pay for maternity leave or social benefits without losing one's position; encouraging social services for parents that allow them to combine work and family life, such as paternity leave and daycare services.[3]

The comprehensive maternity protection included in CEDAW is very relevant, given that it establishes obligations for States to take appropriate measures to modify discriminatory social-cultural patterns on the roles of men and women to achieve a more shared responsibility between men and women on tasks related to work and family. The ultimate goal of this protection should be to guarantee the possibility that women and men can conciliate their work and family life under equal circumstances. As such, the Mexican State is obligated to establish laws and public policies that respect the human rights that protect women's maternity and guarantee men's involvement in the care and raising of children.

Many International Labour Organization (ILO) conventions, including 111 and 183, establish standards and guarantees for maternity protection. Convention 111 on discrimination in the workplace, ratified by Mexico on September 11, 1961,[4] establishes the State Parties' obligation to "declare and pursue a national policy designed to promote, by methods appropriate to national conditions and practice, equality of opportunity and treatment in respect to employment and occupation, with a view to eliminating any discrimination in respect thereof."[5]

Additionally, Conventions 183[6] and 156[7] establish various specific obligations on maternity protection, including the obligation to grant a maternity leave of at least 14 weeks. Unfortunately, neither of these conventions has been ratified by the Mexican State.

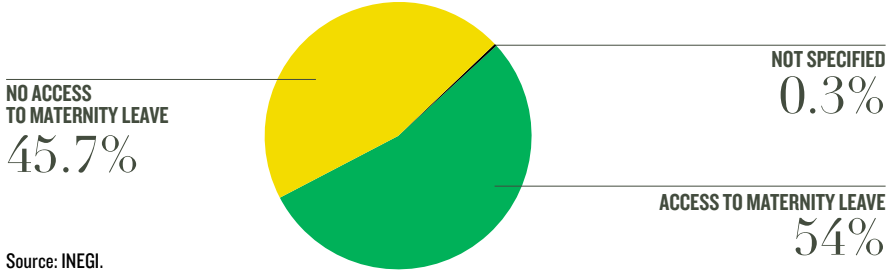
At the international level, in the case of *Fátima Regina Nascimiento De Oliveira and Maura Tatiane Ferreira Alves vs. Brazil*,[8] accepted by the Inter-American Commission on Human Rights, applicants alleged that their right to family life and equality before the law (acknowledged in the American Convention on Human Rights) were violated, as were the rights of the child, after being denied maternity leave upon receiving their youngest daughter in adoption. This case is important because it highlights the protection of all individuals ' right to motherhood without the obligation of marriage or childbirth.

Care, protection and education of children should be a responsibility shared by all members of society and the State must create the necessary conditions and provide support for this process. Gender stereotypes, deeply engrained in culture, define a very different distribution of tasks for men and for women. Nevertheless, any person, regardless of his/her sex, has the right to exercise his/her right to parenthood.

5.2 / SITUATION IN MEXICO

In Mexico, maternity protection is acknowledged in the Constitution and in various secondary laws. Nevertheless, Mexico fails to comply with this legal acknowledgement in practice. According to data from the National Institute of Statistics and Geography (INEGI), in 2009, 45.7% of working women did not have access to maternity of medical leave following childbirth.[9]

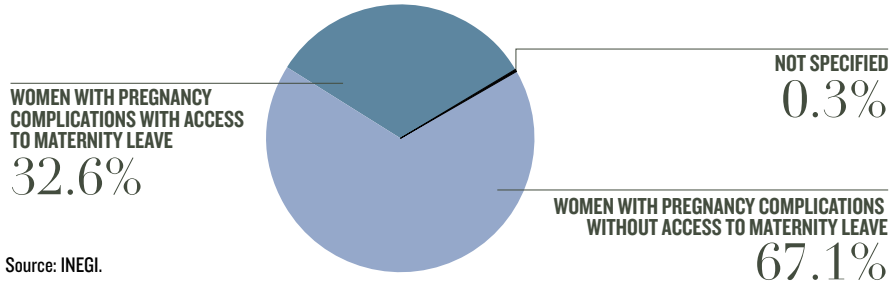
ACCESS TO MATERNITY LEAVE. MEXICO 2009



Source: INEGI.

If we take into consideration cases of women who experienced complications resulting from pregnancy or abortion, this figure increases to 67.1% of working women who did not have access to maternity or medical leave.[10] In addition, we must also take into consideration the insufficient number of daycare facilities, an issue that will be analyzed in the implementation section of this chapter. These data indicate an imbalance between work and family life that seriously affects approximately half of working women in the country.

ACCESS TO MATERNITY LEAVE IN CASES OF PREGNANCIES WITH COMPLICATIONS. MEXICO 2009



Source: INEGI.

Figures related to discrimination against women in the workplace, including discrimination due to pregnancy, are alarming. A survey carried out by the INEGI revealed that, in 2011, 90% of cases related to violence in the workplace consisted of obligating women to take pregnancy tests. Of these women, 18% were dismissed, did not have their contracts renewed or suffered a wage cut due to pregnancy.[11]

In this regard, the Committee on the Elimination of All Forms of Discrimination against Women (CEDAW Committee) expressed its concern for the persistence of discriminatory practices against women in the workplace, such as requiring women to present proof that they are not pregnant in order to access or maintain a job, along with the practice of submitting pregnant women to difficult and dangerous work conditions. The Committee recommended that that State adopt measures to eliminate these discriminatory practices and ratify the ILO's Workers with Family Responsibilities Convention No. 156.[12]

5.3 / LAW AND POLICY FRAMEWORK

In Mexico, labor and social security regulation is based on Articles 73 and 123 of the Mexican Constitution, which designate Congress the power to emit relevant law and policy.[13] Based on the 2011 constitutional reform on human rights, relevant law and policy related to labor rights included in international treaties to which the Mexican State is party, particularly CEDAW and ILO conventions, also apply.

Applicable law and policy related to social security and maternity protection in the workplace are established in the Constitution, the Federal Labor Law, the Federal Labor Law for Government Workers (Regulation of Section B of Constitutional Article 123), the Social Security Law and Institute for Social Security and Services for State Workers Law. In the following chart, we present the manner in which each of these laws regulates women workers' rights in relation to social security and maternity protection in the workplace. The chart presents maternity protection within the Federal Labor Law before the reform approved by Congress in November 2012. Later in the chapter, we will analyze in depth this reform with relation to maternity protection.

MATERNITY PROTECTION WITHIN LABOR LAW

	WORKERS IN GENERAL	GOVERNMENT WORKERS
	MEXICAN CONSTITUTION, ARTICLE 123	
	SECTION A	SECTION B
WORK	Tasks that demand considerable effort and represent a risk for the woman's health during pregnancy are prohibited.	Tasks that demand considerable effort and represent a risk for the woman's health during pregnancy are prohibited.
MATERNITY LEAVE	Six weeks prior to the date of birth and six weeks post-partum. Complete salary. Conserve current position and rights acquired through employment.	One month of leave prior to the date of birth and another two post-partum. Complete salary. Conserve current position and rights acquired through employment.
BREASTFEEDING	Two half-hour breaks per day to breastfeed children.	Two half-hour breaks per day to breastfeed children.
BENEFITS	Daycare services.	Medical and obstetric care. Medicines. Breastfeeding support. Daycare services.
	FEDERAL LABOR LAW[14]	**FEDERAL LABOR LAW FOR GOVERNMENT WORKERS, REGULATION OF SECTION B OF CONSTITUTIONAL ARTICLE 123[15]**
WORK	Tasks that demand considerable effort and represent a risk for the woman's health during pregnancy –lifting, pushing or pulling significant weight– that result in climbing, standing for long periods or that alter her psychological or nervous state. A sufficient number of chairs or benches for working mothers.	An inhumane workday requiring excessive or dangerous work that could represent a risk for the woman's or fetal health is unacceptable.

MATERNITY PROTECTION WITHIN LABOR LAW

	WORKERS IN GENERAL	GOVERNMENT WORKERS
	MEXICAN CONSTITUTION, ARTICLE 123	
	SECTION A	SECTION B
	FEDERAL LABOR LAW[14]	**FEDERAL LABOR LAW FOR GOVERNMENT WORKERS, REGULATION OF SECTION B OF CONSTITUTIONAL ARTICLE 123[15]**
MATERNITY LEAVE	Six weeks prior and six weeks after the date of birth. Leave can be extended as necessary in case of pregnancy or birth complications that make work impossible. The complete salary will be received during leave. If leave is extended, the worker will have the right to 50% of her salary for a maximum of sixty days. Return to the same position, when more than a year has not passed since birth. Maternity leave will be included in the calculation of days worked.	One month of leave prior to the date of birth and another two post-partum.
BREASTFEEDING	Two half-hour breaks per day to feed children.	Two half-hour breaks per day to breastfeed children.
DAYCARE SERVICES	Daycare services will be offered by the Mexican Social Security Institute.	Daycare services.
	SOCIAL SECURITY LAW[16]	**INSTITUTE FOR SOCIAL SECURITY AND SERVICES FOR STATE WORKERS LAW[17]**
MATERNITY BENEFITS	Obstetric care. Six months of in-kind support for breastfeeding. Maternity care package.	Obstetric care. Support for breastfeeding when, according to the physician's diagnosis, there is some sort of physical incapacity or labor impediment to breastfeed the child. This support will be offered in-kind for a maximum period of six months after birth. Maternity care package.
DAYCARE SERVICES	Working women, widowed or divorced men or those that have legal custody of children. Daycare will be provided, when the individual has legal custody and guardianship of children via judicial resolution, but only if he/she is covered by the Institute, up-to-date in his/her rights and cannot offer care for children. Morning and afternoon shifts. An individual who works the night shift has the right to one of these shifts. Hygiene, nutrition, health care, education and recreation for minors. Specialized facilities, in areas conveniently located in relation to commercial and residential areas, and in municipalities where the obligatory regimen is in place. Insured mothers, widowed or divorced men or those that have legal custody of children have the right to daycare services during their working hours, as long as they do not get married again or enter into a common law marriage. Children from the age of 43 days to 4 years.	Services for children's wellbeing and development

The chart above demonstrates that social security and maternity protection in the workplace is similar between women workers in general and those who work for the government. Nevertheless, regulation of daycare facilities is more extensive in the Social Security Law because it establishes the ages of children that can attend, the services the facilities must provide and the people who have a right to this benefit. It is very concerning that the legislation promotes the stereotype that women are the primary caretakers of children. For example, the legislation establishes that populations with a right to childcare facilities are women with social security and men who are widowed, divorced, or have primary custody of their children, but not workers in general. In other words, fathers ' rights to this service are recognized, only when the mother is not available, a fact that continues to emphasize that women are the primary caretakers of children.

5.3.1 REFORMS TO THE FEDERAL LABOR LAW (2012)

After the federal executive branch presented a draft bill to Congress during the LVII Legislature 's first ordinary session, the Senate and the House of Representatives approved various reforms to the Federal Labor Law.[18] The following chart presents those reforms related to social security and maternity protection in the workplace:

REFORM TO FEDERAL LABOR LAW. 2012

TOPIC	TEXT	ARTICLE
EQUALITY AND PROHIBITION OF DISCRIMINATION	Substantive equality is that which is achieved by eliminating discrimination against women that lessens or annuls the recognition, enjoyment or exercise of their human rights and fundamental liberties in the labor environment. Refusal to hire workers based on gender, civil status, or any other criteria that could be discriminatory is prohibited.	2, 56 AND 133 I
PREGNANCY TESTS	The obligation of presenting a negative pregnancy test to be hired, remain in a position or receive a promotion is prohibited.	133 XIV
FIRED DUE TO PREGNANCY	Firing a worker or pressuring her to quit a job due to pregnancy, a change in civil status or for being the primary caregiver of minors is prohibited.	133 XV
LABOR CONDITIONS	In cases of declared health emergencies, pregnant women must not work, without affecting their salary, benefits or rights.	168
PATERNITY LEAVE	Five days of paid leave for male workers, upon the birth or adoption of a child. Six weeks prior to and six week after a birth.	132 XXVII bis
MATERNITY LEAVE	Up to four of the six weeks of leave offered prior to the birth can be transferred to after birth. In the case of a child's disability or in case of hospitalization, the leave can be extended up to eight weeks after birth. Six weeks in case of adoption.	170 II and II bis
BREASTFEEDING	Two half-hour breaks per day for a maximum of six months, with the option of substituting the breaks for one hour less of the workday.	170 IV
DAYCARE SERVICES	Offer daycare services for workers' children.	283 XIII

With regard to maternity protection, the Federal Labor Law reform expands protection for women workers in comparison with previous legislation. For example, maternity leave is provided in the case of adoption, and includes the possibility of extending this leave if the newborn has a disability. Regarding discrimination against women due to pregnancy, it explicitly prohibits refusing to hire a woman or denying her permanence or promotion as a result of pregnancy. It also prohibits firing a woman for the same reason.

