obstetric violence

A HUMAN RIGHTS APPROACH

GIRE
GRUPO DE INFORMACIÓN
EN REPRODUCCIÓN ELEGIDA

Fundación
Angélica Fuentes

OBSTETRIC VIOLENCE

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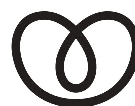

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INTRODUCTION

Regina Tamés

In October 2013, a photograph of an indigenous woman giving birth in the courtyard of a hospital in Oaxaca, Mexico, was published on social media. It did not take long for the public to express their indignation. Irma López, although in labor, had not been admitted to the hospital but was told to wait, and her infant was born during this period of time. Cases such as Irma's are very common in our country, as demonstrated a few days later by a similar case in Puebla and thereafter in Chiapas, where a woman died as the result of a badly performed cesarean.

These and other conducts constitute obstetric violence. Over the course of many years, groups of midwives, civil society organizations and public health experts, among others, have denounced abuses committed by healthcare workers in clinics, health centers and hospitals. It would seem, however, that even more examples are needed for the Mexican State to implement the necessary measures to prevent cases such as these from occurring.

The Grupo de Información en Reproducción Elegida (GIRE), in its 2013 report entitled *Omission and Indifference: Reproductive Rights in Mexico*, states that the magnitude of obstetric violence in the country is unknown. According to the 2010 Population and Housing Census, seven out of every ten Mexican women over the age of 15 have had at least one live birth, which indicates that 71.6% of the female population reproductively active in Mexico have required medical care during pregnancy, labor or the postpartum period, and hence the population susceptible to suffering obstetric violence is enormous.

Obstetric violence is a result of the institutionalization of childbirth, when it became customary to deliver babies in health centers rather than at home. With this paradigm shift, childbirth ceased to be something natural and became a medical practice, as pointed out by Dr. Marbella Camacaro Cuevas, a specialist in the area of gender violence and health, in which health care professionals, instead of midwives, became the main actors. Added to this, the dominant role of the woman during childbirth has been replaced by the health care professional. Camacaro questions whether hospitals, being places where illnesses are treated, are the ideal sites for bringing new life into the world. This means that we are "pathologizing the natural, naturalizing the pathological". Even though this

institutionalization has benefitted women and their infants, it has also intensified abuse and has fostered conduct that did not exist before and which we now denominate "obstetric violence".

Many countries, including Mexico, have wagered on increased access to health centers as a means to reduce maternal mortality. However, many women continue to lack access to these services, either because they live far away from the health institutions or due to mistrust. But even those who live nearby and have access to services face terrifying experiences. It is important to guarantee health services so as to reduce maternal mortality, but as stated in the declaration of the Office of the United Nations High Commissioner for Human Rights (OHCHR), "the premise is that it is necessary to empower women to claim their rights, and not to simply prevent deaths or maternal mortality. To convert women into active agents".

The immediate reaction of the authorities to Irma's case was to suspend two of the doctors who should have provided care for her, only to "exonerate them" a few days later. This strategy has extensive media impact but is not effective in terms of justice for Irma and in preventing similar cases in the future. The Mexican government, regardless of the level, is obligated to take various measures to ensure accountability and avoid impunity. The international human rights norm clearly states that accountability is a fundamental pillar that is not satisfied merely by analysis of the situation or establishment of monitoring mechanisms, but must include suitable means of redress. For the United Nations (UN), accountability is one of the basic phases, in which not only is transparency required by the State, but also active participation by the affected parties and civil society.

In July 2012, the OHCHR published the "Technical guidance on the application of a human rights-based approach to the implementation of policies and programs to reduce preventable maternal morbidity and mortality". This document is the foundation for work aimed at reducing maternal mortality and obstetric violence from a human rights perspective. It does not have a medical but rather a social justice focus, one of preventing both maternal mortality and obstetric violence. It includes the possibility of women or their families to make demands against the State, which has violated their human rights, and it encompasses not only criminal charges against the responsible parties but also administrative and compensatory measures which translate into financial compensation.

In the same vein, accountability is one of the mechanisms considered in other human rights protection systems such as the UN, the Inter-American System of Human Rights and the European system. In 2012, Brazil was condemned by the Committee on the Elimination of Discrimination Against Women (CEDAW) for the death of a 28-year-old Afro-Brazilian woman, who died because of a succession of acts constituting obstetric violence (Alyne da Silva vs. Brazil). The Committee ordered Brazil to pay compensation to her family and to take measures of non-repetition and prevention, such as guaranteeing the right to safe motherhood and facilitating access to obstetric care, giving professional training to health sector workers, allowing access to effective legal remedies and ensuring that health services comply with both international and national standards.

In 2003, the Inter-American Commission on Human Rights resolved by way of a friendly settlement agreement the case of María Mamérita Mestanza vs. Peru. María, a 33-year old woman, living in a rural area and the mother of seven children, was harassed by the health system to undergo a sterilization procedure. She received various visits from health personnel who threatened to report her and her husband to the police, additionally telling her that the government had passed a law which sanctioned people who had more than five children by fining and imprisoning them. Finally, under duress, Ms. Mestanza signed a consent form to undergo a tubal ligation. She was discharged from the hospital the day after the surgery, despite vomiting and intense headaches. She died at home. The Commission declared Peru guilty and ordered an investigation, sanction, compensation and non-repetition measures to be implemented.

In 2011, the European Court of Human Rights analyzed and resolved a case against Hungary (Ternovsky vs. Hungary), in which a pregnant woman wanted to give birth at home but the law, which was unclear, dissuaded health care workers from attending home births and from using a midwife, as they thought that it would put them at risk of breaching the law. The Court argued in favor of the woman, stating that favoring the health system was discriminatory and a violation of women's right to privacy and family life. The Court, in addition to ordering compensation, affirmed that the legislation must be clarified as a measure of non-repetition.

This publication describes in detail the current situation in Mexico concerning the phenomenon of obstetric violence in the last three years. After carrying out exhaustive research and thanks to the support of the Fundación Angélica Fuentes, the Grupo de

Información en Reproducción Elegida presents the results of its findings and possible solutions to obstetric violence, always centered on women, but bearing in mind that both health care personnel and the State could benefit as well.*

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1. WHAT IS OBSTETRIC VIOLENCE?

Obstetric violence is a specific form of violence against women that violates their human rights. It occurs in public and private health care facilities during obstetric care and consists of any act or omission by health personnel that results in physical or psychological harm to a woman during pregnancy, birth and puerperium, expressed by a lack of access to reproductive health services, in cruel, inhumane or degrading treatment, or in over-medication, all of which undermine a woman's ability to make free and informed decisions over her reproductive processes.

1.1 Manifestations of Obstetric Violence

The manifestations of obstetric violence can include:

> […] scolding, taunts, irony, insults, threats, humiliation, manipulation of information and denial of treatment, not providing referrals to other services in order to receive timely assistance, delaying urgent medical care, indifference to women's requests or complaints, failure to inform or ask women about decisions made during the various stages of labor, use of women for didactic purposes without any respect for their dignity, pain management during childbirth used as punishment, and coercion to obtain "consent", and even acts of deliberate harm to a woman's health, among even more serious and obvious violations of their human rights.[1]

Specialists in the field identify two forms of obstetric violence. The first is physical violence, which occurs when invasive practices are carried out and medication is unjustifiably administered, or when natural birth processes and labor birth positions are not respected.[2] The World Health Organization (WHO) has published a series of guidelines which 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.

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: June 4, 2015].

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. Practices for which there is not enough clear evidence to support a recommendation and which should be used with caution while further research clarifies the issue.

4. Practices which are frequently used inappropriately.[3]

Among the recommended practices listed, the following stand out: avoid unnecessary medical interventions such as routine episiotomies, pubic shaving, fetal monitoring and use of enemas; restrict the use of oxytocin, analgesics and anesthesia; comply with the recommended WHO cesarean rate (a maximum of 10% to 15% of births).[4]

The second form of obstetric violence concerns the psychological dimension, which includes dehumanizing and rude behavior, discrimination and humiliation when women request orientation or voice their concerns during obstetric care. It also includes omitting information during the labor process.[5]

Although it has not been defined by international institutions such as the UN, the use of the term "obstetric violence" is important so as to raise awareness that these acts in detriment to pregnant women exist and that the State is obligated to take measures for their prevention and eradication.

Obstetric violence is a product of a multi-factorial framework where institutional and gender violence meet and overlap. In this regard, obstetric violence is a specific form of violence against women committed by the State and constitutes a violation of human rights.

Institutional Violence

Institutional violence, in accordance with Article 18 of the Mexican Law on Women's Access to a Life Free from Violence, consists of acts and omissions of public servants at any level of government that discriminate or intent to delay, obstruct or prevent the enjoyment and exercise of women's human rights, as well as their access to the enjoyment of public policies aimed at preventing, treating, investigating, punishing and eradicating different types of violence.

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3. *WHO, Cuidados en el parto normal: una guía práctica. Informe presentado por el Grupo Técnico de Trabajo,* Geneva, 1996. Available at <http://bit.ly/1Rm6F0a> [accessed: October 20, 2015].

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

5. See note 4.

The Medical *Habitus*

The medical field, comprising all institutions and actors in the health context, is a product of (while at the same time producing) a series of subjectivities, such as those that Roberto Castro has designated medical *habitus*; in other words, all the predispositions that health professionals acquire during their formative years in schools and universities, through the rigid systems of hierarchy, punishments, threats, recriminations and classifications —amongst them class and gender— which they receive and experience during this time, as part of their professional training. These predispositions are strengthened in their years of specialization, and later come to permeate their relationships with health service users.[6]

Thus, within the health care context, deeply asymmetric relationships are constructed between medical personnel and health care service users, wherein the former can impose a position of superiority on the latter, and therefore their rules.[7]

In general, institutional violence in the health arena is reproduced in a naturalized and automatic manner in routine work. This is one of the reasons why medical personnel admit difficulty in identifying certain conduct as harmful for users: from verbal abuse and mockery, indifference, not providing complete information, to neglectful care, inadequate medical care and other conduct on an increasingly serious scale.[8]

Gender-Based Violence

Gender is a social construction whereby roles and expectations are assigned to people according to their sex. Historically, male domination and female subordination have predominated, which has defined power relationships between men and women.[9] Violence against women is a manifestation of these unequal power relationships, which has resulted in discrimination towards women and the hindering of their full development.

Violence against women has been one of the social mechanisms that have forced them into a situation of subordination with regard to men.[10]

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6. See, Castro, Roberto, "Génesis y práctica del *habitus* médico autoritario en México", in *Revista Mexicana de Sociología*, Mexico, vol. 76, no. 2, April-June 2014, pages. 172 and ss. Available at <http://bit.ly/1L1Pboo> [accessed: October 8, 2015)
7. Fabiana Fornari, Lucimara, *et.al.*, "Institutional Violence in Primary Care Centers from the Perspective of Female Service Users", in *Cogitare Enfermagem*, vol. 19, no. 6, Oct-Dec 2014, p. 619. Available at <http://bit.ly/1KRtV5S> [accessed: October 6, 2015].
8. *Ibid.*
9. Maqueda Abreu, María Luisa, "La violencia de género: concepto y ámbito", on the website of the Congreso Internacional de Derecho de Familia, November 22, 2005. Available at <http://bit.ly/1dcGxG5> [accessed: October 3, 2015].
10. United Nations, General Assembly, *Declaración de las Naciones Unidas sobre la eliminación de la violencia contra la mujer [A/RES/48/104]*, 48th period of sessions (1994), preamble. Available at <http://bit.ly/1ts69Ae> [accessed: August 10, 2015].

In this way, all actions or conduct that cause death, physical, sexual or psychological suffering or harm to women, based on gender, exercised in the reproductive health care sphere, constitute a form of violence and discrimination against women.

1.2 Obstetric Violence within a Human Rights Framework

The Mexican State's Human Rights Obligations

The Mexican Constitution and international human rights law recognize a broad —and continuously developing— catalogue of human rights, together with diverse obligations whose implementation falls on different State authorities.

In accordance with Article 1 of the Mexican Constitution, all authorities have the general obligation to promote, respect, protect and guarantee human rights, as well as specific obligations to prevent, investigate, sanction and redress such violations.

The General Obligation to Promote

What Does it Mean?

It is the State's responsibility to ensure that people know their rights and how to demand them. The obligation to promote aims to contribute to the modification of the social perception of any given situation as related to human rights.

Examples of Possible Implications in Terms of Obstetric Violence

- Communicate among the population at large, especially pregnant women, their rights before, during and after childbirth.
- Disseminate information on the practices and conducts that violate the rights of women during pregnancy, birth and postpartum in the health care sphere.
- Disseminate information about the mechanisms that exist to investigate and punish practices that violate women's rights in the obstetric care sphere.
- Include content on women's human and reproductive rights in the educational programs of medicine and nursing schools.
- Design and initiate permanent women's human and reproductive rights education programs for all personnel working in obstetric care.

The General Obligation to Respect

What Does it Mean?

The State is obligated to abstain from acting or interfering in the enjoyment of a right.

Examples of its possible implications in terms of obstetric violence

- Health care personnel must abstain from performing procedures and/or administering medication without medical justification.
- Refrain from imposing contraception on women; do not condition them or coerce them into accepting a contraceptive method.
- Prevent from using offensive, humiliating, discriminatory or sarcastic language.
- Refrain from coercing or threatening women so that they will accept interventions or medication that they neither want nor need.
- Avoid routine practices that the WHO has listed as detrimental or ineffective.

General Obligation to Protect

What Does it Mean?

The State is obligated to ensure the rights of individuals against possible damages by both public servants and others, monitoring their actions with respect to human rights and establishing appropriate mechanisms to enforce them when they have been or are at risk of being violated.

Examples of its Possible Implications in Terms of Obstetric Violence

- Monitor the performance of all health care personnel who participate in any way before, during and after labor and delivery.
- Ensure that there is a suitable system for the development of databases concerning the incidence of situations of obstetric violence at a state and national level.

- Provide mechanisms to enforce rights in an obstetric violence situation:
  - ◊ Units for filing complaints in hospitals and clinics.
  - ◊ Establishing administrative or penal measures relative to the seriousness of the conduct.

General Obligation to Guarantee

What Does it Mean?

The State is obligated to adopt measures to create the conditions necessary for the effective enjoyment of human rights and restore them when they have been violated.

Examples of its Possible Implications in Terms of Obstetric Violence

- Build health facilities and hospitals, giving priority to the most socially and economically marginalized areas.
- Supply enough beds, instruments, medications and duly qualified personnel for obstetric care.
- Guarantee that every woman, regardless of her affiliation to a social security system or her financial situation, receives care in any hospital in case of an obstetric emergency.
- Assure that public policy allows for progressive advancement in terms of women's physical access to health care services before, during and after the delivery but that it also contributes to improving the quality and acceptability of medical care.
- Ensure that health care policies guarantee the labor rights of the hospital staff in order to guarantee that their performance in the provision of services is the best possible.
- Assign sufficient resources for the effective implementation of the health care policy before, during and after labor and delivery.

Human Rights Principles in Accordance with the Mexican Constitution

Article 1 of the Mexican Constitution establishes a set of principles concerning the interpretation and application of human rights. All public servants of the Mexican government, in all three branches and levels (all government workers), are obligated to perform their activities in accordance with these principles.

Principle	Meaning
Interpretation	The interpretation of human rights norms should be carried out in accordance with the human rights meaning, principles, values and framework established in the Constitution and in international agreements ratified by the Mexican government.
Pro Homine	When it is not possible to interpret according to the above, and there is a conflict between norms and interpretation, the most protective option must be chosen when a right is to be recognized, and conversely, the most restricted option when limitations are to be imposed.
Universality	Human rights in their entirety, including the most important ethical requirements, must be recognized for all individuals, without exception.
Interdependence	Inevitably, the enjoyment of any right depends on access to other rights.
Indivisibility	Human rights are a unique set or compendium of rights. Therefore, there cannot be hierarchies or separations between them.
Progressivity	States are obligated to adopt deliberate, concrete measures that aim to achieve the progressive effectiveness of rights.

Progressivity, a principle contained in Article 1 of the Mexican Constitution and Article 2 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), has been historically interpreted by States in a way that they can indefinitely postpone the fulfillment of their human rights obligations.

