2019

THE MISSING PIECE:
REPRODUCTIVE JUSTICE

ADOLESCENT PREGNANCY
CRIMINALIZATION OF ABORTION
OBSTETRIC VIOLENCE
MATERNAL MORTALITY
LIMITED ACCESS TO SOCIAL SECURITY

GIRE

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GIRE

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Foto: Archivo GIRE

INTRODUCTION

At present, Mexico lacks the necessary conditions to enable women to make decisions about their reproductive lives. There are high numbers of pregnant girls and adolescents, affected by the grave consequences of sexual violence that the State has failed to address; there are barriers to services such as emergency contraception and abortion after rape; women who have abortions are criminalized; every day women are victims of obstetric violence during pregnancy, labor and post-partum; and many women die from preventable causes during childbirth, leaving their families behind. In addition to the structural problems of the health system, a large portion of the Mexican population is employed in the informal market. Thus, they have limited access to social security benefits such as maternity leave or daycare. Women, who for the most part continue to be the primary caregivers and responsible for housework, are affected by this lack of access to services, particularly those who experience multiple forms of discrimination—girls and adolescents, indigenous women and women with disabilities.

We, at the Grupo de Información en Reproducción Elegida (Information Group on Reproductive Choice, GIRE), have worked to defend and promote reproductive rights in Mexico for over 25 years. During that time, we have shed light on structural and policy-related obstacles that hinder the full exercise of women's human rights in relation to their reproductive lives. Since 2011, GIRE has documented the situation of reproductive rights in the country through periodic reports that provide information on the debts that, administration after administration, the Mexican State has failed to address.

The Missing Piece: Reproductive Justice addresses the status of five problems that require immediate resolution to achieve women's reproductive justice in Mexico. This report uses information from different sources: federal and state laws and administrative norms; statistical data; public information obtained through 1,856 requests for information between 2012 and 2017; and cases of women and families that GIRE has accompanied to access justice and demand comprehensive reparations for violations of their human rights. The information presented is used as a starting point to determine concrete actions that enable the Mexican State—in the context of the change of the federal administration—to overcome the inertia that of considering women's human rights as a lesser priority and that issues like corruption and impunity have nothing to do with the experiences that women endure in Mexico every day. GIRE has prepared The Missing Piece: Reproductive Justice in the firm belief that Mexico's true transformation into a freer and fairer democracy will never come about if women are left behind.

1 GIRE classifies the cases that it represents into three categories—registration, documentation and accompaniment. Cases in the first category are those where GIRE was unable to directly contact the woman or her family. The second category is comprised of cases where at least one face-to-face interview was held but no action—legal or otherwise—was carried out. The third category includes cases that GIRE accompanied women or their families to access justice (for example, by filing legal stays and complaints before human rights commissions).

1

ADOLESCENT PREGNANCY

ADOLESCENT PREGNANCY

Is associated with high rates of sexual violence and a lack of access to services such as abortion, as well as a lack of information regarding contraception and its universal access.

WORLDWIDE,

50% The risk of miscarriage or stillbirth is 50% higher among adolescents than among women aged 20-29.

Source: WHO, 2014.

SECOND

LEADING CAUSE OF DEATH

among adolescent girls 15-19

Source: WHO, 2014.

11% of all births are adolescent births.

95% occur in low- and middle-income countries.

Source: WHO, 2018.

IN MEXICO

73.6/1000

WOMEN

had a child at 15-19 years of age—the highest adolescent fertility rate among OECD member countries.

Source: OECD, INMUJERES, 2017.

2016

10.09% OF WOMEN WHO HAD AN ADOLESCENT PREGNANCY WERE VICTIMS OF SEXUAL VIOLENCE

Source: ENDIREH, 2016.

2017

390,000

GIRLS AND ADOLESCENT

BECAME MOTHERS;

ONE IN SIX BIRTHS

Source: INEGI, 2018.

48.4%

of all adolescent pregnancies in 2014 were unwanted pregnancies.

Source: OECD, INMUJERES, 2017.

ON AVERAGE THERE ARE 2 BIRTHS TO MOTHERS AGED 10-11 EVERY DAY

Source: INEGI, 2018.


Photo: Quartoscuro

In Mexico, according to the National Institute of Statistics and Geography (INEGI), in 2017, a total of 390,089 women under 20 years of age became pregnant, of whom 9,748 were girls under 15 and 380,341 were adolescents aged 15-19. Adolescent pregnancy is a multifactorial phenomenon that requires effective and comprehensive public policy to promote and ensure non-discriminatory access to user-friendly contraceptive methods; prevent and address sexual violence; provide comprehensive sexuality education; and guarantee access to legal abortion and specialized medical care, among others.

Adolescence, by definition, is the developmental stage that spans the ages of 10 to 19 and is characterized by accelerated growth and change.[1] Adolescent pregnancy is a public health and human rights issue associated with health risks for adolescent mothers and their infants. It can hinder their psychosocial development, have a negative impact on their education and employment opportunities, and contribute to perpetuating intergenerational cycles of poverty and health problems.[2]

1 WHO, *Adolescent development*. Available at: http://www.who.int/maternal_child_adolescent/topics/adolescence/dev/en/ [Accessed on September 16, 2018].