Despite the progress represented by these reforms, it is important to emphasize that the vision of women as the primary caregivers of children persists, as demonstrated by the minimal amount of time permitted for paternity leave.

The approved period of five days of paid leave not only lacks a justification as to why this number of days was chosen, but is also insufficient to comply with the objective of achieving a more equal sharing of responsibilities related to child care and rearing among men and women. Furthermore, such a short period promotes the preservation of the stereotype that women should take on all or most of the responsibility of caring for children.

In the past few years, despite the fact that paternity leave was not regulated in Mexican law, some government institutions such as the Federal Electoral Court, Mexico City 's Human Rights Commission, and the National Women's Institute established policies providing at least ten days of paid leave to male workers, double the amount established by the Federal Labor Law.

5.3.2 GAPS AND DEFICIENCIES IN CURRENT LAW AND POLICY

As previously mentioned, despite recent advances in law and policy related to social security and maternity protection in the workplace, there are various legislative gaps that contribute to perpetuating discrimination and gender inequality in the care and rearing of children. Structural challenges prevent social security and work-related protections from covering all women. The greatest challenge is, perhaps, that a high percentage of women lack social security, whether because they are unemployed, carry out unpaid housework or work in the informal sector. A 2009 survey carried out by INEGI revealed that women account for six of every ten members of the economically active population who lack affiliation to a social security program.[19]

Due to this lack of affiliation, these women do not have access to maternity leave, daycare or other protective services that can help them to better conciliate their work and family lives, avoid double workloads and strengthen shared responsibility for child-rearing between men and women.

National legislation is not fully harmonized with relevant international standards. For example, ILO Convention No. 183 states that maternity leave should last at least 14 weeks and a recommendation made by the ILO in 2000 states that the recommended period should be at least 18 weeks.[20] Legislation in Mexico establishes 12 weeks, below the minimum recommended by the ILO.[21]

Additionally, the ILO recommends extending maternity leave in the case of multiple births. Legislation in Mexico contains no such provision.

ILO standards also establish that maternity leave should be obligatory for at least six weeks following childbirth in order to protect the mother 's health. Mexican legislation establishes six weeks prior and six weeks following childbirth, with the option of transferring four of the six prior weeks to the postpartum period. Nevertheless, legislation should allow women to decide when to use all six prior weeks, based on their needs.

Another important shortcoming in the legislation is related to breastfeeding breaks; it does not include any measures to make these breaks effective in practice, such as establishing breastfeeding rooms in or near the workplace.

5.4 / IMPLEMENTATION OF THE LAW AND POLICY FRAMEWORK

For this chapter, GIRE requested public information from the Mexican Social Security Institute (IMSS), the Institute for Security and Social Services for State Workers (ISSSTE) and the Federal Labor Protection Office regarding the number of maternity leaves granted, the number of daycare facilities, lawsuits presented due to dismissal as a result of pregnancy and complaints related to requests for certificates from women to prove they are not pregnant. The responses are presented in the following charts.

MATERNITY LEAVE / 2009-2012

INSTITUTION	MATERNITY LEAVE			
	2009	2010	2011	2012 (FIRST QUARTER)
IMSS	465,616	486,926	468,239	108,657
ISSSTE	39,680	39,844	41,783	10,214

Source: GIRE, based on data obtained through information requests.

It is interesting that, based on the data presented, the number of maternity leaves granted has remained stable over the past three years (2009-2011). If we analyze the difference between the percentage of women belonging to social security programs and the percentage of those granted maternity leave in the past three years, we can determine the proportion of women who did not access maternity leave or did not request it. According to a survey carried out by the INEGI in 2009, 45.7% of women workers did not have access to medical or disability leave for childbirth. The 468,239 leaves granted by the IMSS in 2011 correspond to a mere 4.3% of the 10,744,609 women who are beneficiaries of this social security scheme.[22]

If we combine these data with those presented in the introduction on discrimination against pregnant women in the workplace, we can deduce that many did not access maternity leave, quit their jobs or were dismissed due to the pregnancy. In addition, these data only represent female beneficiaries of a social security program.

Nevertheless, a high percentage of women (nearly 50% of all women workers, according to data from the INEGI)[23] have no access to social security and, as a result, no access to maternity leave.

DAYCARE SERVICES / 2009-2012

INSTITUTION	NUMBER
IMSS	1,452
MINISTRY OF SOCIAL DEVELOPMENT	9,466
ISSSTE	OWNED: 136
	SUB-CONTRACTED: 120

Source: GIRE, based on data obtained through information requests to the Ministry of Social Development, IMSS and ISSSTE.

As demonstrated in the previous chart, the number of daycare facilities belonging to the ISSSTE is approximately one-fifth of those belonging to the IMSS, due to the difference in the number of beneficiaries affiliated to each institution. However, it is striking that the number of sub-contracted facilities is nearly the same as those run directly by ISSSTE. In this sense, it would be interesting to find similar data regarding the IMSS facilities. The Ministry of Social Development has 9,466 daycare facilities[24] that are part of a program for female workers and single fathers, and benefit those individuals who are not affiliated to either IMSS or ISSSTE. The number of daycare facilities appears very small in comparison with the size of the country and the fact that every year approximately 2.5 million children are born.[25]

This means that a large percentage of children do not have access to daycare facilities, meaning that they either attend paid childcare centers or remain under the care of their parents or family members.

GIRE requested information from the Federal Labor Protection Office regarding the number of reports it received regarding women being dismissed due to pregnancy or complaints of obligatory pregnancy tests. The information received is summarized in the chart below:

REPORTS AND COMPLAINTS / 2009-2012

AGENCY	REPORTS OF BEING DISMISSED DUE TO PREGNANCY	COMPLAINTS OF OBLIGATORY PREGNANCY TESTS
FEDERAL LABOR PROTECTION OFFICE	9	ND

Source: GIRE, based on data obtained through information requests.

The Federal Labor Protection Office responded that it has registered only nine reports of women being dismissed due to pregnancy between January 2009 and March 2012. This number is very small if we take into account that the 2011 National Survey on the Dynamics of Households registered that at least 845,308 women were dismissed, did not have their contracts renewed or suffered a wage cut due to pregnancy at some point in their lives.[26] This demonstrates that the majority of cases of discrimination due to pregnancy are not reported to the Federal Labor Protection Office and go unpunished.

It is very concerning that the Federal Labor Protection Office does not have any information regarding the complaints of obligatory pregnancy tests, indicating that either they do not register such information or that they do not receive these types of complaints. We can compare this last hypothesis with data from the previously mentioned INEGI survey in which 4,099,531 women reported having been obligated by an employer to take a pregnancy test.[27]

These data demonstrate an enormous and persistent discrimination experienced by pregnant women in the workplace, as well as impunity enjoyed by those who carry out most of these actions.

5.4.1 EMBLEMATIC CASE

María Elena López Bretón 's case illustrates the type of discrimination experienced by female workers who decide to become pregnant.[28] In 2011, María Elena, 33 years old, was working as the Head of the Department of Analysis and Integration of Performance Evaluation Reports at the Governor's Office of Oaxaca, when she became the victim of harassment in the workplace due to her pregnancy.

In April 2011, María Elena became pregnant after going through various medical treatments. From the beginning, she was diagnosed with a high-risk pregnancy and was urged by her doctor to make sure to attend all of her prenatal check-ups and follow closely all of the IMSS 's indications regarding care during the pregnancy. After telling her boss, Dr. Jesús Waldo Martínez Soria, about her situation, he began to antagonize her, not only by questioning her on her decision, but also by constantly requiring her to carry out tasks that were inappropriate for her health, such as carrying heavy boxes. This public official also refused her permission to attend medical appointments on several occasions. Furthermore, he told María Elena that, due to high volume of work, he would ask for her resignation if she requested any more time off.

In mid-June, after having been granted only one hour to attend a medical appointment, María Elena was told by her doctor that the fetus had died and that she would need to undergo an abortion. In spite of the emotions she was experiencing upon receiving such news, María Elena immediately told her boss, who, upon hearing the news, reproached her for having abandoned her work at such a time and demanded to see her the next day.

María Elena returned to work a few weeks later, after having taken the appropriate time off due to disability caused by her health condition. During that time, her boss had demanded that she work from the hospital. Upon her return, María Elena met with the Head of the Governor 's Office (now the Technical Secretary of the Head of Oaxaca 's Executive Branch), Dr. Héctor Iturribarría Pérez, who, despite having been informed of the work-related violence experienced by María Elena, asked her to resign, due to an alleged office restructuring.

María Elena filed a complaint with Oaxaca 's Human Rights Ombudsman (DDHPO), which emitted Recommendation 29/2011 on November 17, 2011, stating that, after becoming pregnant, María Elena was subject to harassment in the workplace and discrimination by Dr. Jesús Waldo Martínez Soria, as well as violence in the workplace and institutional violence due to her gender.

The DDHPO was not the only institution that dealt with María Elena 's case. On November 30, 2012, the National Human Rights Commission (CNDH) emitted a conciliation agreement due to additional human rights violations committed against her while she was processing her complaint before the Ombudsman.

María Elena requested the CNDH 's intervention due to the fact that Dr. Héctor Iturribarría Pérez obtained her personal and confidential data and showed it to the DDHPO, attempting to justify his and her boss's actions. According to Dr. Iturribarría Pérez, he requested a medical report from the IMSS on the details regarding María Elena 's preg-

nancy and the death of the fetus. He acknowledged that he presented the medical report, on letterhead and with the IMSS seal, to the DDHPO. This document contained María Elena 's confidential medical information, known only to the IMSS, and was not only shown to the DDHPO, but also to her co-workers, exacerbating her emotional state.

The IMSS has denied having emitted the document, claiming that it was not written by the institution and that the signatures at the bottom of the page were forged.

The CNDH has recommended that the IMSS determine the responsibility of the public officials involved in the case, and that it evaluate the possibility of filing charges for the case. It also recommended that the government of Oaxaca initiate an administrative investigation against the public officials involved.

Both the IMSS and the Government of Oaxaca accepted the Commission 's proposals, and María Elena is waiting for them to comply, with the hope that the damages against her are repaired.

5.5 / CONCLUSIONS

In Mexico, the right to social security and maternity protection in the workplace is acknowledged at the constitutional level as well as in domestic legislation and in international human rights law. However, despite a few forward steps in law and policy, the panorama continues to be discouraging, with constant violations of the right to maternity protection as understood in a broad sense. Both in legislation and in practice, the vision remains that women are the primary caregivers of children.

National law and policy is not harmonized with relevant international standards; for example, regarding the extension of maternity leave and conditions for breastfeeding. In addition, the limited number of days for paternity leave does not allow any real progress towards promoting equality in sharing childcare responsibility.

In practice, many women do not access maternity leave and there continue to be many cases of dismissal or refusal to renew contracts due to pregnancy, in violation of national and international law on the subject. There are an insufficient number of daycare facilities to account for the number of children in the country, limiting women 's possibilities of integrating themselves back into the labor force after childbirth, particularly given the fact that they continue to shoulder nearly all of the responsibility for the care of their children.