Specifically, when rights involve the provision of benefits such as health, States have frequently justified their inaction arguing insufficient resources. Nevertheless, as the Committee on Economic, Social and Cultural Rights (CESCR), the body responsible for monitoring the ICESCR, has affirmed, even in case of demonstrated lack of resources, the State continues to be obligated to ensure the broadest possible enjoyment of rights

under the prevailing conditions.[11] This implies that the State must carefully balance the measures and resources that will be applied, prioritizing the resolution of shortfalls in communities with higher economic, social and geographic marginalization. The principle of progressivity also implies that the State is compelled to establish and continuously monitor the degree of compliance in terms of rights. When speaking of progressivity, it is essential to keep in mind that once advances have been achieved in terms of the enjoyment of rights, the State cannot take regressive measures unless very specific circumstances exist. This is the prohibition of regression.

1.3 Rights at Risk in Situations of Obstetric Violence

When a pregnant woman is a victim of obstetric violence, one or several of her human rights are violated. Each of the rights that could be compromised as a result of this conduct is outlined below, in accordance with the provisions established in human rights treaties.

The Right to Health

The WHO has defined health as "a complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity".[12] The right to health is recognized in Article 4 of the Mexican Constitution, as well as in international agreements of which Mexico is a party, such as the ICESCR and the Convention on the Elimination of all Forms of Violence Against Women (CEDAW).

The CESCR has indicated that the right to health contains both freedoms and rights:

> Freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture and non-consensual medical treatment and experimentation. In addition, the rights include the right to a system of health protection which provides equal opportunities for individuals to enjoy the highest attainable standard of health.[13]

11. United Nations, Committee on Economic, Social and Cultural Rights, *Observación General No. 3. La índole de las obligaciones de los Estados Partes (párrafo 1 del artículo 2 del Pacto) [E/1991/23]*, 5th period of sessions (1990), paragraph 11. Available at <http://bit.ly/1QbbQji> [accessed: September 20, 2015].

12. The definition comes from the Preamble to the Constitution of the World Health Organization, signed on July 22, 1946 by the representatives of 61 states. See WHO, "Constitución la OMS: principios" in *Organización Mundial de la Salud [website]*. Available at <http://bit.ly/1NUtfzq> [accessed: August 10, 2015].

13. United Nations, Committee on Economic, Social and Cultural Rights, *Observación General No. 14 (2000)*: *El derecho al disfrute del más alto nivel posible de salud (artículo 12 del Pacto Internacional de Derechos Económicos, Sociales y Culturales) [E/C.12/2000/4]*, 22nd period of sessions (2000), paragraph 8. Available at <http://bit.ly/1Tem8RK>.

It has also identified the basic elements of the right to health:

Accessibility

Health facilities, goods and services must be accessible to every individual without discrimination within the jurisdiction of the State.

Acceptability

Health facilities, goods and services must be respectful of medical ethics and must be culturally appropriate. This means that they must respect the culture of individuals, minorities, peoples and communities while being sensitive to gender and life-cycle requirements, as well as being designed to respect the confidentiality and improve the state of health of those concerned.

Quality

As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, amongst other things, skilled medical personnel, scientifically-approved medications and equipment that is in good condition, clean potable water and adequate sanitation.

Non-Discrimination

Health facilities, goods and services must be accessible to all individuals, especially the most vulnerable and marginalized sectors of the population, de jure and de facto, without discrimination.[14]

The right to health includes reproductive health, which is defined as "a general state of physical, mental and social wellbeing, and not merely the absence of reproductive disease or infirmity. Reproductive health deals with the reproductive processes, functions and system at all stages of life".[15]

In terms of reproductive health, the CEDAW specifically pointed out that State Parties have an obligation to adopt the appropriate measures to eliminate discrimination against women in their access to health care services as well as to guarantee them appropriate services in relation to pregnancy, labor and postpartum, providing free services when this may be necessary.[16]

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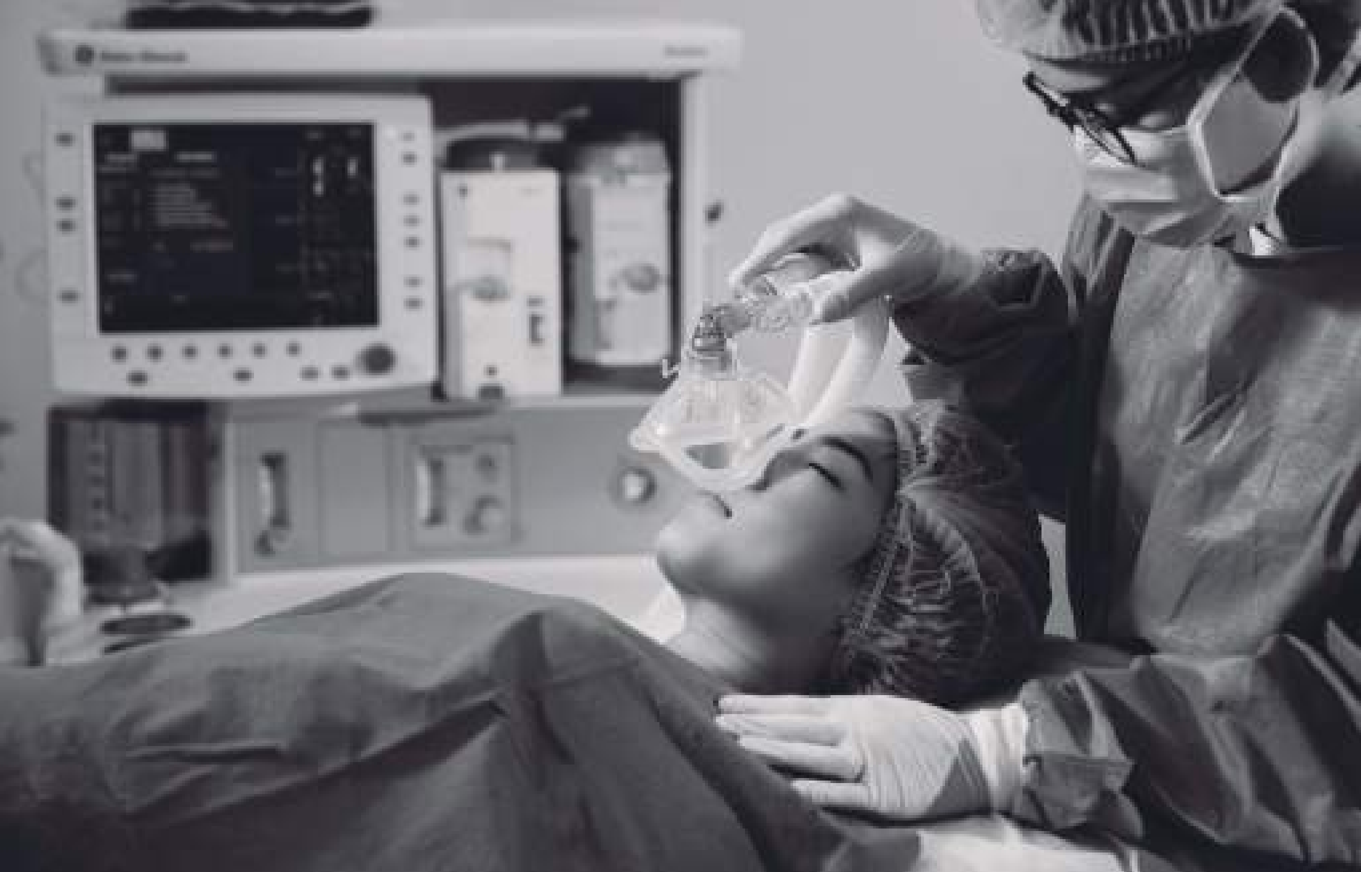
14. *Ibid*, paragraph 12.

15. UNFPA, *Programa de Acción de la Conferencia Internacional Sobre la Población y el Desarrollo, Cairo, Egypt, September 5 to 13, 1994.* Paragraph 7.2. Available at <http://bit.ly/1FVZyEB> [accessed: May 18, 2015].

16. United Nations, CEDAW Committee, *Recomendación general 24. Artículo 12 de la Convención sobre la eliminacion de todas las formas de discriminación contra la mujer - La mujer y la salud*, 20th period of sessions (1999). Available at <http://bit.ly/opp1tq> [accessed: February 25, 2015].



The Right to Personal Integrity, to not be Submitted to Torture or Cruel, Inhuman or Degrading Treatment or Punishment

The right to personal integrity is recognized in the Mexican Constitution and in various international treaties to which Mexico is party, such as the American Convention on Human Rights, and includes the protection and preservation of the core aspects of the individual: physical, mental and moral. This translates both into individuals' right of protection against bodily harm, including murder or causing physical pain or damaging health, along with the right to keep mental and moral faculties intact, which relates to the prohibition of being forced, constrained or manipulated mentally against one's will.[17]

With respect to the scope of the right to personal integrity in relation to the right to health, the Inter-American Court of Human Rights (IACHR) has stated the following:

17. Afanador, María Isabel, "El derecho a la integridad personal, elementos para su análisis" in *Convergencia: Revista de Ciencias Sociales*, vol. 9, no. 30, September-December 2002, p. 148. Available at <http://bit.ly/1Mnu1Pc> [accessed: August 15, 2015].

> [...] in the context of the right to personal integrity, some particularly distressing and stressful situations that affect persons have been analyzed, as well as certain severe impacts because of the absence of medical care or the problems of accessibility of certain health procedures. [...]. Thus, the right to privacy and personal integrity are also found directly and immediately bound to health care. The lack of legal safeguards that consider reproductive health could result in a serious impairment of the right to autonomy and reproductive freedom. There exists, therefore, a connection between personal autonomy, reproductive freedom and physical and psychological integrity.[18]

> The Inter-American Court has stated that, in order to comply with the obligation of guaranteeing the right to personal integrity and health, the States must establish a suitable policy framework that regulates the provision of health care services, establishing quality standards for public and private institutions, which ensures the prevention of any attack that infringes personal integrity in said provision. Similarly, the government must provide state supervision and fiscalization mechanisms of health institutions, as well as administrative and judicial tutelage procedures for the victim, whose effectiveness will ultimately depend on what the competent authority does in practice with regard to this issue.[19]

Additionally, violence against women is considered a violation of personal integrity; it is also a form of discrimination which prevents women from enjoying their rights on an equal footing with men. According to the Convention of Belem do Pará, violence against women is "...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 private sphere".[20]

The right to personal integrity implies the prohibition of torture and cruel, inhuman or degrading punishment or treatment. There are conducts in health care settings that, more than constituting violations to the right to health, can be congruent with cases of torture and ill-treatment, as has been demonstrated by the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Juan E. Mendez, "...while the prohibition of torture may have originally applied primarily in the context of interrogation, punishment or intimidation of a detainee, the international community has begun to recognize that torture may also occur in other contexts."[21]

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18. IACHR, *Artavia Murillo et al. ("In Vitro Fertilization") v. Costa Rica. Preliminary Objections, Merits, Reparations and Costs. November 28, 2012 Sentence, Series C No. 257*, paragraph 147. Available at <http://bit.ly/VUYz0A> [accessed: August 2, 2015].

19. IACHR, Suarez Peralta v. Ecuador. Preliminary Objections, Merits, Reparations and Costs. May 21, 2013 Sentence. Series C No. 261, paragraph 132. Available at <http://bit.ly/1qSIuba> [accessed: August 2, 2015].

20. OAS, "Convención Interamericana para Prevenir, Sancionar y Erradicar la Violencia contra la Mujer: Artículo 1". Available at <http://bit.ly/1cJ5i72> [accessed: August 12, 2015].

21. United Nations, Human Rights Council, Report by the Special Rapporteur on torture and other cruel, inhuman and degrading

The Special Rapporteur, on investigating situations in health care settings from the legal framework of the prohibition of torture and ill-treatment, highlights that the task of eradicating this conduct in a health care context comes up against obstacles such as the unjustified perception of authorities that they can defend certain practices on grounds of administrative efficiency or medical necessity. In this way, he affirms that there is abusive treatment that attempts to justify itself on the basis of health care policies "…taking advantage of the common rubric of its perceived justification as 'health-care treatment".[22]

It is noteworthy that the WHO does not make use of the concepts of international law to designate conduct that can constitute cruel, inhuman or degrading treatment during labor and delivery, but rather, it refers to these as acts in which there is a "lack of respect" or "ill-treatment". The above definition given by this body not only fails to coincide with the human rights framework, but also seems to consider those practices carried out against women at a moment when she may be vulnerable both physically and psychologically,[23] such as childbirth, as less serious.

The Right to Information

The right to information is protected in Article 6 of the Mexican Constitution which states that "everyone has the right to free access to diverse and timely information, as well as to search, receive and disseminate information and ideas of any nature through any means", in addition to international treaties to which Mexico is a party such as Article 19 of the International Covenant on Civil and Political Rights and Article 13 of the American Convention on Human Rights which, based on Article 1 of the Mexican Constitution, are part of the constitutional order.

For this right to be fulfilled in terms of pregnancy, labor and postpartum care, women must have access to information that is accurate, objective, impartial and free of prejudice concerning their options. Moreover, this information must be provided in appropriate and comprehensible language, in an environment free of pressure and coercion.

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treatment and punishments, Juan Méndez, [A/HRC/22/53], 22nd period of sessions (2013), paragraph 15. Available at <http://bit.ly/1WPSNPF> [accessed: July 29, 2015].

22. *Ibid.*, paragraph 13.

23. WHO, *Prevención y erradicación de la falta de respeto y el maltrato durante la atención del parto en centros de salud, 2014*. Available at: <http://bit.ly/1McowsK>.

It is presupposed that access to information in the health care sphere will be provided in a way allowing for the exercise of informed consent. Thus, the concept of informed consent has evolved so as to incorporate the substantial understanding of the procedure offered and not only the formal acceptance of it. It is the responsibility of health care providers to offer clear and precise information, using language and methods that are comprehensible to the user, and to facilitate a decision process that is comprehensive, free and informed.

According to the International Federation of Gynecology and Obstetrics (FIGO), informed consent is a communication process between a health care provider and user that does not end with the signing of a document. For consent to be considered informed, it must be granted in a free and voluntary manner, after the user has received information about the risks and benefits of the procedure and is conscious that there are alternatives that can be equally effective and without being subject to any type of discrimination, threats or pressures.[24]

The Right for Women to Live Free from Violence

The right to a life free from violence is recognized in Article 1 of the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (Convention Belem do Para), which defines violence against women as any act or conduct, based on gender, which causes the death or physical, sexual or psychological harm or suffering to women, whether in the public or private sphere, and establishes the obligation of due diligence of the State to investigate and punish it in its Article 7.

In interpreting Article 7 of the Convention Belem do Para, the *Campo Algodonero vs. Mexico* ruling held that the State has a strict duty to prevent, punish and investigate violence against women and that it must adopt the necessary measures to act with due diligence in such cases.[25]

This right includes, of course, protection against the suffering of physical, sexual and psychological violence perpetrated in health facilities by the State, its agents or any person.

24. FIGO, *Recommendations on ethical issues in obstetrics and gynecology by the Committee for the Ethical Aspects of Human Reproduction and Women's Health*, London 2012. p. 317.

25. IACHR, *Gonzalez et al. ("Cotton Field") v. Mexico. Preliminary Objections, Merits, Reparations and Costs. November 16, 2009 Sentence. Series C. No.205*, paragraph 450. Available at <http://bit.ly/1kho5vc> [accessed: June 6, 2015].

Special protection is recognized in the international human rights framework for women who find themselves in a situation that is highly vulnerable to violence, "…in view, amongst other things, of their race or ethnic background, or their status as migrants, refugees or displaced persons. Similar consideration shall be given to women subjected to violence while pregnant…".[26]

In the context of obstetric violence, it is important to focus attention, within the right of women to live without violence, on the right to be valued free from stereotyping and social and cultural practices based on concepts of inferiority and subordination, since such factors carry significant weight within the configuration of obstetric violence situations.

The Right to Privacy

The right to privacy is recognized in various agreements, such as in Article 11 of the American Convention on Human Rights and Article 17 of the International Covenant on Civil and Political Rights. In general terms, it refers to the guarantee that there is no arbitrary State interference in the private life of a person or their family. In the reproductive context, this implies the right of individuals to make decisions concerning their procreation (reproductive autonomy) —including the decision of women, based on clear, objective and accurate information, to decide on the method of delivery—, a right that is explicitly protected in Article 4 of the Mexican Constitution.

On the basis of Article 11 of the American Convention, the IACHR has maintained that the sphere of privacy is characterized by remaining exempt and immune to invasions, abuse or arbitrary aggressions by third parties or by public authorities.[27] In accordance with the Court, the concept of privacy includes, amongst other protected spheres, sexuality and family life,[28] for which reason State interference diminishes the capacity of women to make decisions in a free

26. OAS, "Convención Interamericana para Prevenir, Sancionar y Erradicar la Violencia contra la Mujer: Artículo 9". Available at <http://bit.ly/1cJ5i72> [accessed: August 12, 2015].

27. IACHR, *Atala Riffo and Daughters v. Chile. Merits, Reparations and Costs. Sentence of February 24, 2012. Series C. No. 239,* paragraph 164. Available at <http://bit.ly/1fB6mue> [accessed: September 20, 2015].

28. IACHR, *Rosendo Cantú et al. v. Mexico. Preliminary Objections, Merits, Reparations and Costs. Sentences of August 31, 2010. Series C No. 216*, paragraph 119. Available at <http://bit.ly/1cJdDuB> [consulted: April 27, 2015]. *Fernández Ortega et al. v. Mexico. Preliminary Objections, Merits, Reparations and Costs. Sentence of August 30, 2010. Series C No. 215*, paragraph 129. Available at <http://bit.ly/1IVMRv4> [accessed: April 27, 2015].

and informed way about pregnancy, labor and postpartum processes, resulting in a violation of this right.

The CEDAW Committee, in its General Recommendation 19 concerning violence against women, indicated the need to prevent acts of coercion with respect to women's fertility and reproduction.[29] One of these acts is precisely obstetric violence which, among other situations, occurs when a contraceptive method is imposed, particularly in a moment such as labor or the performing of a cesarean section, and is a violation of the right to women's privacy.

2. INSTITUTIONAL CONTEXT: THE MEXICAN HEALTH CARE SYSTEM

In accordance with the General Health Law, Mexico's National Health System is composed of public entities and bodies —at both a federal and state level—, and individuals or groups from the social and private sectors that provide health care services. In terms of health, the law establishes responsibilities for both the federal government and state governments.

The Federal Health Ministry is in charge of coordinating the National Health System: the determination of its scope, modalities and the actions necessary to consolidate its performance. It is also responsible for assessing the provision of services in terms of general health throughout Mexico and for monitoring the compliance of all norms.

In order to collaborate on the consolidation and operation of the National Health System, the law gives certain powers to state governments such as the establishment of state-level health systems in accordance with the National System. They are also responsible for formulating and developing state-level health programs, producing state-level statistical information and monitoring health legislation in the areas of their specific competence.

The National Health System is comprised of the public sector, which includes the social sector and state-level services, and the private sector:

29. United Nations, CEDAW Committee, General Recommendation 19. Violence against women, 11th period of sessions (1992), paragraph 24. Available at <http://bit.ly/WAF1QA> [accessed: September 20, 2015].

Functionally, the health system in Mexico is divided into three levels of care:

The primary level of care consists of a network of medical units that provide outpatient care, that is, care that does not require hospitalization. It is the first contact that people have with the health system. A large portion of public health activities in Mexico take place within the units at the primary level of care: health promotion, illness prevention and early detection of ailments such as cervical, uterine and breast cancer, hypertension and diabetes.[30]

The secondary level of care consists of a network of general hospitals which attend to the majority of cases needing hospitalization or emergency care in Mexico. The hospitals in the secondary care level are organized according to the four basic medical specialties: internal medicine, surgery, pediatrics and gynecology-obstetrics.[31]

The tertiary level of care is more complex. It involves a network of highly specialized hospitals which can treat a group of subspecialties that do not exist in the other levels, or that can be dedicated to a specific field, for example, the National Institute of Perinatology, Oncology or Pediatrics. Personnel in these hospitals have more specific knowledge, as well as more complex technology, for the treatment of health problems that cannot be resolved by the other two levels.[32]

2.1 Structural Problems of the National Health System

In order to understand obstetric violence situations, it is important to understand the context in which they are produced.

Different cultures, historical moments, economic interests and struggles of distinct sectors of the population have contributed to shaping the physiognomy of the Mexican Health System.[33] The system is fragmented and complex, both in the normative aspects and the different institutions that comprise it, its method of access and health services coverage and its administrative and financial aspects.

30. Soto Estrada, Guadalupe, *et.al.*, *Rasgos generales del sistema de salud en México*, in González Guzmán Rafael, *et.al.* (coord.), *La salud pública y el trabajo en comunidad*, Mexico, McGraw Hill, 2011, pp. 160-161. Available at <http://bit.ly/1Kiy6n1> [accessed:

31. *Ibid.* p. 161.

32. *Ibid.*

33. *Ibid.* p. 153.

PUBLIC SECTOR

IMSS

ISSSTE

Hospitals for Mexican Oil and Gas Industry employees (PEMEX)
National Ministry of Defense (SEDENA)
Ministry of the Navy (SEMAR)

Ministry of Health hospitals and clinics (SSA)

State health system hospitals and clinics

Program hospitals and clinics IMSS-Prospera

Seguro Popular de Salud

PRIVATE SECTOR

Doctors' offices, clinics and private hospitals

Profile of users attended

Retired persons

Workers from the formal sector

Family of workers from the formal sector

Population that does not have social security:
Self-employed
Workers in the informal sectors
Unemployed persons

Population with the ability to pay for services

Financing

Originating from Three Sources:
Governmental contributions
Contributions from the employer
Contributions from the employee

Federal and state resources
Furthermore, users pay a fee upon receiving services

Seguro Popular is financed by federal resources, state governments and fees.

Premiums from private medical insurance, disbursement from the user upon receiving attention

Source: Gómez, Dantés, Octavio, *et. al.*, "Sistema de Salud de México", *Salud Pública de México*, Mexico, INSP, Vol. 53, supl. 2, Available at: <http://bit.ly/1lmtEwo>.

In Mexico, the exercise of the right to health is characterized by inequality: the possibility for a person to be registered, or not, in a social security schema, or whether a person lives in one or another state, albeit with social security, are factors that make substantial difference, not only in the health of individuals but in their lives.

Under the premise of universal access to healthcare, the resolution of problems concerning poor quality of infrastructure and equipment, which have for years affected the provision of public sector health care services, has been overlooked. Therefore, despite government initiatives such as the free universal health care program (the *Seguro Popular*) —a system designed for people with no formal employment— and the accelerated pace of affiliation to the same, the right to health for many individuals in Mexico continues to be out of reach.

Asa Cristina Laurell has affirmed that, in spite of the fact that the governmental universal health care system has been insistently promoted, its health care problems exceed those of the Mexican Institute of Social Security (IMSS) and the Institute for Social Services and Security for State Workers (ISSSTE). Additionally, its budget, the limited service package it offers, and its personnel, infrastructures and medications, are insufficient to guarantee that its populations' needs are met.[34]

In Mexico, public participation in the financing of health care is one of the lowest among Organization for Economic Cooperation and Development (OECD) countries, and approximately half of the total expenditure on health is paid directly by the health service user. Similarly, the number of doctors per capita in the country (2.2 per every 1,000 inhabitants), nurses (2.6 per every 1,000 inhabitants), and hospital beds (1.6 per 1,000 inhabitants) is below the average of 3.2, 8.8 and 4.8 respectively, of OECD countries.[35]

Rosario Valdés has pointed out the problems that exist in how the health care levels are organized: Mexico has an insufficiently developed primary level of care, which places a heavier load on secondary and tertiary levels, often unnecessarily:

34. Laurell, Asa Cristina, *Impacto del Seguro Popular en el sistema de salud mexicano*, Buenos Aires, CLACSO, 2013, p. 114. Available at <http://bit.ly/1LJd1m4> [accessed: July 5, 2015].

35. OECD, *Estadísticas de la OCDE sobre la salud 2014. México en comparación.* Available at <http://bit.ly/1PrtDVb> [accessed: July 5, 2015].

> …one of the aspects that contribute to its work overload is the way in which the primary care level carries out the referrals of users to the hospitals in the secondary and tertiary levels. Referral of cases without adequate references or ones that can be detected and attended to in the health facility increases their workload and affects the service time provided.[36]

Like other Latin American health care systems, market logic prevails in the Mexican system whose objective is to maximize productivity at all costs. On a concrete level of women's care during labor this means that the woman, medical personnel and nursing staff serve as mere "…parts of a machine which will result in a healthy 'outcome'".[37]

Roberto Castro and Joaquina Erviti point out a "highly rational medical-administrative logic" whereby the medical routine during labor care is intended for and focused on maintaining institutional functionality.[38] The same vocational training for medical and nursing personnel takes place under a rigid scheme of ranks and hierarchies that have been compared to military tactics, with an operative logic based on maximizing productivity —unpropitious in ensuring that relations between medical staff and obstetric health care service patients are established from the perspective of equality and recognition of the their human rights.[39]

2.2 Legislation

General Health Law

The General Health Law[40] (LGS) regulates the human right to health protection considered in Article 4 of the Constitution. This law establishes the bases and modalities for access to health facilities as well as unanimity with the federal government and the states in terms of overall health.

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36. Valdés Santiago, Rosario (coord.), *El abuso hacia las mujeres en salas de maternidad. Nueva evidencia sobre un viejo problema. Resumen ejecutivo*, Mexico, INSP, 2013, p. 21. Available at <http://bit.ly/1k2zzlh > [accessed: August 16, 2015].

37. Campiglia, Mercedes, "Violentar el nacimiento", in *El Cotidiano, revista de la realidad mexicana actual*, year 30, no. 191, May-June 2015, p. 86. Available at <http://bit.ly/1LsHKbd> [accessed: May 20, 2015].

38. Castro, Roberto and Joaquina Erviti, "25 años de investigación sobre violencia obstétrica en México", in *Revista CONAMED*, vol. 19, no. 1, 2014, p. 40. Available at <http://bit.ly/1VQrSG9> [accessed: May 20, 2015].

39. Castro, Roberto, "Génesis y práctica del *habitus* médico autoritario en México", *op.cit*, pp. 191-192.

40. "Ley General de Salud" in *Leyes y Reglamentos Federales de la Secretaría de Gobernación [website]*. Available at <http://bit.ly/1RbaBke> [accessed: July 8, 2015].

Chapter v of this Law, dedicated to maternal and child care, establishes comprehensive health care for women during pregnancy, labor and postpartum, including psychological care, when necessary, as a priority action in Article 61.

It establishes the responsibility of the Federal Health Ministry to foster actions aimed at the identification and eradication of risk factors in the health of pregnant women and to improve the quality of health care during pregnancy, labor and postpartum, by way of measures such as the training of traditional midwives in obstetric care (Article 64, part IV); the participation of civil society and the private sector in Maternal Health Support Networks (Article 64 bis), and the creation of Committees for the prevention of maternal and infant mortality (Article 62).

It is important to note that on October 15, 2015 the Senate unanimously approved[41] additions to the General Health Law, the Social Security Law and the Institute for Social Services and Security for State Workers Law, in terms of obstetric emergency care.

41. The approval bill will pass to the Executive Branch for its approval and publication in the Official Gazette of the Federation, upon which it will enter into effect.

Article 64 bis I was subsequently added to the General Health Law:[42]

> The health services referred to in Article 34 of the present Law, pay expeditious attention to pregnant women with obstetric emergencies, requested directly or by referral from another medical unit, in the units capable of giving urgent obstetric care, independently of their health care affiliation or insurance scheme.

Social Security Law

This Law establishes the bases of the Social Security Program, as a fundamental instrument to provide social security, which is a national public program that guarantees, among other things, the right to health and medical care for the insured working population and their families.

The Mexican Institute of Social Security (IMSS), which is a decentralized public sector body, is in charge of the organization and administration of the Program.

42. Article 34 of the General Health Law classifies health service providers in: I. Public services to the general population; II. Services to members of public social security institutions or those who with their own resources or commissioned by the Federal Executive Branch, provide the same institutions to other user groups; III. Social and private services, depending on the way in which they are contracted; and IV. Other institutions that provide services in conformity with that established by the health authority.

The Law[43] establishes the bases for the coverage of contingencies and provision of services in both of the systems that it establishes —the obligatory system and the voluntary system.

Articles 94 and 95 provide that in any of the systems, the insured woman will receive obstetric assistance during her pregnancy, labor and postpartum.

Article 89, part V[44] establishes that medical care for women with obstetric emergencies is obligatory, regardless of her affiliation or health insurance scheme:

> It will be obligatory for the Institute to offer health care to pregnant women with obstetric emergencies, requested directly or by referral from another medical unit, in terms of the relevant provisions, at the units with the capacity for obstetric emergency care, regardless of their affiliation or insurance system.

Institute for Social Services and Security for State Workers Law (ISSSTE)

This Law organizes the social security programs for government employees and their families. The administration of insurance, benefits and services established by this Law[45] is the responsibility of the ISSSTE, a decentralized body with its own personnel and physical and financial assets.

As with the IMSS, compulsory and voluntary systems are established, and among the insurance offered is health insurance, which, on the one hand, includes preventive medical care, including maternal and child care (Article 34) and on the other, curative and maternity care (Article 35), which includes the necessary obstetric care since the day that the Institute confirms the pregnancy (Article 39).

Mandatory health care for women with obstetric emergencies is covered in Article 31 bis:[46]

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43. "The Social Security Law" in *Leyes y Reglamentos Federales de la Secretaría de Gobernación [website]*. Available at <http://bit.ly/1hEuS5J> [accessed: June 12, 2015].

44. This addition is also part of the reforms that were recently approved by the Senate concerning obstetric emergencies. See note 39.

45. "Institute for Social Services and Security for State Workers Law" in *Leyes y Reglamentos Federales de la Secretaría de Gobernación [website]*. Available at <http://bit.ly/1Nd6l2Y> [accessed: June 12, 2015].

46. This addition is also part of the reforms that were recently approved by the Senate concerning obstetric emergencies. See note 39.

> For the Institute, the care of pregnant women with obstetric emergencies will be mandatory, requested directly or by referral from another medical unit, in the units with emergency obstetric care capabilities, independently of their health care affiliation or insurance system.

2.3 Midwifery in Mexico: A Delivery Care Alternative

It is estimated that by the year 2030 there will be 3.1 million pregnancies in Mexico. In order to fulfill its human rights obligations, the Mexican government will have to provide available, acceptable, accessible and quality health care.

The fulfillment of the Millennium Development Goals (MDG) signed by Mexico in 1990, includes a 75% reduction of the maternal mortality rate (MMR) as well as universal access to sexual and reproductive health services.[47]

The saturation of the health system —in particular in secondary and tertiary care level hospitals, which provide obstetric care to women— significantly affects the quality of care and hampers emergency obstetric care.[48]

In response, some countries have started to opt for the redistribution of complication-free deliveries to the primary care level, guaranteeing the referral of complicated cases when appropriate, and including mid-level professionals —such as obstetric nurses— for obstetric care from preconception to the pregnancy, labor and postpartum phases.

They have thus come to see the importance of training professional midwives and obstetric nurses as qualified personnel in providing obstetric care. In fact, according to a report published in 2014 by the United Nations Population Fund, the WHO and the International Confederation of Midwives, midwives who have the appropriate education and certification in accordance with international norms, may provide the essential care services required by pregnant women and newborns.[49]

The General Health Law and its regulations in terms of the provision of medical care services are legal instruments which regulate the provision of both public and private health services in Mexico. In this regard, healthcare legislation indicates the individuals authorized to provide obstetric and family planning services and to prescribe medica-

47. UNFPA, International Confederation of Midwives, WHO, *El estado de las parteras en el mundo 2014. Hacia el acceso universal en salud, un derecho de la mujer*. New York, June 2014. Available at <http://bit.ly/1KqUGyJ> [accessed: April 20, 2015].

48. Berdichevsky, Karla, *Diagnóstico situacional de la partería profesional y la enfermería obstétrica en México: Final report*, Mexico, MacArthur Foundation, 2013.