Female workers who are not affiliated with any social security program are even more exposed because they have no possibility of accessing maternity leave or daycare facilities operated by the IMSS and ISSSTE.

Discrimination against women due to pregnancy is widespread and the majority of cases go unpunished.

In Mexico, law, policy and practice are far from providing maternity protection and have made little progress towards constructing a society where responsibilities for care and rearing of children are shared between men and women, and where work and family life can be compatible for women.

5.6 / RECOMMENDATIONS

5.6.1 LAW AND POLICY

Reform the Federal Labor Law to bring it in line with relevant international standards regarding the following issues:

- Expand maternity leave to 18 weeks (standard recommended by the International Labour Organization) and establish women 's right to decide when to take their weeks of leave.
- Progressively expand paternity leave as a means of promoting shared responsibility in caring for children.
- Establish flexible work hours to promote shared responsibility in caring for children.
- Modify provisions related to daycare facilities in order to guarantee both male and female workers access to this service, regardless of their marital status.
- Develop a universal social security system that includes all workers.

5.6.2 IMPLEMENTATION OF LAWS AND POLICIES

- Promote women 's effective access to maternity leave as established by law.
- Expand the number of daycare facilities affiliated with the IMSS, ISSSTE and the Ministry of Social Development in order to better meet current child care needs.
- Monitor daycare facilities to guarantee that they have adequate infrastructure and provide quality care.
- The Federal Labor Protection Office must monitor companies more closely to avoid violence and discrimination against pregnant women. It should also investigate all complaints of dismissal due to pregnancy and obligatory pregnancy tests in a timely manner.
- Encourage the installation of childcare centers and breastfeeding rooms in companies and workplaces to promote the compatibility between motherhood and work outside of the home.

NOTES

[1] Article 25.2 Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

[2] Article 10.2 Special protection should be accorded to mothers during a reasonable period before and after childbirth. During such period working mothers should be accorded paid leave or leave with adequate social security benefits.

[3] Article 11.2 In order to prevent discrimination against women on the grounds of marriage or maternity and to ensure their effective right to work, States Parties shall take appropriate measures:
(a) To prohibit, subject to the imposition of sanctions, dismissal on the grounds of pregnancy or of maternity leave and discrimination in dismissals on the basis of marital status;
(b) To introduce maternity leave with pay or with comparable social benefits without loss of former employment, seniority or social allowances;
(c) To encourage the provision of the necessary supporting social services to enable parents to combine family obligations with work responsibilities and participation in public life, in particular through promoting the establishment and development of a network of child-care facilities;
(d) To provide special protection to women during pregnancy in types of work proved to be harmful to them.

[4] ILO, C111-Convention on Discrimination (Employment and Occupation), 1958 (No. 111): June 25, 1958. Available at <http://bit.ly/1cCw71m> [accessed: November 15, 2012].

[5] ILO, C111- Convention on Discrimination (Employment and Occupation), 1958 (No. 111): Article 2. June 25, 1958. Available at <http://bit.ly/1cCw71m> [accessed: November 15, 2012].

[6] ILO, C183- Maternity Protection Convention, 2000 (No. 183), June 15, 2000. Available at <http://bit.ly/1a5s2kA> [accessed: November 15, 2012].

[7] ILO, C156- Convention concerning Equal Opportunities and Equal Treatment for Men and Women Workers: Workers with Family Responsibilities, 1981 (No. 156), June 23, 1981. Available at <http://bit.ly/19tyl1X> [accessed: November 15, 2012].

[8] IACHR, *Fátima Regina Nascimento De Oliveira and Maura Tatiane Ferreira Alves vs. Brasil Case*. Report No. 7/10, Petition 12.378, March 15, 2010. Available at <http://bit.ly/125oKc9> [accessed: November 13, 2012].

[9] INEGI, *Mujeres y hombres en México 2011.* Mexico, INEGI, 2012, p. 164. Available at <http://bit.ly/GNlJ19> [accessed: November 15, 2012].

[10] Idem.

[11] INEGI, *Encuesta Nacional sobre la Dinámica de las Relaciones en los Hogares (ENDIREH) 2011: tabulados básicos.* Available at <http://bit.ly/VOoxnH> [accessed: November 15, 2012].

[12] CEDAW Committee, *Concluding observations of the Committee on the Elimination of Discrimination against Women: Mexico,* 52nd session (2012), paragraph 28 to 29 [CEDAW/C/MEX/CO/7-8]. Available at <http://bit.ly/14GJoha> [accessed: October 30, 2012].

[13] Article 73.- The Congress shall have the power to:
X.- Make rules and regulations over the whole country on hydrocarbons, mining, chemical substances, explosives, pyrotechnics, movie industry, commerce, bets, draw and raffles, intermediation and financial services, electrical and nuclear energy, and to emit labor laws as defined by regulatory provisions in Article 123.

[14] Articles 170, 171 and 172 of the Federal Labor Law.

[15] Articles 14, 28, 43 and 88 of the Federal Labor Law for Government Workers, Regulation of Section B of Constitutional Article 123.

[16] Articles 94, 201, 202, 203, 204, 205, 206, 207 and 237 A of the Social Security Law.

[17] Articles 4 and 39 of the *Law of the Institute for Social Security and Services for State Workers.*

[18] Reforms published in the Official Gazette of the Federation on November 30, 2012. Available at <http://bit.ly/Wy7mq2> [accessed: January 15, 2013].

[19] INEGI, *Encuesta Nacional de Empleo y Seguridad Social. ENESS 2009*. Mexico: INEGI, IMSS, 2010, p. 42. Available at <http://bit.ly/d7n7ak> [accessed: November 15, 2012].

[20] ILO, R191- *Maternity Protection Recommendation, 2000 (No. 191),* June 15, 2000. Available at <http://bit.ly/1a5xzYj> [accessed: November 15, 2012].

[21] ILO, C183- *Maternity Protection Convention, 2000 (No. 183)*, June 15, 2000. Available at <http://bit.ly/1a5s2kA> [accessed: November 15, 2012].

[22] INEGI, *Encuesta Nacional de Empleo y Seguridad Social…, op. cit.* (see *supra*, note 19), p. 43.

[23] INEGI, Encuesta Nacional de Empleo y Seguridad Social..., *op. cit*. (see *supra*, note 19).

[24] Ministry of Social Development, *Programa de Estancias Infantiles para apoyar a Madres Trabajadoras y Padres Solos: Estancias en operación por entidad federativa*. Available at <http://bit.ly/WdcD71> [accessed: November 20, 2012].

[25] INEGI, *Natalidad: Consulted interactiva de datos: información de 1985 a 2011*. Available at <http://bit.ly/yFZBoi> [accessed: November 15, 2012].

[26] INEGI, *Encuesta Nacional sobre la Dinámica de las Relaciones en los Hogares…, op. cit*. (ver *supra*, nota 11).

[27] Idem.

[28] The woman 's name was changed to protect her identity.

6.

ASSISTED REPRODUCTION

6.1 / INTRODUCTION

The World Health Organization defines infertility as the failure to achieve a pregnancy after 12 months or more of regular unprotected sexual intercourse.[1]

A recent study on the levels and trends of global infertility from 1990-2010 indicates that in 2010, 1.9% of women between the ages of 20 and 44 who wanted a child could not get pregnant (primary infertility) and 10.5% of women who already had one child were unable to become pregnant a second time (secondary infertility). In total, 48.5 million couples were unable to have a child.[2]

To assist people in achieving pregnancy, assisted reproduction techniques (ART) have been applied successfully for the last four decades. These comprise all treatments or procedures that include the manipulation of oocytes, sperm or human embryos to bring about a pregnancy.[3] Intrauterine, intracervical or intravaginal insemination also has been used with the partner's or a donor's sperm.

This includes, but is not limited to, *in vitro* fertilization (IVF) and embryo transfer, gamete intrafallopian transfer, zygote intrafallopian transfer, embryo intrafallopian transfer, cryopreservation of oocytes and embryos, donation of oocytes and embryos, and surrogate motherhood.[4]

Access to assisted reproduction involves the exercise of a number of human rights, including the right to form a family, the right to equality, the right to non-discrimination, the right to reproductive autonomy, the right to health and the right to benefit from scientific progress, all contained in the Mexican Constitution and international treaties ratified by Mexico which, according to Article I of the Constitution, are an integral part of the same.

Assisted human reproduction has set the stage for a series of discussions that lawmakers, health care providers, associations of experts in assisted reproduction and society in general must consider in order to regulate its use.

In Mexico, Article 4 of the Constitution states that everyone has the right to make free, responsible and informed decisions on the number and spacing of their children. So that individuals can fully exercise this right, it is necessary to expand health coverage to ensure availability and access to family planning services, which should include both contraceptive methods and assisted reproduction services, plus the provision of accurate information and guidance so that individuals can make free, responsible and informed decisions on their reproduction.

At the international level, on November 28, 2012 the Inter-American Court of Human Rights issued its ruling in the case *Artavia Murillo et al. ("In Vitro Fertilization") vs. Costa Rica*, presented because of the general prohibition on practicing IVF in this country since 2000.[5] In this case, the Inter-American Commission on Human Rights (IACHR) determined that this prohibition constituted arbitrary interference in the right to a private and family life, the right to raise a family and the right to equality for people with infertility problems in Costa Rica, because the State was preventing them access to a treatment that would allow them to overcome their disadvantage with respect to the possibility of biological children. Together with the above, the Commission pointed out that the ban has had a disproportionate impact on women's lives, since it constitutes a source of physical and psychological suffering due to the reproductive role imposed upon them by society.[6] On the basis of these elements, the Court ruled that Costa Rica should adopt, as soon as possible, appropriate measures to remove the ban on practicing IVF and to include it in infertility programs and treatments, in accordance with the duty to guarantee respect for the principle of non-discrimination.

6.2 / SITUATION IN MEXICO

In Mexico, some academic studies estimate that 1.5 million couples have infertility problems.[7] The National Institute of Perinatology "Isidro Espinosa de los Reyes" responded to an information request,

indicating that 48,149 people received infertility treatment at the Institute between January 2006 and June 2012.[8] The National Health Information System indicates that between 2004 and 2011, 24,468 hospital discharges were reported in public health institutions for female infertility and 1,528 for masculine infertility.[9]

These figures indicate that infertility is a major public health issue in Mexico and assisted reproduction is necessary for thousands of people. However, there are no regulations governing such services, which means they are provided based on general regulations that apply to all health facilities without adequate oversight to protect the rights, safety and physical integrity of individuals undergoing these procedures. According to the Federal Commission for Protection against Health Risks (COFEPRIS), in Mexico, there are currently 52 centers authorized to perform ART.[10]

Although there are recognized experts in the field of assisted reproduction who provide services in conformity with the highest international standards, the absence of regulation presents the opportunity for others to engage in abusive and discriminatory practices against those seeking to access assisted reproduction services, and could create the opportunity for other practices such as trafficking fertilized or unfertilized eggs.

6.3 / LEGAL AND POLICY FRAMEWORK

In Mexico, emitting regulations applicable to health services, and specifically to assisted reproduction, falls under federal jurisdiction and, based on Article 73 of the Constitution, the General Health Law must establish regulatory guidelines. Article 3 of this law stipulates that sanitary control of donations of organs, tissues and cells is a matter of general health.

However, as has been pointed out, Mexico lacks regulation in this area, making it essential that Congress debate and establish law to regulate general aspects related to access and provision of assisted reproduction services, and the Federal Ministry of Health must emit an Official Mexican Norm establishing technical provisions on the subject.

In recent years, bills have been presented in both chambers of Congress to regulate assisted reproduction, but so far none has been adopted. It should be noted that some of these bills, rather than fully protecting individuals' human rights, sought to grant legal status to the embryo, restrict access to heterosexual couples,[11] or place excessive limits on access to assisted reproduction services.[12]

Other, more appropriate bills propose comprehensive regulation of the subject, on the basis of human rights and scientific evidence.[13]

Between April 2008 and December 2012 alone, at least eight bills were presented to Congress proposing reforms to the General Health Law to address the issue there, together with the proposed creation of two specific laws: the Assisted Human Reproduction Law[14] and the Surrogacy Law.[15] The following table presents principal data on federal bills presented in 2008-2012.