49. *The state of midwives in the world*, 2014, *op. cit.*

tion, as well as their obligations in the provision of these services. Article 64, part IV, establishes the obligation of health authorities to train said persons with the aim of strengthening their technical expertise in the field. Even though the legal framework includes a reference to traditional midwifery, this is only for the purpose of determining the obligation of the State to provide training courses, without it implying a recognition of midwifery as part of the public or private health system in Mexico.

The Constitution does, however, recognize the right of persons to freely choose the profession or job of their choice as long as it is lawful. It indicates that the legislation of each state will establish the jobs that require a professional title in order to be able exercise this profession. The legislation of certain states regarding the above matter, such as Mexico City and the State of Mexico, expressly considers midwifery as a profession that requires a title and professional credential. Other states, such as Sonora, demand that those professions related to healthcare require a title but do not explicitly mention midwifery. While some states recognize midwifery as an occupation that requires a professional title, it is not the same throughout the country. At the federal level, the State has not issued legislation or policies that define and establish limits of action. This is crucial in establishing legal security for both midwives and pregnant women who are being attended by them.

According to information from the National Center of Gender Equality and Reproductive Health, in October 2013 there were 23 technical midwives employed in hospitals in Guerrero (9), Veracruz (5), San Luis Potosi (5), Puebla (3) and Tabasco(1).[50] Furthermore, according to the United Nations Population Fund, currently there are 78 professional midwives officially registered in Mexico.[51] Although this is an important start, major challenges relating to obstetric care and midwifery remain, such as the lack of clarity in the legal framework with respect to the certification and training of midwives, the absence of recognition of the value of traditional midwifery —in particular in communities where significant barriers are faced in accessing formal health care facilities— and the reticence of the medical profession to include mid-level personnel trained in pregnancy, labor and postpartum care.

In spite of the fact that the changes in NOM 007 (pending publication) make reference to the importance of midwifery for the care of pregnant women and newborns, the Specific Action Program for Maternal and Prenatal Health 2013-2018 does not particularly mention midwifery or the need to include mid-level trained personnel in maternal care as a strategy to reduce maternal mortality in the country. In other words,

50. List of professional technical midwives employed in state health services. Document with information updated in October 2013, developed by the National Center for Gender Equality and Reproductive Health. See Berdichevsky, K., *op. cit*, p.8.
51. *The state of midwives in the world*, 2014, *op. cit*.

the Program has a limited vision of care and does not promote the inclusion of obstetric health services beyond doctors, such as professional midwives or obstetric nurses, who would help satisfy the high demand for and absence of quality in these services in the country. This omission, in the framework of the enormous debt that the Mexican State carries in terms of reducing maternal death, is a clear sign of the urgent need for informed dialogue on the role that mid-level personnel could fulfill in caring for pregnant women in Mexico.

3. LEGAL FRAMEWORK

With the aim of increasing awareness of obstetric violence as one of the forms of violence against women, various reform proposals to the General Law on Women's Access to a Life Free from Violence and to similar state laws have been presented in the last few years. Nonetheless, it should be noted that obstetric violence could be considered within the institutional and gender violence definitions already present in the law. Accordingly, although it was not explicitly defined, the Norm concerning those kinds of violence assumes the State's obligation to take the necessary measures to prevent, eradicate and sanction obstetric violence, for which there are also existing public policies that are indispensable for this objective.

3.1 Legislation

General Law on Women's Access to a Life Free from Violence

The purpose of this law,[52] passed in 2007, is to establish coordination between the federal government, the states, Mexico City and municipalities, to prevent, punish and eradicate violence against women, as well as the principles and modalities which guarantee them a life free from violence which are provided for in Article 1.

The provisions of this Law are public order, social interest and general compliance in Mexico.

In the last few years, various reform proposals to this Law have been presented, with the aim of drawing attention to obstetric violence as a form of violence against

52. "General Law on Women's Access to a Life Free of Violence" in *Leyes y Reglamentos Federales de la Secretaría de Gobernación [website]*. Available at <http://bit.ly/1GHkKQf> [accessed: June 12, 2015].

women. Nevertheless, even when it is not explicitly included in the law, other figures in the law such as psychological, physical or institutional violence, provide an adequate framework for conduct that constitutes obstetric violence:

Psychological Violence in the General Law on Women's Access to a Life Free from Violence:	**Examples of obstetric violence behaviors that comprise psychological violence:**
(Article 6, part I of the Law) Any act or omission which impairs psychological stability, that can consist of: negligence, abandonment, repeated neglect, resentment, insults, humiliation, devaluation, marginalization, indifference, infidelity, destructive comparisons, rejection, restriction to self-determination and threats, which can lead the victim to depression, isolation, the devaluation of her self-esteem and even suicide.	• Scolding. • Humiliation. • Threats. • Ignoring women. • Indifference to their pain and complaints. • Jokes and taunts among health personnel. • Using the woman for didactic purposes without her consent.

Physical Violence in the General Law on Women's Access to a Life Free from Violence:	**Examples of obstetric violence behaviors that constitute physical violence:**
Any act that inflicts harm that is not accidental, with the use of physical force or some kind of weapon or object that can, or not, bring about lesions internally, externally or both internally and externally.	• Performing cesareans when favorable conditions exist for a vaginal birth. • Performing episiotomies and sutures without anesthesia. • Blows to any part of the body. • Kristeller Maneuver without the existing need for it. • Pain management as a form of punishment. • Damage to health.

Institutional Violence in the General Law on Women's Access to a Life Free from Violence:	**Examples of obstetric violence behaviors that constitute institutional violence:**
(Article 18 of the General Law on Women's Access to a Life Free from Violence) Any acts or omissions of public employees at any level of government which discriminate or aim to delay, obstruct, or impede the enjoyment and exercise of women's human rights as well as their access to public policies that prevent, attend, sanction and eradicate the different types of violence.	• The refusal of medical care for women with labor symptoms, who on many occasions are obligated to give birth in bathrooms, hallways, waiting rooms or even in the street, placing the woman's health and life at risk. • Damage to health.

Although some legislators' intention behind including a specific definition of obstetric violence is to solely raise awareness of the phenomena, it would be worrisome if any adopted definition consists of an exhaustive list of specific behaviors, which is limiting and counterproductive for identifying situations of obstetric violence and achieving full compensation for the victims.

Reform Proposals on Obstetric Violence to the General Law on Women's Access to a Life Free from Violence:

Legislator: Congressman Ricardo Mejía Berdeja (Movimiento Ciudadano)

Date of submission: June 5, 2013

Proposal

Article 6.

VI. Obstetric violence: All abuse, intentional act or omission, negligent and willful, carried out by professionals, assistants, technicians and the like, in the different medical areas, that harm, denigrate, discriminate and award inhuman treatment of the woman, during the pregnancy, labor, postpartum period and puerperium; which has as a consequence the loss of autonomy and ability to freely make decisions about her body and sexuality.

Status: Withdrawn on December 5, 2013.

Legislator: Senator Diva Gastélum Bajo (PRI)

Date of submission: November 5, 2013

Proposal

Article 6.

VI. Obstetric violence: Every intentional act or omission by health care personnel which harms, hurts or denigrates the women during the pregnancy and labor, as well as negligent medical care expressed by dehumanizing treatment, excessive medicalization and pathologization of natural processes, resulting in the loss of women's autonomy or ability to freely make decisions about their own bodies and sexuality; examples being the absence of timely and efficient care for obstetric emergencies and the performing of a cesarean section when a natural birth is possible and without the woman's voluntary, express or informed consent.

Status: Approved and passed to the Commission for Gender Equality of the Chamber of Deputies for revision.

Legislator: Congressman Abel Octavio Salgado Pena (PRI)

Date of submission: July 23, 2014

Proposal

Article 6.

VI. Obstetric violence: Every intentional act or omission by health care personnel, both medical and administrative, that physically or psychologically harms, denigrates or discriminates against the woman during the pregnancy, labor, postpartum, puerperium and reproductive processes, expressed by dehumanizing treatment, resulting in the loss of women's autonomy and ability to freely make decisions about their own bodies and reproductive capacity.

Status: Pending in the Health and Legislative Studies commissions.

Legislator: Congresswoman Martha Lucía Mícher Camarena (PRD)

Date of submission: December 15, 2014

Proposal

Article 6.

VII. Obstetric violence: Every act or omission by personnel of the National Health System, either medical or administrative, that harms, injures or denigrates women of any age, during pregnancy, labor, or puerperium, as well as negligent medical care; expressed by an absence of reproductive health services, inhumane or degrading treatment, excessive medication and the pathologization of natural processes, undermining the woman's ability to make free and informed decisions about her own body and reproductive processes. It is characterized by:

a) Denying timely and efficient care for obstetric emergencies.

b) Compelling the woman to give birth in conditions beyond her control or against her cultural practices, when the means exist for a humanized birth.

c) Hindering the attachment of the child to the mother without medical justification, denying her the possibility of carrying and breastfeeding her baby immediately after its birth.

d) Disrupting the natural low-risk birth process through the use of acceleration techniques, without obtaining voluntary, express or informed consent from the woman.

e) Performing a cesarean when a natural birth is possible and without the woman's voluntary, express, or informed consent.

f) Imposing on the woman through any means the use of contraceptives or sterilization procedures without her voluntary, express or informed consent.

Status: In the Gender Equality Commission of the House of Representatives, pending decision.

Legislator: Senator Alejandra Barrales Magdaleno (PRD)

Date of submission: April 28, 2015

Proposal

Article 6.

VI. Every act or omission by personnel of the National Health System, either medical, assistant, or administrative, that, in the exercise of their profession or trade, harm, hurt, or denigrate the woman's physical or psycho-emotional health during the period of pregnancy, childbirth, postpartum, puerperium, and reproductive processes, in which negligence is presumed in medical care, expressed as inhumane treatment, which may lead to the loss of autonomy and ability to decide freely about their bodies and reproductive capacity.

Status: Pending in the Health and Legislative Studies commissions.

Legislator: PRD party

Date of submission: June 23, 2015

Proposal

Article 6.

VII. Obstetric violence: Every act or omission by personnel of the National Health System, either medical or administrative, that harms, injures or denigrates women of any age, during pregnancy, labor or puerperium, as well as negligent medical care; expressed by an absence of reproductive health services, inhuman or degrading treatment, excessive medication and the pathologization of natural processes, undermining the woman's ability to make free and informed decisions about her own body and reproductive processes. It is characterized by:

a) Denying timely and efficient care for obstetric emergencies.

b) Compelling the woman to give birth in conditions beyond her control or against her cultural practices, when the means exist for a humanized birth.

c) Hindering the attachment of the child to the mother without medical justification, denying her the possibility of carrying and breastfeeding her baby immediately after its birth.

d) Disrupting the natural low-risk birth process through the use of acceleration techniques, without obtaining voluntary, express or informed consent from the woman.

e) Performing a cesarean when a natural birth is possible and without the woman's voluntary, express, or informed consent.

f) Imposing on the woman through any means the use of contraceptives or sterilization procedures without her voluntary, express or informed consent.

Status: Pending delivery to commissions.

Legislator: Congresswoman Erika Irazema Briones Pérez (PRD)

Date of submission: October 6, 2015

Proposal

Article 6.

VI. Obstetric violence: An act or omission by medical or administrative personnel which damages, injures or denigrates women during pregnancy, labor or puerperium, as well as negligent medical care; it is expressed by the appropriation of the woman's body and reproductive processes, dehumanizing treatment, excessive medication and pathologization of natural processes, the loss of women's autonomy or ability to freely make decisions about their bodies and sexuality.

Status: Pending delivery to the commissions.

State Laws on Access to a Life Free from Violence

At the state level, the legislatures of ten states —Chiapas, Chihuahua, Colima, Durango, Guanajuato, Hidalgo, Quintana Roo, San Luis Potosi, Tamaulipas and Veracruz— have incorporated definitions of obstetric violence in their respective laws of access to a life free from violence. Nevertheless, the rigidity with which the acts constituting obstetric violence are established in certain laws is troubling.

State: Chiapas

Definition

Article 6.The manifestations of violence against women include:

VII. Obstetric violence: Appropriation of women's bodies and reproductive processes by health care personnel, expressed by dehumanizing treatment, excessive medicalization and pathologization of natural processes, resulting in the loss of women's autonomy or ability to freely make decisions about their own bodies and sexuality; the following are considered as such: the absence of the timely and effective care of obstetric emergencies,

forcing the woman to give birth in the supine position and with her legs raised when the necessary means for a vertical birth are present, hindering the early attachment of the child to its mother without just cause, denying her the possibility of carrying or breastfeeding her infant immediately after birth, disrupting the natural low-risk birth process through the use of acceleration techniques, without obtaining voluntary, express or informed consent from the woman, and performing the delivery by means of a cesarean section when the conditions for a natural birth are present.

Date of publication: September 14, 2011

State: Chihuahua

Definition

Article 5. The manifestations of violence against women include:

VI. Obstetric violence: Every intentional act or omission by health care personnel that damages, injures or denigrates the woman during pregnancy, labor or puerperium, as well as negligent medical care, disrupting the natural low-risk birth process through the use of acceleration techniques, and performing the delivery by means of a cesarean section when the conditions for a natural birth are present without obtaining the voluntary, express or informed consent of the woman.

Date of publication: July 16, 2014

State: Colima

Definition

Article 30 bis.

Obstetric violence is every act or omission by health care personnel, which infringes on the rights of non-discrimination, health, physical integrity, equality and privacy, specifically pertaining to sexual health, women's reproductive rights during

pregnancy, labor and puerperium and her autonomy to exercise them in an informed manner; as well as excessive medicalization and pathologization of natural processes, resulting in the loss of women's autonomy and ability to freely make decisions about their own bodies and sexuality; physical or psychological damage or the death of the mother or infant.

Date of publication: May 16, 2015

State: Durango

Definition

Article 6. The manifestations of violence against women include:

III. Obstetric violence: Any dehumanizing act or treatment carried out by health care personnel during the pregnancy, labor, delivery and puerperium, such as the absence of timely and efficient care for obstetric emergencies, hindering early attachment of the child to its mother without just medical cause, disrupting the natural low-risk birth process through the use of acceleration techniques, and performing the delivery by means of a cesarean section when the conditions for a natural birth are present, without obtaining the informed consent of the woman for the latter two.

Date of publication: March 5, 2015

State: Guanajuato

Definition

Article 5. The manifestations of violence against women include:

VIII. Obstetric violence: Every intentional act or omission by health care personnel which damages, injures or denigrates the woman during pregnancy and labor, as well as negligent medical care.

Date of publication: December 3, 2013

State: Hidalgo

Definition

Article 5. The manifestations of violence against women include:

VI. Obstetric violence: That carried out by the health system or any external agent assisting the woman, or directly influencing her in the process of pregnancy, labor or puerperium, and which can be expressed in any of the following ways:

a) Untimely and inefficient care of obstetric urgencies.

b) Dehumanizing treatment.

c) Pathologization of the pregnancy, labor or postpartum process.

d) Medicalization of the pregnancy, labor or postpartum process without just cause.

e) Denial or obstruction of the early attachment of the newborn to its mother for no therapeutic cause.

f) Preventing the free exercise of the individual's sexual and reproductive rights, undermining their privacy and dignity in the light of their loss of autonomy.

Article 45. Health Ministry obligations:

xii. According to its available budget, it must:

a) Guarantee that health services have the establishments, goods, health services, and trained and suitable staff who contribute to ensure the right of the woman during pregnancy and puerperium.

b) Promote, both in the public and private sector, a reduction in the number of cesareans, in order to coincide with the standards recommended by the WHO.

c) Train and raise health sector personnel awareness, with the purpose of preventing acts of obstetric violence.

d) Implement information and dissemination activities, directed at the public in general, which includes informing them of their rights and the administrative and judicial means that exist through which they can channel their cases of obstetric violence to the authorities, always taking into account the indigenous languages spoken in each state.

e) Establish monitoring mechanisms and administrative sanctions allowing for the identifying and punishing of obstetric violence.

f) Promote specialized care services for women who have been victims of obstetric violence; and

xiii. The remaining provisions for the fulfilling of the present Law.

Date of publication: March 30, 2015

State: Quintana Roo

Definition

Article 5. The manifestations of violence against women include:

vii. Obstetric violence: Every intentional act or omission by health care personnel which damages, injures or denigrates the woman during the pregnancy and labor, as well as negligent medical care expressed by dehumanizing treatment, by abusive medicalization and pathologization of natural processes, resulting in a loss of autonomy and capacity to freely decide about their own bodies and sexuality; the following qualifying as such: the absence of timely and effective care in obstetric emergencies and performing the delivery by means of cesarean when the conditions for a natural birth are present, without obtaining the voluntary, express or informed consent of the woman.

Date of publication: December 9, 2014

State: San Luis Potosi

Definition

ix. Obstetric violence: Any abuse, conduct, intentional act or omission by health care personnel, either directly or indirectly, that damages, denigrates, discriminates and dehumanizes women during pregnancy, labor or puerperium, resulting in the loss of women's autonomy and ability to freely make decisions about their bodies and sexuality.

It can be expressed by:

a) Practices that do not have the informed consent of the woman, such as forced sterilization.

b) The absence of timely and efficient medical care in obstetric emergencies.

c) Not allowing the attachment of the child to their mother for no justifiable medical reason.

d) Disruption of the natural low-risk delivery process by means of its pathologization, excessive medication, or the use of acceleration techniques, without the necessity for any of them.

e) Performing a cesarean when conditions are present for a normal birth (…)

Date of publication: June 30, 2015

State: Tamaulipas

Definition

Article 3. For the purposes of this law, violence against women is manifested in the following ways:

f) Obstetric violence: Every act or omission by medical or health personnel that damages, injures, denigrates or causes death during the pregnancy, labor or puerperium, expressed by:

i. Negligent care resulting from the absence of humane treatment.

ii. Excessive medication and pathologization of natural processes, among them the absence of timely and efficient care for obstetric emergencies.

iii. Performing a cesarean when a natural birth is possible. A cesarean can be performed provided that there are no risks that, according to the doctor, constitute probable damage to the health of the fetus or the patient.

iv. The use of contraceptives or sterilization without the voluntary, express or informed consent of the woman.

v. Hindering the attachment of the baby to their mother for no justifiable medical reason, thereby denying her the possibility of holding and breastfeeding her baby immediately after birth.

Date of publication: March 24, 2015

State: Veracruz

Definition

Article 7. The manifestations of violence against women include:

vi. Obstetric violence: Appropriation by the health care personnel of the woman's body and reproductive processes, expressed by dehumanizing treatment, excessive medicalization and pathologization of the natural processes, resulting in a loss of autonomy and ability to freely make decisions about their bodies and sexuality. The following are considered as such: an absence of timely and efficient care for obstetric emergencies, forcing the woman to give birth in a supine position and with her legs raised when it is possible to perform an upright delivery, hindering early attachment of the child to its mother without just medical cause, denying her the possibility of holding and breastfeeding her child immediately after being born, disrupting the natural process of low-risk labor and delivery by employing acceleration techniques without the woman's voluntary, express or informed consent.

Date of publication: February 28, 2008

Content for a Law on Obstetric Violence

GIRE considers that if the legislative branch decides to incorporate a definition of obstetric violence, it should ensure that the following elements are included:

- That obstetric violence can be committed through acts as well as omissions.
- That it can take place during pregnancy, labor and puerperium care.
- That it is expressed by cruel, inhumane or degrading treatment towards women and/or abuse of the medicalization of natural processes.
- That it results in the loss of autonomy and the capacity to free make decisions about the different stages of pregnancy, labor, birthing process and childbirth.
- That obstetric violence is a structural problem that goes beyond individual attitudes.

Criminalization of Obstetric Violence: An Easy Way Out Without any Real Changes

The penal process within a State implies the most severe punishment on the parties that receive the sanction. There is a vast doctrinal development that sees the need to respect the principles and limitations of criminal law. Resorting to this law in a disproportionate manner for the treatment of social problems of the most diverse kind and origin is not in itself compatible with a democratic state of law.[53]

The purpose of criminal law is to protect the group of interests that is of the greatest importance for life in society. It is not called upon to protect the totality of social interests or to ensure that they are not negatively affected in any way. Instead, it seeks to proscribe only those conducts that cause greatest harm.

For the protection of other interests and/or afflictions, there exists a variety of appropriate measures from other branches of the legal order, such as those of civil or administrative law, for example.[54]

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53. González-Salas Campos, Raúl, *La teoría del bien jurídico en el derecho penal*, 2nd edition, Mexico, Oxford, 2001, p. 97.
54. Ferrajoli, Luigi, *Derecho penal mínimo y bienes jurídicos fundamentales*. Available at <http://bit.ly/1Gq1njK> [accessed: September 21, 2015].

Making the decision to establish a criminal sanction, or to make one more rigid, should always be the last possible option for the treatment of a social problem. The intervention of criminal law should only be employed when other measures have been exhausted.

It is crucial to understand the above before making a decision as sensitive as the criminalization of obstetric violence. As has been established in the present investigation, the incidence of obstetric violence is closely related to a specific context characterized by questions which are completely outside the mission of criminal law, in a country overwhelmed by demand, and one in which investment in health care is low. For example, changing attitudes, biases and harmful practices that are part of the same dynamic in which medical personnel are trained and educated at universities; or the lack of infrastructure, personnel and materials in order to offer adequate care for every health care user. In fact, rather than contribute to protecting women from this kind of violence, penalization could add even more problematic issues.

The individual sanction that criminal law propounds in no way resolves the structural faults identified which cause medical personnel to perform their work in conditions that impair their potential and the quality of care that they offer.

There is no justification for resorting to criminal law when the State provides for a whole range of measures that are less damaging and which are capable of addressing the conflict efficiently by attending to the underlying causes. The answer does not lie in increasing the number of laws in the criminal codes, thereby creating more criminal definitions in an attempt to resolve every conflict; the authorities cannot consider that criminalizing obstetric violence resolves urgent situations that would be better settled at the public policy level in terms of health, including the budgetary aspect and the reinforcement of the normative and human rights framework for obstetric care.

Additionally, criminal legislation has already considered different criminal definitions, which protect legal assets that may be injured in the cases of obstetric violence that are the direct responsibility of health personnel. For example: injuries, threats, abuse of authority, or the denial of medical staff to provide care to a person in case of an emergency, thereby putting her life at risk.[55] All of these actions can be used by women who suffer obstetric violence as arguments in the search for justice via the criminal system.

55. This last crime is listed in the General Health Law, Article 469.

On the other hand, they should ensure that conduct such as forced sterilization is criminally sanctioned: it is only considered in the criminal codes of 15 states.[56]

In spite of the above, obstetric violence is considered a crime in the penal codes of three states: Veracruz, Guerrero and Chiapas. In the case of Veracruz, this penalization was made in the framework of a series of amendments proposed to this regulation so as to achieve effective access to a life free from violence for women.

Article 363 of the Penal Code of Veracruz establishes that the crime of obstetric violence is committed by health care personnel who:

> i. Do not attend to or provide timely and efficient care for women who are pregnant, in labor, in puerperium or in an obstetric emergency.
>
> ii. Disrupt the natural low-risk childbirth process through the use of acceleration techniques, without obtaining the voluntary, express or informed consent of the woman.
>
> iii. Perform a cesarean when a natural birth is possible and without the woman's voluntary, express or informed consent.
>
> iv. Harass or put psychological and offensive pressure on a mother in labor, with the aim of inhibiting her free will about her motherhood.
>
> v. Hinder the attachment of the child to their mother for no justifiable medical reason, thus denying her the possibility of holding and breastfeeding her baby immediately after birth.
>
> vi. Make the woman give birth in the supine position with her legs raised even when it is possible for her to have an upright delivery, or in ways other than those dictated by her mores and obstetric customs and traditions.

The sanctions established range from three to six years in prison and a fine of up to three hundred days of minimum wage in the case of parts i, ii, iii and iv; for those who incur sanctions in parts v and vi, penalties range from six months to three years in prison and a fine of up to two hundred days of minimum wage.

The Penal Code of Guerrero, published on August 1, 2014, defines the crime of obstetric violence in the following way:

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56. Baja California Sur, Chiapas, Coahuila, Mexico City, Durango, Guerrero, Hidalgo, Michoacan, Puebla, Quintana Roo, San Luis Potosi, Tabasco, Tlaxcala, Veracruz and Yucatan.

Article 202. Gender violence: A punishment of two to eight years of imprisonment and a fine of two hundred to five hundred days of minimum wage will be imposed on those who, because of gender, cause injury, financial hardship, physical, obstetric, property, psychological, sexual or work-related harm, whether in the private or public sphere, thereby affecting the human rights or dignity of the person.

Article 203. Obstetric violence: An act or omission which impedes or obstructs timely and efficient medical care during pregnancy, labor, puerperium or obstetric emergencies, or disrupts the reproductive processes without obtaining the voluntary, express or informed consent of the woman.

In the case of Chiapas, a reform to the state penal code was published on December 24, 2014, which defines the crime of obstetric violence in the following way:

Article 183 Third. The crime of obstetric violence is committed when there is appropriation of the woman's body and reproductive processes, expressed by inhumane treatment, excessive medicalization or pathologization of natural processes, resulting in the loss of women's autonomy and ability to freely make decisions about their bodies and sexuality.

Regardless of the injuries inflicted, the person responsible for the crime of obstetric violence will be punished with a prison term from one to three years and a fine of up to two hundred days of minimum wage, as well as suspension from their job and from exercising their profession or trade for an equal period of time.

Article 183 Fourth. Individuals who commit obstetric violence and enable it will be sanctioned in the same way as those who:

i. Fail to provide timely and effective care during obstetric emergencies.

ii. Hinder the early attachment of the infant to their mother for no justifiable medical reason, thus denying her the possibility of holding and breastfeeding her baby immediately after birth.

iii. Disrupt the natural process of low-risk labor and delivery by employing acceleration techniques without the woman's voluntary, express or informed consent.

iv. Perform a cesarean section when a natural birth is possible.

3.2 Public Policies

NOM 007

NOM-007-SSA-2010, *For the care of women during pregnancy, childbirth, and the postpartum, and of the newborn* establishes, as its name indicates, the minimum criteria for women's health care throughout pregnancy, labor and childbirth, in the puerperium and of the newborn. This set of criteria is mandatory in all the health care units of the public, social and private sectors of the National Health System. Its objective is to standardize care procedures for pregnant women and avoid practices that either threaten pregnancy development or do not comply with the highest quality standards.

For labor and delivery care, among other issues, it stipulates that:

- During normal labor and delivery no analgesics, sedatives or anesthetics should be used routinely.
- The artificial rupture of membranes should not be undertaken for the sole reason of accelerating the birth.
- Episiotomies should only be carried out by qualified personnel who know the appropriate reparation technique, stating it in writing and informing the woman.
- During normal labor and delivery, the position that the woman wants to adopt must be respected when there is no medical contraindication.
- As a part of normal labor and delivery, the woman must be kept well hydrated.
- Breastfeeding should be initiated exclusively in the first 30 minutes after the delivery provided that the woman's health permits it.
- It establishes that the recommended rate of cesareans be 15% for primary care level and 20% for tertiary care level.

Regarding the quality of care, it is established that this should be imparted with quality and warmth, and it envisages the participation of midwifery assistants and obstetric nurses with the aim of achieving less intervention in the physiological

and natural process during labor. In respect to the procedures to be carried out during labor care, it recognizes the need to depend on scientific evidence and respect women's informed consent.

On April 1, 2014, the Modification Project of the NOM 007 was approved for publication in the Official Gazette of the Federation, which meant that it would be updated in accordance with the most recent scientific and technical evidence, and would push for the strengthening of obstetric health services.

Nonetheless, as the present edition went to press, the modifications to NOM 007 approved by the National Advisory Committee on Standardization for Disease Prevention and Control (CCNPC) have not been published by the Federal Health Ministry.

The updated Norm contains highly relevant provisions which signify a step forward in the effort to prevent obstetric violence. The fact that the issuing of these modifications has been inexplicably halted for more than a year and a half after their approval is a serious infringement of the reproductive rights of women.

Inter-Institutional Agreement for the Universal Attention of Obstetric Emergencies

The complexity and fragmentation of the National Health System is a barrier to women being able to access health care services in the event of an obstetric emergency. In May 2009, the Health Ministry, the IMSS and the ISSSTE signed the Inter-Institutional Agreement for the Universal Attention of Obstetric Emergencies with the intention to reduce maternal mortality through greater collaboration between the hospital medical units of these institutions.

This Agreement states that every pregnant woman can seek medical assistance from any of the medical units of participating institutions to establish whether she has an obstetric emergency. If so, the medical unit will decide if it is possible to adequately attend to the patient given its resolution capacity, or if the seriousness of the case makes it necessary to immediately transfer her to another medical unit nearby that has a better resolution capacity, infrastructure and medical staff. All of this is free of charge and irrespective of the affiliation of the woman.

Despite this Agreement representing a positive step in terms of public policy, the Observatory of Maternal Mortality in Mexico (OMM) has identified the following flaws in its implementation:[57]

The Agreement and the obligations derived from it are often unknown to women as well as medical personnel. The OMM states that the employment of the Agreement has been fortuitous on many occasions, whether because a family member or doctor knows about its existence and requests it, or because, women demand the care due to the gravity of the situation.

- The Agreement has been used sparingly because the hospital medical units of participating institutions are accustomed to referring patients to other units of their institution, in spite of the fact that it could signify more time wasted during the transfer and, as a consequence, a delay in care for the individual.

- Although principal health institutions participate in the Agreement, the resolution capacity for obstetric emergency care is inconsistent. Additionally, there are only 414 health care units in the whole country that participate in the Agreement, with hospitals such as the National Institute of Perinatology and health facilities of Mexican Oil and the Ministry of Defense and the Navy not being a part of it.

On April 28, 2015, the draft bill was presented by the joint Senate Commissions of Social Security and Legislative Studies, by Senator Flor de María Pedraza (PAN), was passed, with the aim of including said Agreement in the General Health Law, the Social Security Law and the Institute for Social Services and Security for State Workers Law. The reform seeks to establish in these norms that women who present an obstetric emergency will be able to access expedited care in any health facility, regardless of their affiliation, and free of charge for women living in poverty or high levels of marginalization.

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57. Ramírez Rojas, Guadalupe and Graciela Freyermuth Enciso, "Consideraciones sobre la construcción del Sistema Nacional de Salud Universal: la experiencia de la atención de las emergencias obstétricas" in *Observatorio de Mortalidad Materna en México. Documents [website].* Available at <http://bit.ly/1jBjE3K> [accessed: June 12, 2015].

It thus seeks to include Article 64 bis in the General Health Law as follows:

> **Article 64 bis I.** The health services referred to in Article 34 of the present Law will pay expeditious attention to pregnant women with obstetric emergencies, requested directly or by referral from another medical unit, in those units with the capacity for obstetric emergency care, irrespective of affiliation or insurance program.

Additionally, it sees to add a Part V to Article 89 of the Social Security Law:

> It will be obligatory for the Institute to attend to pregnant women with obstetric emergencies, requested directly or by referral to another medical unit, in terms of the relevant provisions, at the units with the capacity for obstetric emergency care, regardless of their affiliation or insurance program.

On October 15, 2015, the Senate unanimously approved additions to the General Health Law, the Social Security Law and the Institute for Social Services and Security for State Workers Law, and as a result they were incorporated into the legislation of the Agreement. As the present report went to press, it is yet to be published by the Executive branch.

Maternal and Perinatal Health Program

The Federal Health Ministry in 2014 belatedly published the Maternal and Perinatal Health Program for the 2013-2018 period. This program establishes as its principal objective that women can exercise their reproductive rights over the course of their lives, specifically those related to maternal and perinatal health.

The Program points out that in 2012, institutions were identified in the National Health System that performed more than 50% of deliveries by cesarean section, a figure which is notably higher than what is recommended by both the WHO and the NOM 007.