BILLS PRESENTED TO CONGRESS 2008-2012

DATE	LAWMAKER	LAW
APRIL 28, 2008	SENATORS FERNANDO CASTRO TRENTI (PRI) AND ERNESTO SARO BOARDMAN (PAN)	ASSISTED HUMAN REPRODUCTION LAW GENERAL HEALTH LAW
AUGUST 26, 2009	SENATORS MARÍA DEL SOCORRO GARCÍA QUIROZ (PRI), MARÍA DE LOS ÁNGELES MORENO (PRI) AND SENADOR RAMIRO HERNÁNDEZ GARCÍA (PRI)	GENERAL HEALTH LAW

BILLS PRESENTED TO CONGRESS 2008-2012

DATE	LAWMAKER	LAW
APRIL 8, 2010	REPRESENTATIVE MARÍA CRISTINA DÍAZ SALAZAR (PRI)	GENERAL HEALTH LAW
APRIL 22, 2010	REPRESENTATIVE MARÍA DEL PILAR TORRE CANALES (PANAL)	GENERAL HEALTH LAW
JULY 28, 2010	REPRESENTATIVE LETICIA QUEZADA CONTRERAS (PRD)	SURROGACY LAW GENERAL HEALTH LAW
DECEMBER 14, 2010	SENATOR JULIO AGUIRRE MÉNDEZ (PRD)	GENERAL HEALTH LAW
JULY 13, 2011[16]	SENATORS MARÍA DE LOS ÁNGELES MORENO URIEGAS, MARÍA DEL SOCORRO GARCÍA QUIROZ (PRI) AND OTHERS REPRESENTATIVES[17]	GENERAL HEALTH LAW
DECEMBER 20, 2012	SENATOR MAKI ORTIZ DOMÍNGUEZ (PAN) AND OTHERS[18]	ASSISTED HUMAN REPRODUCTION LAW GENERAL HEALTH LAW

Aspects of these bills that create cause for concern include: the use of concepts contrary to medical science and to current regulations, such as "conception" and "fertilization" without distinction; in terms of regulation, referring to guidelines and/or protocols to regulate specific processes, when they should refer to Official Mexican Norms. In addition, it is concerning that attempts are being made to grant legal status to embryos, which would prohibit cryopreservation of fertilized ovules, as well as attempts to deny access to these techniques to single people and same-sex couples, violating the human rights of individuals who do not fit the description of the traditional family model.

It is worth noting that the bill presented by Senator María de los Ángeles Moreno in July 2011 is the only one that refers to "individuals" rather than "couples" as recipients of ART, and includes the possibility for cryopreservation of genetic material, which is consistent with a protective vision of human rights.

In 2011, the Health Commission of the House of Representatives jointly discussed a report that brought together seven initiatives on assisted reproduction presented over the 12 previous years.[19] The result of combining such a diverse range of proposals –some of them surpassed by the advances in science and research– could result in a highly restrictive regulation inconsistent with the recent constitutional reform on human rights.

The following aspects of that report caused concern: the ban on the cryopreservation of fertilized ovules due to their treatment as individuals with rights, to the absurd extent of determining that such regulation protects the higher interests of the child. It was, moreover, discriminatory and unconstitutional as it allowed only heterosexual married or cohabiting couples access to assisted reproduction. Also, the draft report closed the door to research on embryonic cells for use in regenerative medicine. For these reasons, a group of lawmakers[20] decided to come together to develop a proposal that contested these deficiencies and they presented a joint initiative on July 13, 2011.[21]

In December 2012, Senator Maki Ortiz Domínguez (National Action Party, PAN), president of the Senate's Health Committee, presented a bill on assisted reproduction,[22] which reiterates almost the entire bill presented by lawmakers Saro Boardman and Castro Trenti during the 60th Legislature, repeating the same rights violations, unconstitutionality and technical inaccuracies. The bill contains, as stated, a number of provisions that violate human rights and are clearly unconstitutional; some of them are described below. First, it is discriminatory because it restricts assisted reproduction to couples with proven infertility, excluding unmarried or same-sex couples.

Second, as was the case with the other bills mentioned, cryopreservation of embryos, and the production and transfer of more than three embryos is prohibited, which, if the first attempt fails –highly likely given the scientifically proven success rate of these procedures– would force the woman to undergo more treatments and, therefore, unnecessary risks to her physical and emotional wellbeing.

The initiative also prohibits research on embryos, which implies a disproportionate limitation on the right to benefit from scientific progress.

In addition, women providing surrogate pregnancies are prohibited from requesting an abortion except when their life is in danger, in clear contradiction with state legislation and international standards in the field.

The regulation of assisted human reproduction services requires a detailed analysis of technical aspects that are beyond the scope of this report; however, in terms of the legal and policy framework, some issues related to the exercise of human rights should be raised, for example the fact that the period for cryopreservation is limited by the woman's reproductive age or that surrogacy only can be used when there is no functional uterus, among others.

It is essential that the regulations on assisted reproduction are truly comprehensive and reflect both the highest standards of human rights protection and scientific progress.

6.3.1 SURROGATE MOTHERHOOD

Although, as already pointed out, the regulation of assisted reproduction services is under federal jurisdiction, some aspects of surrogate pregnancy could be subject to state regulation, making it necessary to open up the debate and propose how the civil and family aspects of this practice should be regulated.

In Mexico City and Guerrero, bills have been submitted, while in Puebla, a bill has been drafted but not yet presented to the state congress. In Tabasco, Article 92 of the Civil Code regulates surrogate pregnancy as a matter of parentage and sets out the definitions of a gestational surrogate mother and surrogate mother.

This regulation is summarized in the following table:

ARTICLE 92 OF THE CIVIL CODE OF TABASCO

TERM	DEFINITION
GESTATIONAL SURROGATE MOTHER	WOMAN WHO CARRIES THE PREGNANCY TO TERM AND PROVIDES THE COMPONENT FOR GESTATION, BUT NOT THE GENETIC COMPONENT.
SURROGATE MOTHER	WOMAN WHO CARRIES THE PREGNANCY TO TERM AND PROVIDES BOTH THE GESTATION AND THE GENETIC COMPONENTS.
CONTRACTING MOTHER	WOMAN WHO CONTRACTS THE SERVICES OF A GESTATIONAL SURROGATE MOTHER OR SURROGATE MOTHER.
PRESUMPTION OF MATERNITY	IN THE CASE OF CHILDREN BORN AS A RESULT OF THE INVOLVEMENT OF A GESTATIONAL SURROGATE MOTHER, MATERNITY IS PRESUMED TO BELONG TO THE CONTRACTING MOTHER. IN CASES INVOLVING A SURROGATE MOTHER, ARRANGEMENTS FOR FULL ADOPTION MUST BE MADE.

While the issue of parentage is regulated through this provision of the Civil Code of Tabasco, there is no further regulation regarding contracts for surrogate pregnancies and rules and procedures according to which they should be performed, in order to avoid jeopardizing the rights of both the surrogate mother and the applicants. In other words, there is a major regulatory vacuum that is unresolved in the code's provisions.

In Guerrero, a Surrogacy Bill was presented on September 8, 2011 but was not debated by the state congress. It set out the requirements and formalities for surrogate gestation in both the civil and health spheres. The proposal contained several problematic aspects which placed the guarantee of women's human rights at risk. First, it talked about the best interests of the child when referring to the fetus, which can not be equated with a minor. The proposal also stipulated that the pregnant woman would have to carry the pregnancy to term under any circumstances, which conflicts with women's right to terminate a pregnancy in the cases set out in Article 121, Sections II and III, of the State Criminal Code. Furthermore, although it states that surrogacy must not be carried out for financial gain, the bill says nothing about ensuring the surrogate mother payment to cover medical expenses for prenatal care, childbirth, and other related expenses. A final troubling aspect of the initiative is that it prohibits cryopreservation, which is outside of the state Congress's jurisdiction, since the donation of cells falls under federal regulation.

On November 30, 2010 Mexico City 's Legislative Assembly approved the Mexico City Law on Surrogate Pregnancy; however, the legislation was not published. The Executive branch made comments on the bill on September 17, 2011, which were debated but not approved.[23] The following table summarizes the main issues addressed by that law, as well as the observations made by the state 's executive branch.