Among the strategies and courses of action established by the Program, the following are especially important for supporting actions to eradicate situations of obstetric violence:

Strategy 2.1	Courses of action
Promote the formation, update and development of human resources for comprehensive preconception, prenatal, labor, postpartum and neonatal care.	2.1.1 Encourage the availability of personnel trained in preconceptional, prenatal, labor and puerperium care, and obstetric and neonatal emergencies. 2.1.2 Raise awareness and train personnel to deliver maternal and perinatal care that is safe, competent and respectful of human rights.
Strategy 2.3	**Courses of action**
Support the administering of equipment and materials to medical units that attend to maternal and perinatal care.	2.3.1 Promote the acquisition of materials and equipment for maternal and neonatal care, prioritizing locations where there is a high marginalization and concentration. 2.3.2 Support the implementation of labor care units focused on intercultural needs and priorities.
Strategy 2.4	**Courses of action**
Strengthen the linking of administration, monitoring, follow-up and evaluation processes for implementation and accountability.	2.4.1 Contribute to the strengthening and linking of maternal health and perinatal information and monitoring systems. 2.4.4 Follow up on the efficient use of resources and their linking with results.

Among the challenges identified in the Program is the application of services with a gender and interculturality perspective with respect to human rights, a reduction in the number of cesareans and the provision of the necessary trained staff, infrastructure and inputs.

4. COMPARATIVE EXPERIENCE: OBSTETRIC VIOLENCE IN THE LAW

As a precedent to the inclusion of obstetric violence in Mexico's legislation, other countries in the region reformed their laws to recognize and sanction this kind of violence against women. These are the cases of Venezuela and Argentina which, in 2007 and 2009 respectively, established obstetric violence as a crime. It is therefore relevant to become acquainted with the terms of the regulation and the effects that it has had on the prevention and elimination of obstetric violence.

4.1 Venezuela

Venezuela was the first country in Latin America to categorize and criminalize obstetric violence as a form of gender violence against women. The Organic Law on the Right of Women to a Life Free of Violence was published on March 15, 2007 and Article 15 includes the description of obstetric violence as:

> …the appropriation of women's bodies and reproductive processes by health personnel, expressed by dehumanizing treatment, excessive medicalization and pathologization of natural processes, resulting in the loss of women's autonomy and ability to freely make decisions about their bodies and sexuality, causing a negative impact on the quality of their lives.

In Article 51 it additionally indicated the conduct constituting the crime of obstetric violence:

- Failure to attend to obstetric emergencies in a timely and effective manner.
- Forcing the woman to give birth in a supine position with her legs raised, when it is possible to give birth in an upright position.
- Hindering the attachment of the child to their mother for no justifiable medical reason, denying her the possibility of holding or breastfeeding her baby immediately after birth.
- Disrupting the natural process of low-risk labor and delivery by using acceleration techniques without the woman's voluntary, express or informed consent.
- Performing a cesarean when a natural birth is possible and in the absence of the woman's voluntary, express or informed consent.

The punishment for persons responsible for obstetric violence is a fine of two hundred and fifty thousand tax units.

In an exploratory study that encompassed 425 users in the Concepción Palacios maternity hospital in Caracas, it was discovered that 66.8% had medical procedures performed on them without their consent and that 49.4% of users had suffered some type of dehumanizing treatment by medical personnel: 23.8% were denied contact with their newborn infants and 21.6% were criticized for crying or shouting out during the delivery.[58]

The same study indicated that there are no official statistics in Venezuela that take into account the incidence of obstetric violence, and that there is a high level of ignorance from both medical personnel and women in this regard.[59]

Venezuela is an example of how considering obstetric violence to be a crime is a measure that is not ideal for tackling the problem, given that hospitals in Venezuela have work routines that comply with a pattern in accordance with the institutional model of Venezuelan obstetric care, as has been explained by doctor Marbella Camacaro Cuevas,[60] a Venezuelan expert on the subject of obstetric violence. The solution should be focused primarily on transforming the hegemonic model of obstetric care, prior to individualizing sanctions for medical personnel.

During the elaboration of this investigation, a Bill for Labor and Humanized Birth is being discussed in the National Assembly. If this law is passed, the traditional protocols for pregnancy care will be modified —upon publication of this law, health care facilities would have six months to adapt their protocols and infrastructures in order to be able to comply with the conditions of humane care that the norm would supposedly demand.

It also implies shutting down hospitals for a period from forty-eight hours to two years, with medical staff being dismissed or penalized with fines.[61] Nevertheless,

58. Terán, Pablo, *et. al.*, "Violencia obstétrica: percepción de las usuarias", in *Revista de Obstetricia y Ginecología de Venezuela*, vol. 73, no. 3, year 2013, p. 175. Available at <http://bit.ly/1K6CxjQ> [accessed: June 12, 2015].

59. *Ibid*, p. 178

60. Camacaro Cuevas, Marbella, *et. al.*, "Conductas de rutina en la atención al parto constitutivas de violencia obstétrica", in *Utopía y praxis latinoamericana*, year 20, no. 68, p. 116. Available at <http://bit.ly/1jvkJJJ> [accessed: August 22, 2015].

61. Tejero, Suhelis, "La Ley del Parto Humanizado espera por segunda discusión en la AN", in *Contrapunto [website]*, May 20, 2015. Available at <http://bit.ly/1L9mAO1>.

there is evidence, and GIRE agrees on this matter, that if the problem of scarce resources is not solved, it is unlikely that the contents of the bill will be able to be enforced.[62]

Once again, the penalization of medical personnel is ineffective when the problem is closely linked to issues related with the inadequacy of the infrastructure of women's health care during pregnancy, labor and the postpartum period.

4.2 Argentina

Like Venezuela, Argentina suffers from a dearth of official data regarding the incidence of obstetric violence: "It is understood that there are only a few isolated accounts that make the existence of this kind of violence known, those that come from certain women in the private sphere who talk about their experiences and tell them to other women in the private sphere".[63]

An investigation carried out at the third largest maternity hospital in Argentina, where surveys were carried out to both users and medical personnel, revealed the persistence of practices constituting obstetric violence: of the women questioned, 44.4% affirmed to having received verbal abuse. Concerning medical procedures without informed consent, 86.6% had had their amniotic sac artificially broken, 96.6% were given medication to accelerate labor, 63.3% were given repeated vaginal examinations and by different people, and 73.3% were given an episiotomy. One hundred percent of the women affirmed that their infants were taken away from them immediately after the delivery.[64]

The same investigation indicates that there is a lack of knowledge concerning obstetric violence on the part of health personnel, or rather, a denial of the fact that they have carried it out, but that the women are also unaware of their rights and how to assert them.

On the other hand, the Ombudsman of Buenos Aires has indicated that obstetric violence is one of the most invisible manifestations of violence, and that "…the absence of anesthesia in certain practices, the concealment of information that would allow the patient to make decisions about their body and health, the violation of her

62. *Ibid.*

63. Quevedo, Paula, Violencia *Obstétrica: una manifestación oculta de la desigualdad de género*, Mendoza, Argentina, Nacional de Cuyo University, Faculty of Political and Social Sciences, 2012, p. 3. Available at <http:// bit.ly/1ZzoIWD> [accessed: May 10, 2015].

64. Information from the investigation carried out by Paula Quevedo at the Hospital Luis C. Lagomaggiore.

intimacy and the disregard of cultural patterns, are concrete complaints received by the ombudsman...".[65]

In Argentina in 2009, the definition of obstetric violence in the Law of Comprehensive Protection to Prevent, Sanction and Eradicate Violence Against Women was established, applying to a national level:

> Obstetric violence: that which health care personnel exercise on women's bodies and reproductive processes, expressed by dehumanizing treatment, excessive medicalization and pathologization of natural processes, in accordance with Law 25.929.[66]

This law is focused mainly on promoting and guaranteeing the development of public policies regarding violence against women, the removal of socio-cultural patterns that foster gender inequality, and ensuring women's right to a life free of violence.

It establishes types of violence against women: physical, psychological, sexual, economic and property related, and symbolic; as well as manifestations of the same: domestic, institutional, labor, against reproductive freedom, obstetric and unwanted media attention.

Provisions relevant to denunciations for violence against women are included in one of the four headings that make up this Law:

- On the one hand, every woman who has suffered violence in terms of this Law can file a complaint before any judge in any jurisdiction and instance, or before the Public Prosecutor, either in writing or orally.[67]

- On the other hand, the Law establishes the obligation of every person working in the care, social, educational and health services, both in the public and private sphere, to file a criminal complaint when, in the course of their work, they learn of a woman who has suffered violence, provided that the conduct may be constituted as a crime.

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65. As declared in the institutional announcement dated May 21, 2015 from the Ombudsman however, there is no information concerning complaints received. See <http://bit.ly/1GFWcHl>.
66. Argentina, "Law 26.485. Law of comprehensive protection to prevent, sanction and eradicate violence against women in sphere of the development of their interpersonal relations, Article 6" in *Boletín Oficial de la República de Argentina*, 1st section, Year XVII, No. 31.632, April 14, 2009. Available at <http://bit.ly/1VQ0qbH> [accessed: March 20, 2015].
67. Although the complaint can be filed before any of the bodies indicated, the competent judge will study the cause, according to the kinds and modalities of violence that it concerns, according to Article 22.

However, it also provides that it is the obligation of these individuals to file complaints when they have knowledge of violence against women even though this does not constitute a crime.

In addition to this, as already explained in this Report, in GIRE the criminal route is not considered to be ideal for obstetric violence, as it is confusing in the case of this Law that the obligation to file a complaint, whether criminal or not, falls on the party that can materially carry out acts or omissions constituting obstetric violence —the health personnel.

The Law of Comprehensive Protection to Prevent, Sanction and Eradicate Violence Against Women is linked to the National Law of Parents' and Children's Rights during the Birth Process, in which Article 2 recognizes the following rights of women in relation to pregnancy, labor, childbirth and postpartum:

- To be informed about the different medical procedures that could occur during these processes in such a way that they can opt freely for an alternative should there be one.
- To be treated with respect, in an individual and personalized manner, which guarantees her intimacy throughout the care process and takes her cultural patterns into consideration.
- To be considered, throughout the birth process, as a healthy person, in such a way that she can participate actively in her own delivery.
- In the case of a natural birth, to be respectful of biological and psychological time, avoiding invasive practices and the provision of medication not justified by the state of health of the mother.
- To be informed about the evolution of her labor, the condition of her child and, in general, to become involved in the different roles of the professionals.
- To not be subjected to any exam or intervention with research purposes, unless consent has been given in writing under the protocol approved by the Bioethics Committee.
- To be accompanied by a trusted person chosen by her during the labor, delivery and postpartum period.

- To have her baby with her during her stay at the care facility, provided that the newborn child does not need special care.
- To be informed, from the point of pregnancy, about the benefits of maternal breastfeeding and to receive assistance with the breastfeeding.
- To receive counseling and information about her own care and that of her child.

In regard to this law, critics have held that it is built upon the hegemonic medical model as it reinforces a unique childbirth care model and considers the medical hospital context as the only place where this would occur.[68]

68. Aragón, Mariana, "Violencia obstétrica vs. Parto respetado. Apuntes para un debate urgente a través del texto de la Ley Nacional 25.929", in *X Jornadas de Sociología.Facultad de Ciencias Sociales, Universidad de Buenos Aires, 2013: memorias.* Available at <http://bit.ly/1Qom93> [accessed: March 20, 2015].

5. ACCESS TO JUSTICE

Despite the existence in Mexico of a variety of procedures that can be initiated in situations of obstetric violence —civil, criminal or administrative— none of them assume the establishment of comprehensive reparations measures for violations of human rights. The State must ensure that victims of obstetric violence have access to effective resources and judicial protection, which is fundamental for guaranteeing the investigation of human rights violations and, where appropriate, sanctioning them. Through the attribution of responsibility to the State for situations of obstetric violence, the practices that perpetuate it, reparation for violations of the human rights of the victims and the fostering of guarantees of non-repetition, can be identified. With this background, GIRE has impelled the use of complaint mechanisms before the human rights commissions, both at a state and national level, since this involves the mechanism that can establish comprehensive reparations.

5.1 Administrative Mechanisms

The most immediate resource in a situation of obstetric violence is the presentation of a written complaint before the health institute's internal comptroller unit. Based on it, an investigation will be initiated pertaining to the shortcomings in the medical care that have been reported. The complaint procedure that should be followed is determined by each health institution. The lack of uniformity creates uncertainty regarding the procedure that a woman who has suffered obstetric violence must follow, in addition to the fact that the complaint is filed at the same institution that is being denounced for obstetric violence, and that it is the same institution that decides the procedure and the final result, which can create a conflict of interest in establishing the responsibility of the health care personnel.

Complaints Filed against Service Providers as a Result of Obstetric Care:

	Complaints received for mistreatment and medical negligence against women in the labor and delivery context	Complaints received for obstetric violence
IMSS	Responded that it does not have competence to answer the request.	Responded that it does not have competence to answer the request.
ISSSTE	60	33
Federal Health Ministry	Referred to CONAMED.	

State Health Ministries	Complaints received for mistreatment and medical negligence against women in the labor and delivery context	Complaints received for obstetric violence
Aguascalientes	2	1
Baja California	2	1
Baja California Sur	3	1
Campeche	0	0
Chiapas	-	9
Chihuahua	4	6
Coahuila	3	3
Colima	0	0
Distrito Federal	18	18
Durango	5	-
Guanajuato	The required information is not registered in the system.	The required information is not registered in the system.
Guerrero	44 (29 for mistreatment and 15 for negligence).	130
Hidalgo	10	None for obstetric violence, but 5 complaints for medical specialties and obstetrics.
Jalisco	10	There are no documents with the characteristics described.
México	14	14
Michoacán	0	0
Morelos	54	54
Nayarit	0	0
Nuevo León	2	1
Oaxaca	6	0

Puebla	0	0
State Health Ministries	**Complaints received for mistreatment and medical negligence against women in the labor and delivery context**	**Complaints received for obstetric violence**
Querétaro	1	2
Quintana Roo	0	0
San Luis Potosí	8	2
Sinaloa	8	5
Sonora	-	-
Tabasco	The authority claimed to not have competence to reply.	The authority claimed to not have competence to reply.
Tamaulipas	-	-
Tlaxcala	-	-
Veracruz	14	14
Yucatán	-	-
Zacatecas	8	0
TOTAL	**216**	**266**

(-) No response.

On the other hand, the trials for administrative responsibility only proceed in cases where health personnel from public institutions are involved. In accordance with the Federal Law of Administrative Responsibilities of Public Servants —which regulates this mechanism— in the case of a breach of obligations, the public servant can be submitted to an administrative procedure and the corresponding sanctions, which can consist of a private or public warning, suspension of employment or position, dismissal from their post, a pecuniary sanction and temporary prohibition from holding jobs, posts or commissions in the public service.

Besides the sanctions envisaged for public health service providers, whether through written complaint or administrative responsibility processes, the Federal Law of State Patrimonial Responsibility regulates this kind of state-level responsibility. By means of the procedures established in this Law, recognition of the right to compensation for those who suffer damage to their property and rights as a consequence of the irregular administrative activity of the State can be achieved.

It is therefore possible to demand from the State a compensation for damages suffered as a consequence of obstetric violence. Nevertheless, this neither implies comprehensive reparation for the violation of human rights, nor does it include guarantees of non-repetition that modify the structural problems that caused the incidence of obstetric violence to begin with.

5.2 Medical Arbitration Commissions

The National Medical Arbitration Commission (CONAMED) is a decentralized body of the Federal Health Ministry with technical independence to issue settlements and rulings. It was created in 1996 with the aim of offering alternative solutions for conflicts between health care providers and users.

Each state has their own regulations concerning the internal functioning of their medical arbitration organs. However, not every state has one.[69]

Although CONAMED and state arbitration commissions could be a possibility for victims of obstetric violence to obtain compensation in a faster and simpler manner than in court, by focusing this mechanism exclusively on the individual behavior of health personnel, it does not analyze the obstacles or structural issues that caused the situation of obstetric violence, it does not allow for the establishment of guarantees of non-repetition, and the settlement or ruling in which it concludes limits its effects only to the parties involved. GIRE carried out access to information requests to both CONAMED and state commissions for the number of complaints received for mistreatment and medical neglect against women in the context of labor care and also for the number of complaints received for obstetric violence. The purpose of these questions was to identify how much the concept of obstetric violence has permeated these entities.

69. Baja California Sur, Chihuahua, Mexico City, Durango, Quintana Roo and Zacatecas do not have medical arbitration commissions.

Complaints to the Commission of Medical Arbitration

National Commission of Medical Arbitration (CONAMED)	Complaints received for mistreatment and medical negligence against women in the labor and delivery context	Complaints received for obstetric violence
	0	0

State Commissions	Complaints received for mistreatment and medical negligence against women in the labor and delivery context	Complaints received for obstetric violence
Aguascalientes	4	Complaints for obstetric violence are not received because it is not a competent body to receive them.
Baja California	0	0
Baja California Sur	There is no local arbitration commission.	There is no local arbitration commission.
Campeche	6	0
Chiapas	0	0
Chihuahua	There is no local arbitration commission.	There is no local arbitration commission.
Coahuila	-	-
Colima	-	-
Distrito Federal	There is no local arbitration commission.	There is no local arbitration commission.

State Commissions	Complaints received for mistreatment and medical negligence against women in the labor and delivery context	Complaints received for obstetric violence
México	22	0
Guanajuato	0	0
Guerrero	3	3
Hidalgo	-	-
Jalisco	24	The concept of obstetric violence is not registered.
Michoacán	-	-
Morelos	-	-
Nayarit	1	1
Nuevo León	11	-
Oaxaca	-	-
Puebla	-	-
Querétaro	0	0
Quintana Roo	There is no local arbitration commission.	There is no local arbitration commission.
San Luis Potosí	17	15
Sinaloa	12	0
Sonora	-	-
Tabasco	-	-
Tamaulipas	4	0
Tlaxcala	-	-
Veracruz	-	-
Yucatán	-	-
Zacatecas	There is no local arbitration commission.	There is no local arbitration commission.
TOTAL	**203**	**118**

(-) No response.

Even though obstetric violence is still classified as ill-treatment and medical negligence, there is evidence that the concept of obstetric violence is now beginning to

be viewed differently (a total of 118 complaints for obstetric violence). However, the elevated number of complaints for poor treatment and negligence during labor care and for obstetric violence together provide evidence of structural faults that require urgent attention.

5.3 Criminal Trials

As noted above, GIRE considers that for issues relating to the access of health services, the route to a legal solution should not be the criminal one, since a large part of obstetric violence cases are related to structural flaws in the health system and the precarious conditions in which health service providers have to do their work. Imposing criminal sanctions on health personnel who commit acts of obstetric violence owing to the serious weaknesses inherent in the health system, leaves the causes at the heart of the phenomenon unresolved, resulting in inefficient measures to resolve incidences in Mexico.

Nevertheless, in cases where crimes have been committed by medical personnel, such as forced sterilization, injuries or threats, criminal prosecution is a mechanism of access to justice for the victims and their families. Article 228 of the Federal Penal Code also foresees those crimes for medical responsibility, by stating that: "Professionals …will be responsible for those crimes committed in the carrying out of their profession". Apart from the criminal sanctions derived from the crimes that are committed, health care professionals and assistants can be suspended temporarily or permanently from practicing as well as having the responsibility of repairing the damage caused. GIRE carried out access to information requests to public prosecutors offices in the states (Chiapas, Guerrero and Veracruz) where obstetric violence is classified according to the number of complaints for obstetric violence.

The authorities that were questioned reported a total of one complaint (Veracruz) while Chiapas reported zero complaints. The Public Prosecutors of those states were also questioned on the number of criminal trials for obstetric violence and the sentences emitted. With respect to the number of criminal trials, the state judiciaries of Guerrero and Veracruz reported zero criminal processes while in the case of Chiapas it was reported that the recording mechanism that they manage does not operate at the level of detail of the information requested. With regard to the number of sentences issued, both Guerrero and Veracruz reported zero, and Chiapas alleged that the mechanism that it uses does not operate at the level of detail of the information requested.

Complaints, Criminal Trials and Sentences Relative to Obstetric Violence

State	Number of complaints received for obstetric violence (State Public Prosecutor)	Number of criminal trials for the crime of obstetric violence (State Public Prosecutor)	Number of sentences for the crime of obstetric violence (State Public Prosecutor)
Chiapas	0	Responded that the mechanisms for information capture do not operate at the level of detail of the requested information.	Responded that the mechanisms for information capture do not operate at the level of detail of the requested information.
Guerrero	-	0	0
Veracruz	1	0	0

(-) No response.

5.4 Human Rights Commissions

The National Human Rights Commission (CNDH) and state human rights commissions are founded in the Constitution in Article 102 section b.

These autonomous bodies are empowered to receive complaints concerning acts or omissions that violate human rights committed by public servants, as well as issuing public, autonomous and non-binding recommendations since they are not judicial entities. Due to the latter, their compliance depends ultimately on the political will of the public institution in question.

Nevertheless, a diligent investigation and clear recommendations stating unequivocal obligations of public institutions can contribute to the improvement of administrative activity. In cases of obstetric violence, the federal and states human rights commissions can offer an effective route to access justice, which includes recommendations from a human rights perspective and contributes to demanding and implementing measures of non-repetition. GIRE carried out access to information requests to the CNDH and state commissions. It questioned them on the number of complaints received for mistreatment and medical negligence against women during labor and delivery and also for the number of complaints received for obstetric violence.

The aim of asking in a differentiated manner is in the interest of knowing to what extent the concept of obstetric violence is utilized by these bodies. From the requests, it was established that in the period from January 1 to June 30, 2015, a total of 132 complaints were received for obstetric violence, with 14 recommendations being issued, accepted and fulfilled for the same concept.

Complaints against Health Service Providers for Obstetric Violence

National Human Rights Commission	Complaints received for ill-treatment and medical negligence against women during labor and delivery care	Number of recommendations issued for ill-treatment and medical negligence against women during labor and delivery care	Complaints received for obstetric violence	Number of recommendations issued for obstetric violence
	119	9	1	10

Although at GIRE it has been possible to observe that deficiencies in recommendations issued for obstetric violence persist, it is also recognized that they have been decisive in reaching agreements with the competent authorities in order to adequately repair the violations to human rights committed.

Nevertheless, it is important to point out that the CNDH, in its 2014 activity report, stated that the violations that are most frequently reported were those concerning the right to health which had to do with medical neglect, medical negligence, neglect of the patient, hospital isolation, irregular integration of clinical records, inadequate medical procedures, and various omissions related to the provision of medication, hospital services, information about state of health and implementation of the necessary infrastructure for the adequate provision of health services, to name a few.[70] The IMSS is the institution that has received the most recommendations by the CNDH for violations to the right of health. This information is another illustration of the serious structural problem that the Health System is suffering from, and which needs to be addressed urgently.

70. CNDH, *Informes de actividades del 1 de enero al 31 de diciembre de 2014*, Mexico, 2015. Available at <http://bit.ly/1fjTRdL> [accessed: June 11, 2015].

5.5 Comprehensive Reparations of Human Rights Violations

The IACHR has determined that the concept of comprehensive reparations (*restitutio in integrum*) entails "the reestablishment of the previous situation and the elimination of the effects produced by the violation as well as the payment of compensation for the damage caused".[71] Reestablishment does not mean physically restoring the victim to the condition they were in before the violations occurred, but rather to place them in a state where such violations will not continue. The fact of being able to fully enjoy their human rights has a legal basis in Article 1, paragraph three of the Mexican Constitution, and in Articles 51.2 and 63.1 of the American Convention, concerning the general obligation to respect human rights, stated in Article 1.1 of the Convention.

When human rights violations are a result of structural discrimination, as it generally happens in cases of obstetric violence, the IACHR has established that comprehensive reparations must "have a transformative effect on such situation". Thus, the effects of the reparation must not only be restitution but also rectification; reestablishment of the same structural context of discrimination is not acceptable.

The reparation should therefore not only be a measure that restores the victims to the situation prior to the violation of their rights, but also an action that takes into account the consequences that such violation had for the victims, by acknowledging the seriousness of the facts that led to it.

In virtue of the fact that in the majority of cases it is impossible to restore things to the state that they were in before the violation, nullifying every negative outcome, it is necessary to employ other kinds of measures to make reparations for the consequences of the situation generated by the human rights violations:

Investigation of the Facts to Identify, Try and, if Necessary, Punish the Parties Responsible: Although the Mexican government is inherently compelled to investigate and punish all human rights violations under the right to access to justice, the Inter-American System has stated that this obligation is part of the reparation.

71. IACHR, *González et al ("Cotton Field") v. Mexico. Preliminary Objections, Merits, Reparations and Costs. Sentence from November 16, 2009. Series C No. 205*, paragraph 450. Available at <http://bit.ly/1kho5vc> [accessed: June 6, 2015].

Example in terms of obstetric violence: Investigation of the acts of obstetric violence and imposition of the appropriate sanctions, in accordance with the gravity of the act or omission is, for example, a private or public warning or suspension of the employment or position in the case of a judgment of administrative responsibility, or the criminal sanction determined by the judge, in those cases where the act or omission constitutes the crime.

Restitution: The main purpose of restitution is to restore the victim to the situation that existed before the violation of their human rights, not only in terms of material aspects but also in the exercise of their rights.

Example in terms of obstetric violence: Raising awareness and training health care personnel in women's reproductive rights.

Satisfaction: Its main aim is the reparation of immaterial damage; in other words, the suffering and grief caused by human rights violations such as impairment of the highly significant values of individuals and non-pecuniary changes to their living conditions. The Inter-American System holds that satisfaction also includes other acts or works of public repercussion such as non-pecuniary measures to compensate for non-material damage.

Example in terms of obstetric violence: A public declaration by the State accepting responsibility for the obstetric violence stemming from substandard and inadequate health care.

Rehabilitation: These measures include medical and/or psychological or psychiatric care which the State must guarantee the victims. Legal and social services must also be included.

Example: Timely and specialized medical care.

Guarantees of non-repetition: These measures transcend the concrete case since they aim to prevent a recurrence of the situation that caused the violation. This type of measure is particularly important when there are recurring patterns of similar acts causing human rights violations. The guarantees commonly include prescribing the adoption or reform of local legislation or the adoption of administrative measures.

Example: Effective implementation of reproductive health programs in accordance with women's needs and with sufficient state funding; modification of study programs for the professional training of health staff, fostering an education permeated by the human right, gender and interculturality perspective.

Compensation: This includes both material and non-material damage, and awards a monetary redress to the victims, which distinguishes it from satisfaction, also an element of comprehensive reparation.

When establishing reparation measures for human rights violations, the Mexican government must take into account both material and immaterial damage. The former is "the loss or detriment of the income of victims, the expenses incurred because of the acts and the pecuniary consequences that have a causal nexus with the facts of the case".[72] The latter includes "both the suffering and distress caused to the direct victim and their close relatives, the impairment of values that are highly significant to them"[73] that in both cases can mean the payment of a specified amount of money as compensation.

Example: Full pecuniary compensation.

6. CASES REGISTERED, DOCUMENTED AND LITIGATED BY GIRE

These are cases of girls and women who were victims of obstetric violence[74] that GIRE has accompanied.[75] From January 2013 to August 2015, GIRE registered 16 cases, documented six cases and has litigated another six.

72. IACHR, *Bámaca Velázquez v. Guatemala. Reparations and Costs. Sentence from February 22, 2002. Series C No. 91*, paragraph 43. Available at <http://bit.ly/1KLT4yi> [accessed: June 6, 2015].

73. IACHR, *"Niños de la Calle" (Villagrán Morales et al) v. Guatemala. Reparations and Costs. Sentence from May 26, 2001. Series C No.77*, paragraph 84. Available at <http://bit.ly/1fkcqqT> [accessed: June 6, 2015].

74. In the 2015 GIRE report *Women and Girls Without Justice: Reproductive Rights in Mexico*, the cases of maternal mortality that GIRE accompanied from January 2013 to May 2015 can be consulted; in several of these cases whose outcome was the death of the women, obstetric violence was committed. In the referenced period, GIRE had three registered cases and six cases that were litigated or in litigation. The report is available at <http://bit.ly/1K3F7ft>.

75. Some of the names have been changed to protect the women's privacy.

6.1 Registered Cases

For the cases that are classified as *registered* there is no complete documentation because the victim or their families could not be contacted. GIRE registered them from different sources such as media clips, information provided by authorities or members of civil society organizations throughout the country.

NAME	AGE	STATE	YEAR
Georgina	-	Distrito Federal	2013
Guadalupe	33	Querétaro	2013
Laura	-	Zacatecas	2013
Zamira	20	Oaxaca	2013
María	-	México	2014
Elsa	38	Puebla	2014
Lucía	23	Oaxaca	2014
Emilia	-	Distrito Federal	2014
Valeria	30	Sinaloa	2014
Andrea	30	Yucatán	2014
Natalia	21	Oaxaca	2014
Paula	16	Oaxaca	2014
Federica	24	Oaxaca	2014
Alina	29	México	2014
Amanda	16	Tabasco	2014
Romina	-	Chiapas	2015

6.2 Documented Cases

In the cases that are classified as *documentation*, there was direct contact —at the very least the victim or their family members were interviewed, either by telephone or at their place of residence. In the cases where legal action had been initiated, records were reviewed, with the aim of obtaining more information about the case, but no legal action was taken by GIRE.

Violeta

Violeta lives in Villahermosa, Tabasco. She was 40 weeks pregnant at the age of 15. When she began to go into labor she went to the Highly Specialized Women's Regional Hospital of Villahermosa, but was refused medical care, forcing her to return on various occasions. As a result of this lack of medical care, Violeta gave birth in the waiting room of the hospital. This case was taken up by the media at large and the CNDH issued Recommendation 35/2014 against the Governor of the state of Tabasco. GIRE documented the case, but had no success in contacting Violeta once the recommendation had been emitted.

Location of the events: Health Ministry of Tabasco, Highly Specialized Women's Regional Hospital of Villahermosa, Tabasco.

NAME

Violeta

AGE

15

STATE

Tabasco

YEAR

2014

Gladis

Gladis, 20 years of age, was pregnant with twins and was a user of the free universal government healthcare plan. She lives in Santo Domingo de Morelos, Oaxaca, a community of difficult access due to a lack of transportation infrastructure. The nearest hospital in San Pedro Pochutla is at least an hour and a half away. Her lack of financial resources led her to attempt to cross the border with her husband in spite of her being pregnant. They were unsuccessful and returned to their community to work the fields. When her pregnancy came to term, she sought care at the San Pedro Pochutla Hospital where her

NAME

Gladis

AGE

20

STATE

Oaxaca

YEAR

2014

children were born with low birth weight and respiratory difficulties. They died a few hours later since the hospital does not have a neonatal intensive care unit. GIRE made contact with the family who decided not to take legal action.

Location of the events: Health Ministry of Oaxaca, San Pedro Pochutla Regional Hospital, Oaxaca.

Marielos

Marielos is 13 years old and lives in Culiacán, Sinaloa. She found out that she was pregnant when she went to the Topolobampo Health Center suffering from pains in her stomach. There she was told that besides being five months pregnant, she was at risk of miscarrying and of pre-eclampsia. Because of this diagnosis, Marielos was transferred to the General Hospital of Los Mochis, where she was not given treatment to control the pre-eclampsia.

NAME

Marielos

AGE

13

STATE

Sinaloa

YEAR

2015

The day that she arrived at the hospital with labor pains, she had to wait to be attended for almost seven hours, despite awareness of her high-risk pregnancy. During the cesarean, Marielos' health worsened. After much persuading from the family, the relevant tests were performed and it was discovered that Marielos suffered from HELLP Syndrome.

Currently, Marielos must undergo hemodialysis, and has to commute to Los Mochis. A hernia was also detected as a possible consequence of poor suturing to the cesarean wound, which requires surgery, which has not been performed because of

the family's fear due to the medical care that she received in the Hospital at Los Mochis.

Location of the events: Health Ministry of Sinaloa, Regional Hospital of Los Mochis, Sinaloa.

Mirta

Mirta is from Chetumal. When she was 38 weeks pregnant, at a consultation with a general practitioner from the IMSS, she was informed that the fetus was underweight and undernourished, and that they would not know until her appointment with the gynecologist whether the delivery would be natural or a cesarean. Uneasy with this news, Mirta and her husband went to a private clinic where they confirmed what she had been told before; however they assured her that the fetus was fine, and with proper nutrition once delivered would not have any problems. A few hours later, Mirta felt some discomfort and decided to go to the emergency room of a public hospital. There they informed her that they would perform a cesarean. When she arrived at the area where they operate, and tried to explain her situation to the doctor, he answered that he wasn't interested, and after giving her a pelvic exam, shouted at her "there is nothing wrong with you". After this, Mirta, on repeated occasions, expressed that she did not feel well, but nobody paid any attention to her. It wasn't until the medical personnel realized that Mirta was bleeding that they prepared her for an urgent cesarean. After coming round from the anesthetic, and still not fully conscious, they made

NAME

Mirta

AGE

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STATE

Quintana Roo

YEAR

2015

her sign some papers and told her that the placenta had detached from the wall of the uterus and that her baby had been born dead as a result of drowning in the amniotic fluid.