MEXICO CITY LAW ON SURROGATE PREGNANCY APPROVED BY MEXICO CITY´S LEGISLATIVE ASSEMBLY ON NOVEMBER 30, 2010

CONCEPT	REGULATION	OBSERVATIONS MADE BY MEXICO CITY´S EXECUTIVE BRANCH	ARTICLE
SURROGATE PREGNANCY	MEDICAL PRACTICE CONSISTING OF THE TRANSFER OF HUMAN EMBRYOS TO A WOMAN THAT ARE THE PRODUCT OF THE FERTILIZATION OF AN EGG AND SPERM FROM A COUPLE UNITED BY MARRIAGE OR COHABITING AND WHO PROVIDE THEIR GENETIC MATERIAL.	THE SURROGACY IS CARRIED OUT BY TRANSFERRING EMBRYOS, PRODUCT OF THE FERTILIZATION OF AN EGG AND SPERM, TO A PERSON, FOR A COUPLE UNITED BY MARRIAGE OR COHABITING, ACCORDING TO APPLICABLE HEALTH LEGISLATION.	2
	NO MONEY WILL EXCHANGE HANDS BETWEEN THE APPLICANTS AND THE PREGNANT WOMAN FOR THE SURROGACY, WHO WILL CARRY THE PREGNANCY TO TERM ONCE EMBRYO IMPLANTATION IS PERFORMED.	NO MONEY WILL EXCHANGE HANDS BETWEEN THE APPLICANTS AND THE PREGNANT PERSON FOR THE SURROGACY, WHO WILL CARRY THE PREGNANCY TO TERM.	
WOMAN REQUESTING THE SERVICE	LEGALLY COMPETENT WOMAN WHO SUFFERS A MEDICAL CONTRAINDICATION OR PERMANENT INABILITY TO CARRY A PREGNANCY IN HER UTERUS AND WHO PROVIDES HER EGGS FOR FERTILIZATION, AND AGREES, THROUGH A SURROGACY AGREEMENT AND FROM THE MOMENT OF IMPLANTATION, TO THE REGULATIONS STIPULATED BY CURRENT LEGISLATION REGARDING MATERNITY, TO ENSURE THE CHILD'S BEST INTERESTS AND TO EXERCISE THE RIGHTS AND OBLIGATIONS ARISING AS A RESULT OF MATERNITY.	LEGALLY COMPETENT PERSONS WHO ARE PHYSICALLY OR GENETICALLY INCAPABLE OF CARRYING A PREGNANCY, AND AGREE, THROUGH A SURROGACY AGREEMENT, TO ENSURE THE BEST INTERESTS OF THE CHILD BORN AS A CONSEQUENCE OF THE SURROGACY AND TO EXERCISE THE RIGHTS AND OBLIGATIONS ARISING FROM MATERNITY AND/OR PATERNITY.	3
INDIVIDUALS REQUESTING THE SERVICE	LEGALLY COMPETENT INDIVIDUALS WHO PROVIDE THEIR GENERIC MATERIAL FOR FERTILIZATION AND AGREE, THROUGH A SURROGACY AGREEMENT, AND FROM THE TIME OF IMPLANTATION, TO THE REGULATIONS STIPULATED BY CURRENT LEGISLATION REGARDING MATERNITY AND PATERNITY, TO ENSURE THE CHILD'S BEST INTERESTS AND TO EXERCISE THE RIGHTS AND OBLIGATIONS ARISING FROM MATERNITY OR PATERNITY.	LEGALLY COMPETENT INDIVIDUALS WHO ARE PHYSICALLY OR GENETICALLY INCAPABLE OF CARRYING A PREGNANCY, AND AGREE, THROUGH A SURROGACY AGREEMENT, TO ENSURE THE BEST INTERESTS OF THE CHILD BORN AS A CONSEQUENCE OF THE SURROGACY AND TO EXERCISE THE RIGHTS AND OBLIGATIONS ARISING FROM MATERNITY AND/OR PATERNITY.	3
SURROGATE MOTHER	LEGALLY COMPETENT WOMAN WHO, WITHOUT PAYMENT, AGREES TO ALLOW IMPLANTATION OF THE EMBRYO RESULTING FROM FERTILIZATION OF A COUPLE UNITED BY MARRIAGE OR COHABITING WHO PROVIDE THEIR GENETIC MATERIAL AND TO ENSURE THE PREGNANCY COMES TO TERM, AT WHICH TIME HER SURROGACY CONCLUDES.	LEGALLY COMPETENT INDIVIDUAL WHO, WITHOUT PAYMENT, AGREES TO ALLOW TRANSFER AND EVENTUAL IMPLANTATION OF ONE OR MORE EMBRYOS AND CARRY THE PREGNANCY TO TERM, AT WHICH TIME HER SURROGACY CONCLUDES.	3
	A SURROGATE MOTHER SHOULD PREFERABLY HAVE A BLOOD, MARRIAGE OR CIVIL RELATIONSHIP WITH ONE OF THE APPLICANTS.	A SURROGATE PERSON SHOULD PREFERABLY HAVE A BLOOD, MARRIAGE OR CIVIL RELATIONSHIP WITH ONE OF THE APPLICANTS.	16
SURROGACY AGREEMENT	CONTRACT WHICH MANIFESTS CONSENT BY A LEGALLY COMPETENT WOMAN, BEFORE A PUBLIC NOTARY, TO IMPLANTATION OF AN EMBRYO AND CARRYING THE PREGNANCY TO TERM, TO THE BENEFIT OF TWO PEOPLE, UNITED IN MARRIAGE OR COHABITING, WHO ALSO EXPRESS THEIR CONSENT, AND WHO PROVIDE THEIR EGGS AND SPERM FOR FERTILIZATION AND TO FORM AN EMBRYO TO BE IMPLANTED INTO THE UTERUS OF THE SURROGATE MOTHER.	AGREEMENT WHICH MANIFESTS CONSENT BY A LEGALLY COMPETENT PERSON, BEFORE A PUBLIC NOTARY, FOR THE TRANSFER OF AN EMBRYO OR EMBRYOS AND, IN THE EVENT OF IMPLANTATION, CARRY THE PREGNANCY TO TERM, TO THE BENEFIT OF TWO INDIVIDUALS, UNITED IN MARRIAGE OR COHABITING OR SINGLE WHO MEET THE REQUIREMENT STIPULATED IN PARAGRAPH 3 OF ARTICLE 2 OF THIS LAW, WHO ALSO EXPRESS THEIR CONSENT TO THE TRANSFER OF ONE OR MORE EMBRYOS TO THE UTERUS OF THE SURROGATE MOTHER.	3
	THE SURROGACY AGREEMENT MAY BE WITHDRAWN BY THE APPLICANTS OR THE SURROGATE MOTHER, BEFORE ANY TRANSFER OF HUMAN EMBRYOS. REVOCATION SHALL RESULT IN THE PAYMENT OF DAMAGES.	THE SURROGACY AGREEMENT MAY BE WITHDRAWN BY THE APPLICANTS OR THE SURROGATE PERSON, BEFORE ANY TRANSFER OF HUMAN EMBRYOS. REVOCATION SHALL RESULT IN THE PAYMENT OF DAMAGES.	32
AUTHORIZATION	THE MEDICAL PRACTICE OF SURROGACY CAN ONLY BE CARRIED OUT IN PUBLIC OR PRIVATE HEALTH INSTITUTIONS WITH AUTHORIZATION TO TRANSFER HUMAN EMBRYOS.	THE ASSISTED REPRODUCTION TECHNIQUE THAT WILL LEAD TO THE SURROGACY CAN ONLY BE CARRIED OUT IN PUBLIC OR PRIVATE HEALTH INSTITUTIONS WITH AUTHORIZATION TO TRANSFER HUMAN EMBRYOS.	4
ABORTION	THE PREGNANT WOMAN'S RIGHT TO TERMINATE THE PREGNANCY IS ONLY RECOGNIZED IN CASES OF SERIOUS HEALTH RISKS AND GENETIC OR CONGENITAL ABNORMALITIES IN THE FETUS THAT MAY RESULT IN PHYSICAL OR MENTAL HARM.	KNOWLEDGE OF THE PARTIES ON THE RIGHT OF THE SURROGATE MOTHER TO DECIDE REGARDING THE TERMINATION OF PREGNANCY BASED ON THE TERMS ESTABLISHED BY CRIMINAL LAW AND MEXICO CITY HEALTH REGULATIONS.	20

MEXICO CITY LAW ON SURROGATE PREGNANCY APPROVED BY MEXICO CITY'S LEGISLATIVE ASSEMBLY ON NOVEMBER 30, 2010

CONCEPT	REGULATION	OBSERVATIONS MADE BY MEXICO CITY'S EXECUTIVE BRANCH	ARTICLE
PROHIBITIONS	FORMATION OF EMBRYOS FOR PURPOSES OTHER THAN PROCREATION. ANY FORM OF MARKETING OR ECONOMIC USE OF EMBRYONIC CELLS AND TISSUES DERIVED FROM ASSISTED REPRODUCTION. CRYOPRESERVATION OF EGGS AND SPERM FOR ANY OTHER PURPOSE THAN REPRODUCTION.	*These prohibitions are eliminated.*	7
CRIME	CIVIL AND CRIMINAL LIABILITY WILL BE ASSIGNED TO THOSE PHYSICIANS PERFORMING HUMAN EMBRYO TRANSFER WITHOUT THE CONSENT AND FULL ACCEPTANCE OF THE PARTIES INVOLVED, APPLYING THE PENALTIES ESTABLISHED BY THE CRIME OF ASSISTED REPRODUCTION AND ARTIFICIAL INSEMINATION.	CIVIL AND CRIMINAL LIABILITY WILL BE ASSIGNED TO THOSE PHYSICIANS PERFORMING HUMAN EMBRYO TRANSFER WITHOUT THE CONSENT AND FULL ACCEPTANCE OF THE PARTIES INVOLVED, APPLYING THE PENALTIES ESTABLISHED BY THE CRIME OF ASSISTED REPRODUCTION REFERRED TO IN CHAPTER I, TITLE II OF MEXICO CITY'S PENAL CODE.	34

The protection of the rights to equality and non-discrimination by the bill are questionable, since access for single men and same sex couples is unclear, as this would require heterologous fertilization. It also restricts access to legal pregnancy termination. According to the principle of exact application of criminal law and the fact that rights cannot be transferred by agreement, the decree should refer to the current health and criminal legislation, instead of creating new regulation specific to the case.

Moreover, as illustrated by the above table, creating legislation on surrogate pregnancy as an assisted reproduction technique implies the regulation of elements that go beyond this specific technique, which implies an invasion of federal powers. For these reasons Mexico City 's Executive Branch presented the afore-mentioned observations.

This reinforces the importance that Congress issue regulations on assisted reproduction including surrogate pregnancy and, based on that regulation, that Mexican states regulate matters within their jurisdiction, such as those relating to agreements and parentage.

The regulation of surrogate pregnancy is a highly complex matter that has been discussed at the international and national level, but, to date, without the establishment of a standard model that combines medical and legal views. Additionally, the regulations adopted in each state should take into account cultural aspects that are crucial to avoid discrimination, in order to guarantee the rights of women who decide to permit the use of their uterus for the development of a pregnancy, as well as those of individuals for whom it is the only alternative to achieve reproduction, whether for health reasons or in the case of single people or same sex couples.

6.4 / CONCLUSIONS

The lack of regulation on assisted reproduction services in Mexico has a negative impact on the exercise of human rights, particularly the right to found a family and decide on the number and spacing of one 's children. It is essential to develop standards that reflect reality. In this sense, the country is lagging behind.

It is therefore urgent that Mexico 's legislative bodies regulate assisted reproduction services through comprehensive law to provide legal certainty and to protect the human rights of all persons involved.

6.4.1 ADEQUATE CONTENT FOR COMPREHENSIVE LAW AND POLICY ON ASSISTED REPRODUCTION

Comprehensive legislation on assisted reproduction must recognize that access to such services is based on human rights and that, as such, the State has specific obligations, including guaranteeing access to these services. It is essential to regulate assisted reproduction services already provided in Mexico at a federal level in order to provide legal certainty to the population and to ensure access to the benefits of scientific progress to those who need it for health reasons or because they choose to use them as a reproductive alternative, in accordance with the highest standards of protection of human rights recognized by the Constitution.

It is also essential that regulation developed by Congress regarding assisted human reproduction does not involve granting personhood to embryos or fertilized eggs, a situation that would limit access to certain techniques, the development of research on embryonic stem cells (stem cells from fertilized ovules) and individuals ' right, particularly women 's right, to reproductive autonomy. Another situation to be avoided, as previously mentioned, is restricting access to assisted reproduction for people who do not fit with the traditional family model, for example, same sex couples or single people. It should further be ensured that the regulations prohibit the trafficking of fertilized or unfertilized eggs. Finally, in compliance with the Constitution, it is essential that legislation respects the distribution of powers between the federal government and the states.

Regulation that is restrictive, discriminatory and inconsistent with human rights and science would imply the failure of compliance with obligations assumed by the Mexican State, both those enshrined in the Constitution and those contained in international human rights treaties to which Mexico is party. The regulatory and legislative proposals should be drawn up and analyzed from a democratic perspective that respects human rights and promotes the advancement of science, and is not based on moral beliefs or religious principles.

In this sense, it would be worth analyzing the regulations on the issue made by countries such as the United Kingdom, Germany, Israel and New Zealand, all of which have laws that respect human rights and not only permit but encourage medical research on stem cells from fertilized ovules.

6.5 / RECOMMENDATIONS

- Congress must regulate the general aspects of assisted reproduction services to provide legal certainty and to protect the human rights of those who access these services.
- The Ministry of Health should issue an Official Mexican Norm to regulate the technical aspects of the provision of assisted reproduction services in the public, private and social domains.
- This law and policy should be based on the protection of human rights and scientific advances, recognizing reproductive rights at all times, particularly those of women.

NOTES

[1] *International Committee for Monitoring Assisted Reproductive Technology (ICMART) and the World Health Organization (WHO)* revised glossary of ART terminology, 2009, p. 3. Available at: <http://tinyurl.com/o99osa8> [accessed: February 6, 2013].

[2] Mascarenhas, Maya et al., "National, Regional, and Global Trends in Infertility Prevalence since 1990: A Systematic Analysis of 277 Health Surveys" in *PLOS Medicine*, vol. 9, no. 12, December 2012. Available at: < http://bit.ly/13nM5st> [accessed: February 1, 2013].

[3] *Glossary of ART terminology… op. cit.* (see above, note 1).

4 *Ibid*.

[5] Inter-American Court of Human Rights, *Case of Artavia Murillo et al. (In Vitro Fertilization) vs. Costa Rica. Preliminary objections, merits, reparations and costs. Judgment of November 28, 2012 Series C No. 257.* Available at: <http://tinyurl.com/q32sagr> [accessed: December 21, 2012].

[6] *IACHR, Case No. 12.361. Gretel Artavia Murillo et al. (In Vitro Fertilization) vs. Costa Rica. Note of Referral of the Case to the Court and Merits Report, July 29 2011.* Available at: <http://tinyurl.com/ogcz6pb> [accessed: December 3, 2012].

[7] González Cervera, Alfonso, Subfecundidad e infertilidad en mujeres mexicanas in Papeles de Población, no, 50, 2006, pp. 277-291. Carreño Meléndez, Jorge, Guía clínica de intervención psicológica de la paciente con esterilidad in *Perinatología y Reproducción Humana,* vol., 21, no. 1, January-March 2007, pp. 44-53.

[8] Federal Government, Instituto Nacional de Perinatología, *Sistema de Acceso a la Información Pública: Infomex,* File 1225000007512. Available at: <http://bit.ly/WFV3Z5> [accessed: January 31, 2013].

[9] Ministry of Health, National Health Information System, *Base de datos de egresos hospitalarios por morbilidad en Instituciones Públicas del Sector Salud, 2004-2011,* Mexico, SINAIS, 2013. Available at: <http://bit.ly/dBHezo> [accessed: January 31, 2013].

[10] Federal Government, Comisión Federal para la Protección contra Riesgos Sanitarios, *Sistema de Acceso a la Información Pública: Infomex*, File 1215100150212. Available at: <http://bit.ly/XYxpHd> [accessed: January 31, 2013].

[11] "Iniciativa con Proyecto de Decreto por el que se crea la Ley de Reproducción Humana Asistida y se reforman distintos artículos de la Ley General de Salud, a cargo de los Senadores Fernando Castro Trenti del Grupo Parlamentario del PRI y Ernesto Saro Boardman del Grupo Parlamentario del PAN in Senate, LX Legislatura, Gaceta del Senado, Mexico, no. 237, Monday April 28, 2008. Available at: <http://bit.ly/U3vLIP> [accessed: January 31, 2013].

[12] Iniciativa que reforma y adiciona los artículos 314 y 327 de la Ley General de Salud, a cargo de la diputada Oralia López Hernández del Grupo Parlamentario del PAN in Chamber of Representatives, LXI Legislatura, *Gaceta Parlamentaria*, Mexico, year XV, no. 3427-IV, Wednesday, January 11, 2012. Available at: <http://bit.ly/Wi0sJj> [accessed: January 31, 2013].

[13] Iniciativa de los legisladores María de los Ángeles Moreno Uriegas, María del Socorro García Quiroz, Rosalinda Elena Mondragón Santoyo et al. que contiene proyecto de decreto por el que se derogan, reforman y adicionan diversos artículos de la Ley General de Salud in Senate, LXI Legislatura, *Gaceta del Senado,* Mexico, no. 21, Wednesday, July 13, 2011. Available at: <http://bit.ly/W2RxcM> [accessed: January 31, 2013].

[14] "Iniciativa con Proyecto de Decreto por el que se crea la Ley de Reproducción Humana Asistida..." *op. cit.* (see above, note 11).

[15] Iniciativa que crea la Ley Federal de Subrogación Gestacional, y adiciona y reforma diversas disposiciones de la Ley General de Salud, recibida de la diputada Leticia Quezada Contreras, del Grupo Parlamentario del PRD, en la sesión de la Comisión Permanente del miércoles, 28 de julio de 2010" in Chamber of Representatives, LXI Legislatura, *Gaceta Parlamentaria*, Mexico, year XIII, no. 3064, Friday, July 30, 2010. Available at: <http://bit.ly/9QLTMv> [accessed: January 31, 2013].

[16] The bill involved lawmakers from the majority of the parties, reiterating and supporting the concepts contained in the bill submitted by Senators María del Socorro García Quiroz, María de los Ángeles Moreno and Ramiro Hernández García in 2009; the consensus created by the lawmakers who signed it with regard to assisted reproduction may be invoked to guide the discussion currently underway on the issue in Congress.

[17] Rosalinda Elena Mondragón Santoyo, Margarita Villaescusa Rojo, Rodrigo Reina Liceaga, María Cristina Díaz Salazar, Diva Hadamira Gastélum Bajo, Carolina Viggiano Austria, Claudia Ruiz Massieu Salinas, Clara Gómez Caro, Yolanda de la Torre Valdez, Marcela Guerra Castillo (PRI); Yeidckol Polevnsky Gurwitz, Rosalinda López Hernández, María Rojo e Incháustegui, Francisco Javier Castellón Fonseca, Enoé Uranga Muñoz, Esthela Damián Peralta, Dolores de los Ángeles Názares Jerónimo, Heladio Gerardo Verver y Vargas, Olga Luz Espinosa Morales, Leticia Quezada Contreras (PRD); Ludivina Menchaca Castellanos, Javier Orozco Gómez and Rosario Brindis Álvarez (PVEM), and Víctor Hugo Círigo Vásquez (Convergencia).

[18] Ernesto Javier Cordero Arroyo; José Rosas Aispuro Torres; Jorge Luis Lavalle Maury; Fernando Torres Graciano; César Octavio Pedroza Gaitán; María del Pilar Ortega Martínez; Javier Corral Jurado; Salvador Vega Casillas; María Marcela Torres Peimbert; Daniel Gabriel Ávila Ruiz; José María Martínez Martínez; Víctor Hermosillo y Celada; Adrian Dávila Fernández; Silvia Guadalupe Garza Galván; Ernesto Rufo Appel; Roberto Gil Zuarth; Francisco Domínguez Servién; Fernando Yunes Márquez; Sonia Mendoza Díaz; Francisco de Paula Búrquez Valenzuela; Raúl Gracia Guzmán; Carlos Mendoza Davis; Martín Orozco Sandoval; Francisco García Cabeza de Vaca; Francisco Salvador López Brito; Juan Carlos Romero Hicks; Héctor Larios Córdoba (PAN); Miguel Romo Medina, María Cristina Díaz Salazar; Manuel Cavazos Lerma, integrantes del Grupo Parlamentario (PRI); Fernando Enrique Mayans Canabal, Víctor Manuel Camacho Solís; Isidro Pedraza Chávez; Dolores Padierna Luna; Alejandro de Jesús Encinas Rodríguez; Adán Augusto López Hernández; Angélica de la Peña Gómez (PRD); María Elena Barrera Tapia (PVEM); Martha Palafox Gutiérrez; Ana Gabriela Guevara Espinoza (PT); and Layda Sansores San Román (independent).

[19] Bill proposed by Representative Emilio González Martínez (PVEM) presented on April 27, 1999. Available at: <http://bit.ly/UICEym> [accessed: February 20, 2013]. Bill proposed by Representative Francisco Salvador López Brito (PAN), presented on September 26, 2002. Available at: <http://bit.ly/ZrVzAc> [accessed: February 20, 2013]. Bill proposed by Representative Rafael García Tinajero Pérez (PRD), presented on December 2, 2004. Available at: <http://bit.ly/Vwdi5Z> [accessed: February 20, 2013]. Bill proposed by Representative Jesús Emilio Martínez Álvarez (Convergencia), presented on April 19, 2005. Available at: <http://bit.ly/ZrWdxH> [accessed: February 20, 2013]. Bill proposed by Representative María Cristina Díaz Salazar (PRI), presented on April 28, 2005. Available at: <http://bit.ly/WaEHaW> [accessed: February 20, 2013]. Bill proposed by Representative María Cristina Díaz Salazar (PRI), presented on April 8, 2010. Available at: <http://bit.ly/WRaS1f> [accessed: February 20, 2013]. Bill proposed by Representative María del Pilar Torre Canales (Nueva Alianza), presented on April 22, 2010. Available at: <http://bit.ly/ZrXqFf> [accessed: February 20, 2013].

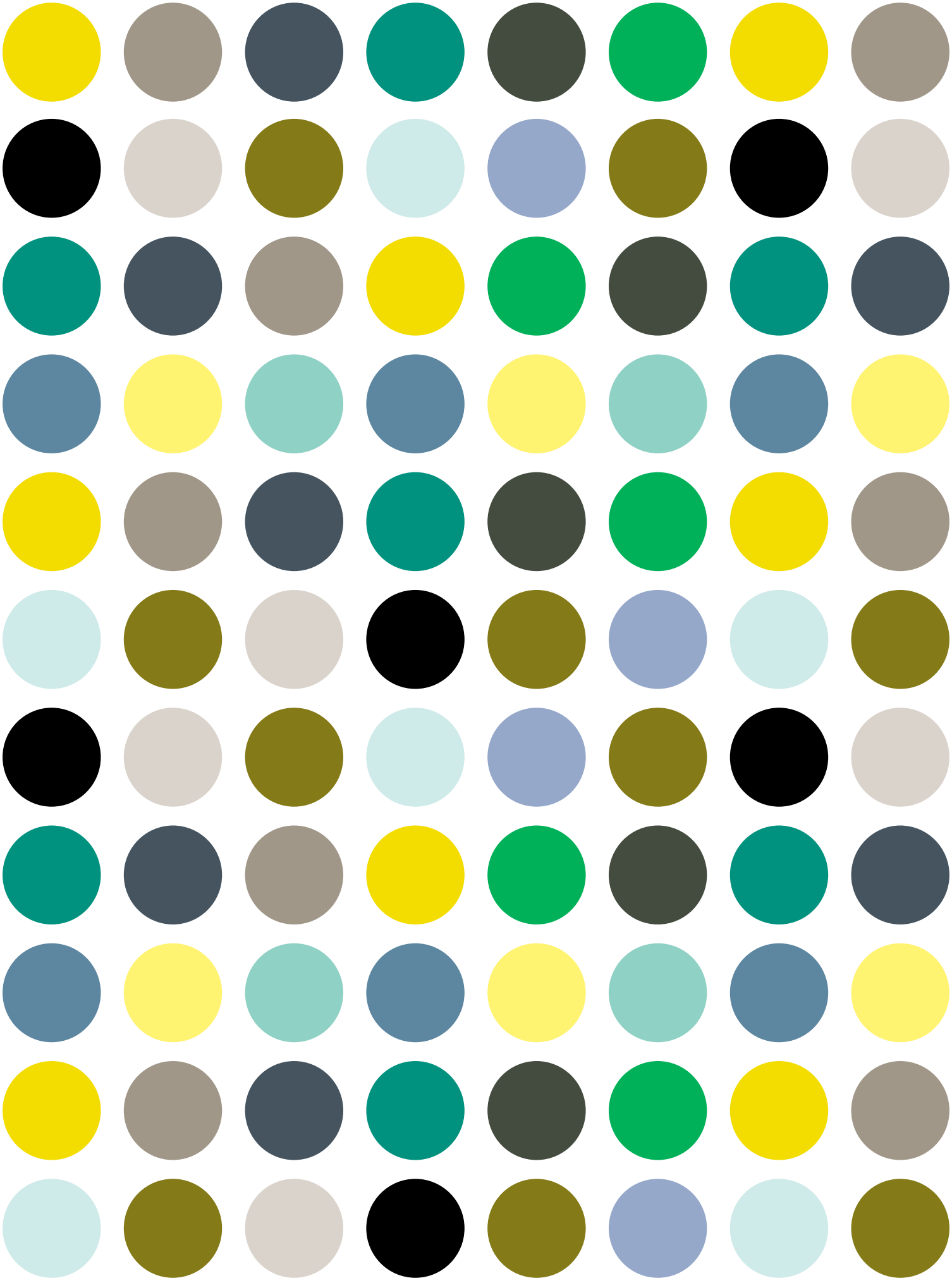
[20] See above, note 17.

[21] See above, note 13.

[22] Iniciativa de la Senadora Maki Esther Ortiz Domínguez, a nombre propio y de diversos Senadores de los Grupos Parlamentarios, la que contiene proyecto de Ley de Reproducción Humana Asistida y reforma diversas disposiciones de la Ley General de Salud in Senate, LXII Legislatura, *Gaceta del Senado*, Mexico, no. 77, Thursday, December 20, 2012. Available at: <http://bit.ly/VUccNI> [accessed: January 31, 2013].

[23] GIRE was involved in preparing these observations.

ANNEX



REQUESTS FOR ACCESS TO INFORMATION

To create this report, GIRE presented more than 600 requests for access to information. The institutions to which these requests were sent and the questions presented are listed below.