A week later she returned to the hospital so that they could remove her stitches. After advancing only a few meters as she was leaving for home, her wound opened, and she had to return to the hospital where she was admitted for two days.

Location of the events: IMSS, General Hospital Number 1 of the Zone, in Chetumal, Quintana Roo.

Rosalía

Rosalía, 26, was in her third pregnancy and diagnosed as high risk due to placenta previa. In April 2015, during her monthly checkup, she started to feel discomfort and to see "stars". On being checked, it was found that her cervix was between three and four centimeters dilated, and she was transferred to the General Hospital of Chetumal. The next day the medical staff decided that she needed emergency surgery, but they never informed her that she was in labor. In the midst of strong pain, various resident doctors and nurses made her sign a number of documents and she overheard one of the doctors asking the others why she had not been operated on the night before. Rosalía was not shown her daughter —neither in the operating room nor in the recovery room.

A few days after being discharged, she experienced heavy bleeding, so she went to the emergency room

NAME

Rosalía

AGE

26

STATE

Quintana Roo

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2015

of the Chetumal General Hospital, where she was admitted. Shortly afterwards, Rosalía went into a coma. Rosalía's husband was not informed of this situation, he was only told that she needed blood. A few hours later the doctor informed him that there had been nothing they could do for Rosalía and that they had not managed to stop the bleeding; remains of the placenta had been left in her uterus, which had injured it, causing the bleeding.

On May 8, Rosalía came out of the coma. Nowadays she uses a catheter because she has a vesico-vaginal fistula and she has to take anticoagulants, which are leading to a loss of sight. She is prone to strokes, memory loss and hypertension, and she also needs to undergo between one and four operations in order to repair her bladder.

Location of the events: Health Ministry of Quintana Roo, Chetumal General Hospital, Quintana Roo.

Rosa María

NAME

Rosa María

AGE

22

STATE

Mexico City

YEAR

2015

Rosa María is a cashier at a supermarket in Mexico City. She is 22 years old. During her first pregnancy, at one of her prenatal appointments at the IMSS clinic where she is a registered beneficiary, she was attended to by a social worker who pressured her by way of trickery, scolding and by confiscating her social security identity card, into signing a page "accepting" the fitting of an IUD.

In December 2014 she went to the IMSS Gynecological Obstetric Hospital Number 4 with contractions. She was given five minutes to choose a con-

traceptive method, since “there are many children” and told that she could not leave the hospital without choosing a method. The only “option” she was given was the IUD.

One week later, she returned to the hospital due to complications from the episiotomy that had been performed on her during labor. As a consequence, she had to undergo a second suturing procedure, after which Rosa María expressed that she was in a lot of pain. But she was discharged in spite of instructions from the doctor who said that she should be kept under observation until the following Monday. She was not given any painkillers upon leaving the hospital.

As time went by Rosa Maria’s pain continued and her condition did not improve. At an appointment with her general practitioner on January 14, 2015, she was told that her discomfort was due to having been poorly sutured and also because the suture thread was expired. He also told her that the IUD that she had been forced to accept had been poorly inserted and was causing an infection.

As a consequence of the above, Rosa María was hospitalized a third time from January 14 to 26, 2015 at which time the IUD was removed.

The substandard surgery required her to take antibiotics which meant that she could not breastfeed her baby. Although the IMSS had given her infant formula, it was not enough to feed Rosa María’s baby, who she could not carry for months, due to back and leg pain.

With GIRE's assistance, Rosa Maria's clinical file was requested and a technical opinion is being prepared.

Location of the events: IMSS, Highly Specialized Medical Unit, Gynecological Obstetric Hospital Number 4 in Mexico City

6.3 Litigated Cases

The *litigated* cases refer to the cases in which GIRE took legal action in order to accompany victims or their families.

Catalina

On October 2, 2013, Catalina, 26 years of age, sought medical care for a 41.2 week pregnancy at the San Felipe Ecatepec Clinic of San Cristóbal de las Casas, Chiapas. The nurse who attended her informed her that a cesarean would probably be performed due to her high blood pressure. The attending gynecologist nevertheless decided that she would have a vaginal birth. Catalina felt very ill and repeatedly asked the medical staff for assistance, but to no avail. It was only when she had a seizure that the health providers intervened, performing a cesarean on her. Her infant died some hours later.

NAME

Catalina

AGE

26

STATE

Chiapas

YEAR

2013

In March 2014 Catalina filed a complaint before the Fifth Investigative Unit of the CNDH based in San Cristóbal de la Casas, Chiapas.

At Catalina's request, GIRE filed a request for access to public information to obtain her clinical file but was denied.

Based on the records, a technical opinion was issued in which the deficiencies of the health service that attended Catalina were laid out. Based on the technical opinion, in June 2014 an extension of the complaint was filed with the CNDH. To date, the National Commission has not issued a recommendation.

The investigative unit requested an expert opinion from the CNDH in Mexico City but no report has been presented and therefore no recommendation has been issued.

Location of the events: IMSS, San Felipe Ecatepec Clinic in San Cristóbal de las Casas.

Irma

Irma is a Mazatec woman and lives in precarious economic conditions. Upon arriving to the San Felipe Jalapa de Díaz Health Center in Oaxaca, nursing staff told her to go for a walk, confident that her baby was not yet going to be born. While Irma was walking in the hospital's courtyard, her waters broke and moments later her son was born, in the absence of any medical assistance whatsoever.

The image of Irma giving birth in the hospital courtyard was captured and published in the media, resulting in the CNDH filing a complaint. Due to the above, on January 29, 2014, the CNDH issued Recommendation 1/2014 in which it was determined that Irma and her son's human rights had been violated by the government of the state of Oaxaca for denial of adequate medical care. When GIRE took on the case the Government of Oaxaca showed political will to comply with the recommendation. In March 2014, Irma, the government of Oaxaca and GIRE as Irma's legal representative, signed an agreement that established obligations for the State, including the following up of criminal and administrative procedures initiated as a consequence of the denial of health care services, and guarantees of non-repetition comprising the following:

a) Making the necessary arrangements for the construction of the Jalapa de Díaz Basic Hospital within a period of eight months, comprising a medical and hospital infrastructure.

b) The construction, setting up and refurbishment of 50 delivery rooms in six jurisdictions of the state.

NAME

Irma

AGE

30

STATE

Oaxaca

YEAR

2013

Irma, woman that GIRE accompanied in a case of obstetric violence.

Foto: Fungifilms

c) Diffusion of the criteria and procedures contained in NOM 007 SSA2-2010.

At the present time there are no delivery rooms, nor has the construction of the Jalapa de Díaz Basic Hospital been completed. The CNDH has additionally requested the Executive Commission for Attention to Victims to register Irma and her son as victims; this has however not been done.

Location of the events: Health Ministry of Oaxaca, San Felipe Health Center, Jalapa de Díaz.

Recommendation (CNDH) addressed to the Governor of the state of Oaxaca.

Gilda

Gilda is 30 years old, has three children and comes from Zacatecas. She was 37 weeks pregnant when on July 3, 2014 she sought attention at the Women's Hospital because her waters had broken. At around 10 o'clock that night she was informed that a cesarean had to be performed on her. After her daughter was born, Gilda was told that she would be transferred to the neonatal unit because of her daughter's low birth weight. Gilda was in pain and had bruising as a consequence of the cesarean and doctors decided to operate on her again. She stayed in the hospital until July 7 with pain and discomfort. During the time that she was in the hospital, Gilda was not allowed to see her daughter as she was in the neonatal unit, but she was assured that she was well. On being discharged, she was informed that her baby needed surgery because of an intestinal infection. She was not given any more information.

NAME

Gilda

AGE

30

STATE

Zacatecas

YEAR

2014

On July 9 her daughter died. In September 2014 Gilda filed a complaint with the CNDH in Zacatecas to which she has had no response. For that reason, GIRE is accompanying her to file an extension of the complaint.

Location of the events: Health Ministry of Zacatecas, General Hospital of Zacatecas

Liliana

NAME

Liliana

AGE

30

STATE

Quintana Roo

YEAR

2014

On November 12, 2013 Liliana sought medical care at the General Hospital of Family Medicine Unit 1 of the Mexican Social Security Institute (IMSS) in Chetumal, Quintana Roo, as she was in labor. Despite being eligible for a vaginal delivery, the doctor on the next shift emphatically insisted that she undergo a cesarean, despite her status not having changed. Liliana clearly told the doctor that she wanted a vaginal birth, to which the doctor responded, "if that is what the patient wants, I can go on my medical rounds to check on my patients and return in an hour and a half, but if the baby has gone into fetal distress, that's her responsibility". Fearful of what might happen to her daughter, Liliana agreed to a cesarean. During the surgery she lost consciousness and was therefore not aware of either the procedure or the birth of her baby. After coming round, she had a fever and acute abdominal pain and had to insist for an hour and a half for an examination by a nurse. The doctor who performed the cesarean finally prescribed her medication without assessing her condition. After being discharged from the hospital, she returned to the same hospital because she had a fever and was suffering from severe abdominal pain. She was seen by the same doctor

who had performed the cesarean who, once again, was indifferent to her situation. Liliana therefore asked her family to take her to a private clinic where, after six days of tests and three surgeries —one of which was to remove her uterus— Liliana discovered that during the cesarean her bladder and uterus had been perforated. Her condition was serious and she had to stay at the clinic until December 6 without being able to hold her daughter.

Liliana filed a complaint with the CNDH, who in turn decided to refer the case to the CONAMED, arguing that it concerned a case of medical negligence and not of obstetric violence, nor was it a violation of human rights. Liliana —represented by GIRE— submitted an extension of the complaint in which it was clarified and argued that her case was one of obstetric violence and that she had suffered a violation of her human rights. Her complaint is still being processed by the CNDH.

In the process before the CONAMED, a conciliation hearing was held, with no agreement being reached, since the IMSS does not accept its responsibility in virtue of a collaboration agreement between the IMSS and the CONAMED, and as such Liliana will have to try to find other means of redress. In this regard, a document was presented before the CNDH, enforcing this circumstance and requesting the case be reviewed in order to emit a recommendation. To date, this petition has not been answered.

Location of the events: IMSS, General Hospital Family Medicine Unit 1 in Chetumal.

Liliana, woman that GIRE accompanied in a case of obstetric violence.

Alba

Alba is from San Antonio de la Cal, Oaxaca. At the time that the events happened, she was 24 years old and the mother of a little boy.

On November 5, 2013 she went with her mother to the San Antonio de la Cal Health Center because she was in pain. She was 36 weeks pregnant. There, she was told that she was not in labor yet and she was sent home. Two hours later, Alba felt more frequent pains and so at 3:30 in the morning walked back to the Health Center with her husband and her mother. However, a few meters from home she felt that her baby was about to be born and so she asked her mother to run to the Health Center to request an ambulance.

Upon arriving at the corner where the Health Center was situated, her water broke. She sat down to give birth but the wet baby slipped from her hands, hitting its head on the street. Her husband lifted the baby up and covered it with a sheet.

NAME

Alba

AGE

24

STATE

Oaxaca

YEAR

2014

As a result of these occurrences, the CNDH filed an official complaint. Accompanied by GIRE, Alba filed an extension of the complaint with the aim of raising awareness that her baby's and her human rights were violated. The CNDH issued Recommendation 15/2014 addressed to the government of Oaxaca, where compensation for damages for Alba and her baby are established, as well as the implementation of guarantees of non-repetition at the Health Center and the monitoring of penal and administrative processes before the corresponding entities.

Additionally, on December 2, 2014 an agreement was signed between Alba —with GIRE as her legal representative— and the government of Oaxaca, for full compensation for abuses committed to her and her baby. As a result of the above agreement, Alba was awarded compensation. However, other aspects, such as guaranteeing medical coverage for her child up until the age of 18, are still outstanding.

Location of the events: Health Ministry of Oaxaca, San Antonio de la Cal Health Center.

Recommendation (CNDH) addressed to the Governor of the state of Oaxaca.

Sandra

Sandra is Testal. She is 36 years old and lives in the Nahá community in Chiapas. Her husband and her live on limited financial resources. They have always wanted to have a baby. Sandra miscarried her first pregnancy due to the poor medical care that she received.

She became pregnant a second time but when she went into labor she was denied access to health care facilities at the closest health institution to her home, on the grounds that the doctors were on vacation. This forced her to travel to Villahermosa in search of medical care at the Highly Specialized Women's Regional Hospital. There, she was once again denied access because she is from Chiapas.

After insisting, she was hospitalized for three hours without receiving any information about her state of health or the medical care she would be receiving. In addition, she was subjected to ill treatment and insults by the medical staff.

That same day, a cesarean was performed on her and four hours later she was discharged. After the birth, Sandra and her husband were not allowed contact with their daughter and were extorted by the medical staff of the hospital, who told her that she would be given her baby in exchange for ten thousand pesos, alleging that she did not have medical insurance even though her parents have governmental health coverage. For seven days, while they tried to obtain the money requested, the hospital would only let her see her daughter through a window. They told her that the infant's health was delicate without explaining what was wrong or the severity of her situation. On the eighth day when they returned to see her, the hospital personnel told them that she had died.

NAME

Sandra

AGE

36

STATE

Chiapas

YEAR

2014

They do not know why this happened.

On April 14, 2014 Sandra, accompanied by GIRE, filed a complaint before the CNDH for human rights violations to Sandra and her daughter.

On March 27, 2015, an extension of the complaint was filed after obtaining more elements of the case. To date, more than one year since the complaint was filed, there has been no response by the CNDH, who have not even been to Nahá to interview Sandra. Compensation for the violations that she suffered is still pending.

Sandra became pregnant again. The pregnancy came to term but she had very high blood pressure and her pregnancy was high risk. There is no specialty clinic in Nahá for her to go to.

With GIRE's assistance, she was transferred to Comitán, where she was seen by specialists in the Women's Hospital, and on May 1, 2015 her son was born. Today she and her husband are finally parents of a healthy son and Sandra is in good health.

Location of the events: Health Ministry of Chiapas, Regional Hospital of Palenque.

7. RECOMMENDATIONS

The following recommendations are addressed from GIRE to he three branches of government. Should they be adopted, they would help in the prevention and gradual eradication of obstetric violence.

LAWS AND POLICIES

To Federal Congress and state legislatures:

Reforms to penal codes should not criminalize obstetric violence.

To the state legislatures of Veracruz, Chiapas and Guerrero:

Reform penal codes to eliminate the crime of obstetric violence.

To the Federal Health Ministry:

Publish NOM 007-SSA2-2010, *For the care of women during pregnancy, childbirth, and the postpartum, and of newborns.*

IMPLEMENTATION OF LAWS AND POLICIES

To the Federal Health Ministry, IMSS, ISSSTE and state-level health ministries:

Identify obstetric violence as a form of institutional and gender violence recognized in the General Law of Women's Access to a Life Free from Violence in state laws to eradicate the practice thereof.

Guarantee universal access to obstetric health services, specifically during labor and delivery, to all women.

Encourage pregnant women and women in labor to know their rights and have their decisions recognized, and ensure that the health services are provided with informed consent.

ACCESS TO JUSTICE

To the Federal Health Ministry, IMSS, ISSSTE and state-level health ministries:

Strengthen the complaint systems and internal control in hospitals that attend to women delivering babies, to promote access to justice in cases of obstetric violence.

To the CNDH, state-level human rights commissions and courts of justice:

Ensure access to justice and full reparation of damages to the victims of obstetric violence in accordance with the highest human rights standards and take into account the victims' requests and monitoring of the implementation of these recommendations.

To CONAMED and state commissions for medical arbitration:

Strengthen complaint mechanisms in cases of obstetric violence, removing barriers and facilitating access to decisions in accordance with human rights standards.

Obstetric Violence: A Human Rights Approach

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