PERIOD IN WHICH THE INFORMATION WAS PRESENTED AND ANALYZED	APRIL TO DECEMBER 2012
FEDERAL INSTITUTIONS	MINISTRY OF HEALTH MEXICAN INSTITUTE OF SOCIAL SECURITY INSTITUTE FOR SOCIAL SECURITY AND SERVICES FOR STATE WORKERS MINISTRY OF PUBLIC SECURITY ATTORNEY GENERAL´S OFFICE FEDERAL JUDICIAL BRANCH FEDERAL LABOR PROTECTION OFFICE NATIONAL COMMISSION OF MEDICAL ARBITRATION FEDERAL COMMISSION FOR PROTECTION AGAINST HEALTH RISKS NATIONAL INSTITUTE OF PERINATOLOGY
AUTONOMOUS INSTITUTIONS	NATIONAL HUMAN RIGHTS COMMISSION
STATE INSTITUTIONS	MINISTRIES OF HEALTH MINISTRIES OF PUBLIC SECURITY SOCIAL REHABILITATION CENTERS PUBLIC PROSECUTOR´S OFFICES STATE JUDICIAL BRANCHES GOVERNMENT HUMAN RIGHTS ORGANISMS STATE COMMISSIONS OF MEDICAL ARBITRATION

1. SAFE AND LEGAL ABORTION

INSTITUTION	QUESTION
MINISTRIES OF HEALTH (FEDERAL AND STATE) MEXICAN INSTITUTE OF SOCIAL SECURITY	"I FORMALLY REQUEST THE FOLLOWING PUBLIC INFORMATION, VIA DOCUMENTS THAT CONTAIN: NUMBER OF LEGAL PREGNANCY TERMINATIONS DUE TO SEXUAL VIOLENCE, DURING THE PERIOD BETWEEN APRIL 1, 2007 AND JULY 31, 2012. I REQUEST THAT THE INFORMATION BE DESEGREGATED BY: A) GEOGRAPHIC LOCATION B) MONTH AND YEAR C) AGE OF THE WOMEN WHO RECEIVED LEGAL PREGNANCY TERMINATION SERVICES D) GESTATIONAL AGE."
INSTITUTE FOR SOCIAL SECURITY AND SERVICES FOR STATE WORKERS	"I FORMALLY REQUEST THE FOLLOWING PUBLIC INFORMATION, VIA DOCUMENTS THAT CONTAIN: NUMBER OF LEGAL PREGNANCY TERMINATIONS DUE TO CAUSES SUCH AS PREGNANCY TERMINATION RESULTING FROM A "CARELESS ACT", RISK TO THE WOMAN'S LIFE, AND NON-CONSENSUAL ARTIFICIAL INSEMINATION DURING THE PERIOD BETWEEN APRIL 1, 2007 AND JULY 31, 2012. DESEGREGATE INFORMATION BY: A) GEOGRAPHIC LOCATION B) AGE OF THE WOMEN WHO RECEIVED LEGAL PREGNANCY TERMINATION SERVICES C) GESTATIONAL AGE D) METHODS USED TO CARRY OUT THE LEGAL PREGNANCY TERMINATION."
	"I FORMALLY REQUEST THE FOLLOWING PUBLIC INFORMATION, VIA DOCUMENTS THAT CONTAIN: NUMBER OF AUTHORIZATIONS RECEIVED BY THE ATTORNEY GENERAL'S OFFICE OR STATE PUBLIC PROSECUTOR'S OFFICE TO CARRY OUT A LEGAL ABORTION DURING THE PERIOD BETWEEN APRIL 1, 2007 AND JULY 31, 2012."
FEDERAL ATTORNEY GENERAL'S OFFICE AND STATE PUBLIC PROSECUTORS OFFICES	"I FORMALLY REQUEST THE FOLLOWING PUBLIC INFORMATION, VIA DOCUMENTS THAT CONTAIN: NUMBER OF REPORTS PRESENTED FOR THE CRIME OF ABORTION AGAINST WOMEN AND MEN, DESEGREGATED BY GENDER AND YEAR, DURING THE PERIOD BETWEEN APRIL 1, 2007 AND JULY 31, 2012. PROVIDE DATE AND GEOGRAPHIC LOCATION OF THE REPORT. NUMBER OF PRE-TRIAL INVESTIGATIONS INITIATED FOR THE CRIME OF ABORTION AGAINST WOMEN AND MEN, DESEGREGATED BY GENDER, DURING THE PERIOD BETWEEN APRIL 1, 2007 AND JULY 31, 2012. PROVIDE DATE AND GEOGRAPHIC LOCATION OF THE REPORT. "
	"I FORMALLY REQUEST THE FOLLOWING PUBLIC INFORMATION, VIA DOCUMENTS THAT CONTAIN: NUMBER OF LEGAL PREGNANCY TERMINATIONS DUE TO SEXUAL VIOLENCE. ATTACH PUBLIC VERSION OF DOCUMENTS THAT CONTAIN THE PROCEDURE TO EMIT THE AUTHORIZATION, THE PERIOD FOR THE AUTHORIZATION (LAPSE BETWEEN THE PRESENTATION THE REPORT AND THE EMISSION OF THE AUTHORIZATION) AND THE REQUIREMENTS (FOR EXAMPLE, MEDICAL REPORT, CONSENT OF PARENTS OR GUARDIANS IN THE CASE OF MINORS) DURING THE PERIOD BETWEEN APRIL 1, 2007 AND JULY 31, 2012."
	"I FORMALLY REQUEST THE FOLLOWING PUBLIC INFORMATION, VIA DOCUMENTS THAT CONTAIN: NUMBER REPORTS PRESENTED FOR THE CRIME OF SEXUAL VIOLENCE AGAINST WOMEN DURING THE PERIOD BETWEEN APRIL 1, 2007 AND JULY 31, 2012. DESEGREGATED BY DATE AND GEOGRAPHIC LOCATION. NUMBER PRE-TRIAL INVESTIGATIONS OPENED FOR THE CRIME OF SEXUAL VIOLENCE AGAINST WOMEN DURING THE PERIOD BETWEEN APRIL 1, 2007 AND JULY 31, 2012. DESEGREGATED BY DATE AND GEOGRAPHIC LOCATION."
	"I FORMALLY REQUEST THE FOLLOWING PUBLIC INFORMATION: STATE WHETHER ABORTION IS PUNISHED ACCORDING TO APPLICABLE LEGISLATION, AND IF SO, REPORT WHETHER IT IS PUNISHED WITH PSYCHOLOGICAL AND/OR MEDICAL TREATMENT. I REQUEST INFORMATION REGARDING THE NUMBER OF WOMEN SENTENCED FOR THE CRIME OF ABORTION AND PUNISHED WITH PSYCHOLOGICAL OR MEDICAL TREATMENT, AND THE AGE OF THESE WOMEN, DURING THE PERIOD BETWEEN APRIL 1, 2007 AND JULY 31, 2012. DESEGREGATE BY DATE AND GEOGRAPHIC LOCATION. INCLUDE THE DOCUMENT DESCRIBING THE PSYCHOLOGICAL OR MEDICAL TREATMENT, INCLUDING ITS DURATION AND CHARACTERISTICS, AS APPLIED TO WOMEN WHO HAVE ABORTED DURING THE PERIOD BETWEEN APRIL 1, 2007 AND JULY 31, 2012."
MINISTRIES OF PUBLIC SECURITY (FEDERAL AND STATE) AND/OR STATE SOCIAL REHABILITATION CENTERS	"I FORMALLY REQUEST THE FOLLOWING PUBLIC INFORMATION: NUMBER OF PERSONS ACCUSED OF THE CRIME OF ABORTION THAT ARE CURRENTLY IN PRISON. DESEGREGATE THE DATA BY YEAR, SEX, AGE AND TYPE OF ABORTION DURING THE PERIOD BETWEEN APRIL 1, 2007 AND JULY 31, 2012. NUMBER OF PERSONS SENTENCED FOR THE CRIME OF ABORTION CURRENTLY IN PRISON AND THEIR SENTENCES. DESEGREGATE THE DATA BY SEX, AGE AND TYPE OF ABORTION DURING THE PERIOD BETWEEN APRIL 1, 2007 AND JULY 31, 2012."
JUDICIAL BRANCHES (FEDERAL AND STATE)	"I FORMALLY REQUEST THE FOLLOWING PUBLIC INFORMATION, VIA DOCUMENTS THAT CONTAIN: NUMBER OF PENAL PROCEEDINGS INITIATED FOR THE CRIME OF ABORTION AGAINST THE WOMAN AND THE NUMBER OF CASES IN WHICH PENAL ACTION WAS EXERCISED DURING THE PERIOD BETWEEN APRIL 1, 2007 AND JULY 31, 2012. NUMBER OF WOMEN SENTENCED FOR THE CRIME OF ABORTION THAT WERE DEPRIVED OF THEIR LIBERTY AND HOW MANY OF THESE HAD THE RIGHT TO PAY BAIL. DESEGREGATE BY THE AGE OF THE WOMEN DURING THE PERIOD BETWEEN APRIL 1, 2007 AND JULY 31, 2012 AND BY DATE OF INDICTMENT. REPORT CASES THAT HAVE YET TO BE RESOLVED, IF THEY EXIST."

2. CONTRACEPTION

INSTITUTION	QUESTION
MINISTRIES OF HEALTH (FEDERAL AND STATE) MEXICAN INSTITUTE OF SOCIAL SECURITY INSTITUTE FOR SOCIAL SECURITY AND SERVICES FOR STATE WORKERS	"I FORMALLY REQUEST THE FOLLOWING PUBLIC INFORMATION: 1) PROCEDURES AND GUIDELINES REGARDING THE PROVISION OF EMERGENCY CONTRACEPTION PILLS IN THE STATE MINISTRY OF HEALTH. ATTACH DOCUMENT USED BY PUBLIC OFFICIALS IN THE DELIVERY OF EMERGENCY CONTRACEPTION PILLS. 2) BRAND OF THE CONTRACEPTIVE PILLS AVAILABLE AND THE INFORMATION PROVIDED TO WOMEN (ATTACH DOCUMENTS). 3) NUMBER OF WOMEN WHO REQUESTED EMERGENCY CONTRACEPTION PILLS AND THE NUMBER OF WOMEN TO WHOM PILLS WERE PROVIDED DURING THE PERIOD BETWEEN APRIL 1, 2007 AND JULY 31, 2012. DESEGREGATE INFORMATION BY AGE AND HEALTH CENTER. 4) BUDGET ALLOCATED AND SPENT ON THE PURCHASE OF CONTRACEPTIVE PILLS BETWEEN 2009 AND 2012. 5) CONTRACT BETWEEN THE MINISTRY OF HEALTH AND THE PROVIDER OF EMERGENCY CONTRACEPTION PILLS. 6) NUMBER OF DOSES OF EMERGENCY CONTRACEPTION ACQUIRED BY THE MINISTRY OF HEALTH EACH YEAR.
	"I FORMALLY REQUEST THE FOLLOWING PUBLIC INFORMATION: WHAT DO YOU REQUIRE FROM MINORS IN ORDER TO PROVIDE THEM WITH INFORMATION ON CONTRACEPTIVE METHODS AND FAMILY PLANNING AND, IF NECESSARY, THE PROVISION OR APPLICATION OF THE REQUESTED CONTRACEPTIVE METHODS?"
	"I FORMALLY REQUEST THE FOLLOWING PUBLIC INFORMATION: SUBMIT REPORT WITH INFORMATION ON THE MANNER IN WHICH PATIENTS PROVIDE CONSENT FOR THE APPLICATION OF PERMANENT CONTRACEPTIVE METHODS. SUBMIT REPORT WITH DATA DESEGREGATED BY TYPE OF METHOD, SEX AND AGE OF THE INDIVIDUALS WHO PROVIDED CONSENT FOR THE APPLICATION OF PERMANENT CONTRACEPTIVE METHODS."
FEDERAL ATTORNEY GENERAL'S OFFICE AND STATE PUBLIC PROSECUTORS OFFICES	"I FORMALLY REQUEST THE FOLLOWING PUBLIC INFORMATION: REGARDING SEXUAL VIOLENCE, WHAT INFORMATION DO YOU PROVIDE WOMEN ON EMERGENCY CONTRACEPTION WHEN THEY REPORT THIS CRIME? IF YOU PROVIDE THEM WITH A BROCHURE OR DOCUMENT, PLEASE ATTACH."

3. MATERNAL MORTALITY

INSTITUTION	QUESTION
MINISTRIES OF HEALTH (FEDERAL AND STATE)	"COPY OF THE MINISTRY OF HEALTH'S STATE PROGRAM ON MATERNAL MORTALITY AND MORBIDITY FOR 2011." "COPY OF THE DOCUMENT THAT CONTAINS THE RESULTS OBTAINED IN THE MINISTRY OF HEALTH'S STATE PROGRAM ON MATERNAL MORTALITY AND MORBIDITY FOR 2011."
FEDERAL MINISTRY OF HEALTH	"NUMBER OF COMPLAINTS PRESENTED DUE TO CASES OF MATERNAL MORTALITY IN WHICH WOMEN DIE DUE TO NEGLIGENCE IN MEDICAL CARE RELATED TO PREGNANCY BETWEEN 2008 AND 2012." "COPY OF THE BULLETINS FOR THE ROAD TO EXCELLENCE PROGRAM FOR 2011 AND 2012."
FEDERAL ATTORNEY GENERAL'S OFFICE	"NUMBER OF PRE-TRIAL INVESTIGATIONS INITIATED BETWEEN 2008 AND 2012, FOR CRIMES COMMITTED BY PHYSICIANS, AUXILIARY STAFF AND OTHERS, RELATED TO MEDICAL PRACTICE, IN CASES OF PREGNANT WOMEN WHO DIE AS A RESULT OF NEGLIGENT CARE DURING PREGNANCY. DISAGGREGATE DATA BY YEAR. HOW MANY OF THESE PRE-TRIAL INVESTIGATIONS RESULTED IN PENAL PROCEEDINGS?"
STATE PUBLIC PROSECUTORS OFFICES	"NUMBER OF PRE-TRIAL INVESTIGATIONS INITIATED BETWEEN 2008 AND 2012, FOR CRIMES COMMITTED BY PHYSICIANS, AUXILIARY STAFF AND OTHERS, RELATED TO MEDICAL PRACTICE, IN CASES OF PREGNANT WOMEN WHO DIE AS A RESULT OF NEGLIGENT CARE DURING PREGNANCY. DISAGGREGATE DATA BY YEAR. HOW MANY OF THESE PRE-TRIAL INVESTIGATIONS RESULTED IN PENAL PROCEEDINGS?"
GOVERNMENT HUMAN RIGHTS ORGANISMS	"NUMBER OF RECOMMENDATIONS EMITTED BY THE COMMISSION IN RESPONSE TO COMPLAINTS RELATED TO CASES OF PREGNANT WOMEN WHO DIE AS A RESULT OF NEGLIGENT CARE DURING PREGNANCY AND A COPY OF THESE RECOMMENDATIONS."
NATIONAL HUMAN RIGHTS COMMISSION	"NUMBER OF RECOMMENDATIONS EMITTED BY THE COMMISSION IN RESPONSE TO COMPLAINTS RELATED TO CASES OF PREGNANT WOMEN WHO DIED AS A RESULT OF NEGLIGENT CARE DURING PREGNANCY AND A COPY OF THESE RECOMMENDATIONS."
STATE JUDICIAL BRANCHES	"NUMBER OF PENAL PROCEEDINGS INITIATED BY YEAR, BETWEEN 2000 AND 2012, FOR CRIMES COMMITTED BY PHYSICIANS, AUXILIARY STAFF AND OTHERS, RELATED TO MEDICAL PRACTICE, IN CASES OF PREGNANT WOMEN WHO DIED AS A RESULT OF NEGLIGENT CARE DURING PREGNANCY. INCLUDE THE RESULTS OF THESE PROCESSES."

4. OBSTETRIC VIOLENCE

INSTITUTION	QUESTION
MINISTRIES OF HEALTH (FEDERAL AND STATE) MEXICAN INSTITUTE OF SOCIAL SECURITY	"I FORMALLY REQUEST THE FOLLOWING PUBLIC INFORMATION FOR THE PERIOD 2009-2012: WHAT INFORMATION IS PROVIDED TO PREGNANT WOMEN REGARDING THEIR CHILDBIRTH OPTIONS, ALONG WITH THE RISKS AND ADVANTAGES OF EACH OPTION? ATTACH PROTOCOL. HOW MANY WOMEN GAVE BIRTH EACH YEAR? ATTACH REPORT WITH DATA, BY AGE, ON THE NUMBER OF WOMEN WHO GAVE BIRTH EACH YEAR. HOW MANY CAESAREANS WERE CARRIED OUT EACH YEAR? ATTACH REPORT WITH DATA, BY AGE AND MEDICAL JUSTIFICATION, ON THE NUMBER OF CAESAREANS CARRIED OUT EACH YEAR."
INSTITUTE FOR SOCIAL SECURITY AND SERVICES FOR STATE WORKERS	"I FORMALLY REQUEST THE FOLLOWING PUBLIC INFORMATION FOR THE PERIOD 2009-2012: HOW MANY COMPLAINTS WERE PRESENTED EACH YEAR AGAINST HEATH PROVIDERS DUE TO ILL-TREATMENT OF WOMEN AND/OR MEDICAL NEGLIGENCE, RELATED TO GYNECOLOGICAL AND/OR OBSTETRIC CARE? HOW MANY HEATH PROVIDERS WERE SANCTIONED FOR ILL-TREATMENT OF WOMEN AND/OR MEDICAL NEGLIGENCE, RELATED TO GYNECOLOGICAL AND/OR OBSTETRIC CARE? PLEASE ATTACH REPORT WITH IMPOSED SANCTIONS."
NATIONAL HUMAN RIGHTS COMMISSION AND GOVERNMENT HUMAN RIGHTS ORGANISMS	"I FORMALLY REQUEST THE FOLLOWING PUBLIC INFORMATION: OF THE COMPLAINTS PRESENTED AGAINST HEATH PROVIDERS, DURING THE PERIOD BETWEEN JANUARY 1, 2009 AND JULY 31, 2012, DUE TO ILL-TREATMENT OF WOMEN AND/OR MEDICAL NEGLIGENCE, RELATED TO GYNECOLOGICAL AND/OR OBSTETRIC CARE, PLEASE DISAGGREGATE BY INSTITUTION AND DATE OF RECOMMENDATION EMITTED, ACCEPTED AND IMPLEMENTED: > NUMBER OF RECOMMENDATIONS EMITTED > NUMBER OF RECOMMENDATIONS ACCEPTED > NUMBER OF RECOMMENDATIONS IMPLEMENTED, SPECIFYING CASES IN WHICH THIS OCCURRED THROUGH CONCILIATION."
NATIONAL COMMISSION OF MEDICAL ARBITRATION	HOW MANY COMPLAINTS WERE PRESENTED EACH YEAR AGAINST HEATH PROVIDERS DUE TO ILL-TREATMENT OF WOMEN AND/OR MEDICAL NEGLIGENCE, RELATED TO GYNECOLOGICAL AND/OR OBSTETRIC CARE?

5. WORK AND FAMILY LIFE

INSTITUTION	QUESTION
MEXICAN INSTITUTE OF SOCIAL SECURITY	"THE FEDERAL LABOR LAW HAS VARIOUS MECHANISMS TO PROTECT MOTHERHOOD. WE FORMALLY REQUEST THE FOLLOWING PUBLIC INFORMATION FOR THE PERIOD JANUARY 1, 2009 AND MARCH 31, 2012: 1. HOW MANY MATERNITY LEAVES WERE AUTHORIZED BY YOUR INSTITUTION PER YEAR? PLEASE ATTACH REPORT WITH DATA BY AGE AND PERIOD AUTHORIZED FOR MATERNITY LEAVES. 2. HOW MANY WOMEN ARE AFFILIATED TO YOUR INSTITUTION? PLEASE ATTACH REPORT WITH THE NUMBER OF WOMEN BY AGE RANGE. 3. HOW MANY DAYCARE FACILITIES DOES YOUR INSTITUTION HAVE IN THE COUNTRY? PLEASE ATTACH REPORT WITH NUMBER OF DAYCARE FACILITIES DESEGREGATED BY STATE AND NUMBER OF CHILDREN ATTENDING."
INSTITUTE FOR SOCIAL SECURITY AND SERVICES FOR STATE WORKERS	"THE FEDERAL LABOR LAW FOR GOVERNMENT WORKERS HAS VARIOUS MECHANISMS TO PROTECT MOTHERHOOD. WE FORMALLY REQUEST THE FOLLOWING PUBLIC INFORMATION FOR THE PERIOD JANUARY 1, 2009 THROUGH MARCH 31, 2012: 1. HOW MANY MATERNITY LEAVES WERE AUTHORIZED BY YOUR INSTITUTION PER YEAR? PLEASE ATTACH REPORT WITH DATA BY AGE AND PERIOD AUTHORIZED FOR MATERNITY LEAVES. 2. HOW MANY WOMEN ARE AFFILIATED TO YOUR INSTITUTION? PLEASE ATTACH REPORT WITH THE NUMBER OF WOMEN BY AGE RANGE. 3. HOW MANY DAYCARE FACILITIES DOES YOUR INSTITUTION HAVE IN THE COUNTRY? PLEASE ATTACH REPORT WITH NUMBER OF DAYCARE FACILITIES DESEGREGATED BY STATE AND NUMBER OF CHILDREN ATTENDING."
FEDERAL LABOR PROTECTION OFFICE	"THE FEDERAL LABOR LAW HAS VARIOUS MECHANISMS TO PROTECT MOTHERHOOD. WE FORMALLY REQUEST THE FOLLOWING PUBLIC INFORMATION FOR THE PERIOD JANUARY 1, 2009 AND MARCH 31, 2012: 1. HOW MANY LAWSUITS WERE PRESENTED FOR CASES OF WOMEN DISMISSED DUE TO PREGNANCY BETWEEN JANUARY 1, 2009 AND MARCH 31, 2012? PLEASE ATTACH REPORT WITH DATA BY AGE AND WOMEN'S OCCUPATIONS. 2. HOW MANY COMPLAINTS WERE MADE BY WOMEN WHO WERE OBLIGATED TO PRESENT NEGATIVE PREGNANCY TESTS IN ORDER TO BE HIRED? PLEASE ATTACH REPORT WITH DATA BY AGE AND WOMEN'S OCCUPATIONS."

6. ASSISTED REPRODUCTION

INSTITUTION	QUESION
FEDERAL COMMISSION FOR PROTECTION AGAINST HEALTH RISKS	"I FORMALLY REQUEST A LIST WITH THE COMPANY NAMES, ADDRESSES, MEDICAL LICENSE NUMBERS AND NAMES OF THOSE INDIVIDUALS OPERATING AN ASSISTED REPRODUCTION CENTER IN MEXICO AS OF OCTOBER, 2012"
NATIONAL INSTITUTE OF PERINATOLOGY	"HOW MANY PATIENTS WITH INFERTILITY PROBLEMS OR CONDITIONS ARE PROVIDED CARE AT THE NATIONAL INSTITUTE OF PERINATOLOGY (FROM 2006 TO DATE)? WHAT TREATMENTS ARE PROVIDED TO DEAL WITH THIS CONDITION? [EXTERNAL REQUEST FOR INFORMATION FOUND THROUGH THE FEDERAL GOVERNMENT SEARCH ENGINE FOR INFORMATION AND APPEALS FOR REVIEW, LOCATED IN THE IFAI PORTAL].

OMISSION AND INDIFFERENCE / REPRODUCTIVE RIGHTS IN MEXICO
2013 Grupo de Información en Reproducción Elegida, A.C.
Apartado postal 21-147 Admón. 21, Coyoacan, Mexico City, Mexico.

Telephone: (+52 55) 5658-6684 and 6645
correo@giremx.org.mx
www.gire.org.mx

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