2 Pan American Health Organization, *Accelerating progress toward the reduction of adolescent pregnancy in Latin America and the Caribbean. Technical Consultation Report*, 2016. Available at: http://iris.paho.org/xmlui/handle/123456789/34493.

1.1

SITUATION IN MEXICO

A. SEXUAL VIOLENCE

The considerable number of pregnancies among girls and adolescents in Mexico should not only be associated with an early onset of their sexual life or a lack of information on the use and access to contraception. It is also necessary to consider the few opportunities available to young people for realizing their life project, as well as diversity of their experiences, including the high rates of sexual violence that girls and adolescents face in Mexico. According to the 2016 National Survey on the Dynamics of Household Relationships (ENDIREH), of the women who reported having had an early pregnancy, 10.09% had suffered sexual violence.[3] The Survey also shows that of the women who were raped during childhood and had an adolescent pregnancy, 80.31% had been attacked by a relative, whereas 50.23% had been raped by a neighbor or an acquaintance.[4]

This reality makes it necessary to acknowledge the role of sexual violence in child and adolescent pregnancy in the country. It is also urgent to address the Mexican State's non-compliance with its obligation of ensuring the right of all women to a life free of violence and to emergency care services as stated in the legislation, including emergency contraception and abortion in cases of rape.

3 ENDIREH, 2016.

4 *Ibidem*. The total percentage of perpetrators is more than 100% because the informants had the possibility of choosing more than one option.

SERVICES FOR VICTIMS OF SEXUAL VIOLENCE

In Mexico, emergency contraception has been gradually included in various general regulations issued by the Ministry of Health (MOH), which are mandatory for all health institutions. These regulations contemplate the provision of emergency contraception information and services. Since January 2004, use of emergency contraception has been stipulated in Official Mexican Norm 005-SSA2-1993 On Family Planning Services (NOM 005), in cases of consensual unprotected sexual relations, when a contraceptive method was used but failure is suspected, and in cases of rape. In July 2015, a product for emergency contraception was included in the MOH Essential List of Medicines.

Further, NOM 046-SSA2-2005, Domestic and Sexual Violence and Violence against Women (NOM 046), establishes that health personnel are obligated to provide emergency contraception to victims of sexual violence within 120 hours of the assault. The General Law on Victims (LGV) also recognizes the right to these services and stipulates that public agencies that provide care for victims of sexual violence must have personnel trained in the provision of such care from a gender perspective.[5] According to this law, there should be no requirements to request the services.

To determine the degree of compliance with the above norms, GIRE submitted public information requests to federal and state health institutions. With this information, GIRE received official information on the number of women under 18 who had requested and received emergency contraception pills (ECP) between December 1, 2012 and October 2017.

At the federal level, only the federal MOH National Homeopathic Hospital reported having provided ECPs twice to individuals under 18. Both the Mexican Navy (SEMAR) and the Mexican state-owned petroleum company PEMEX (both provide health services to their employees) reported not having provided any EPC during the period under study. Surprisingly, the Mexican Social Security Institute (IMSS), the Institute for Social Security and Services for State Workers (ISSSTE), and the rest of the federal MOH agencies do not have information about emergency contraceptive provision. This finding is particularly unexpected because, according to INEGI estimates, of all IMSS users, 33.46% are adolescents, compared to only 6.45% of the ISSSTE user population.[6] Jointly, the two institutions serve around 40% of the adolescent women that are entitled to their services—a percentage that is slightly smaller than those affiliated with the Universal Health Insurance Program (Seguro Popular) (57.43%). The lack of information on ECP provision makes it impossible to develop appropriate public policies to ensure access to the services and adequately evaluate existing barriers.

At the state level, most health institutions did not specify the number of women who had requested ECPs. They only provided information on the number of pills provided. Therefore, it is impossible to determine if demand of emergency contraceptives was appropriately met. Moreover, nine states did not have disaggregated data by age on ECP provision for individuals under and over 18 years of age. Thus, we were unable to determine whether the pills are provided to minors or if there are obstacles that exist.

5 LGV, Article 35. For all victims of sexual violence or of any other behavior that compromises their physical or psychological integrity, access to emergency contraception and voluntary abortion services will be guaranteed in the cases stipulated by law, in strict respect for the victim's will. In addition, the victim will undergo regular examinations and specialized treatment for as long as deemed necessary for their complete recovery and in accordance with the medical diagnosis and recommended treatment. Particularly, as part of their treatment, the personnel will prioritize follow-up on any sexually transmitted disease and the Human Immunodeficiency Virus.

6 National Survey of Occupation and Employment (ENOE) 2018. Available at: http://www.beta.inegi.org.mx/proyectos/enchoga-res/regulares/enoe/default.html [Accessed on October 3, 2018].

In Mexico, health personnel are obligated to provide information and abortion services after rape. Nevertheless, as documented by GIRE, women still face obstacles in accessing the services, due to confusion and ignorance of existing legislation as well as prejudice among health staff. Between 2012 and September 2018, GIRE accompanied 38 cases of denial of abortion, of which 26 were minors whose access to abortion after rape was hindered by authorities.[7]

In accordance with current norms, a sworn statement from the woman asserting that her pregnancy is the result of rape suffices to access abortion services. Moreover, adolescents over the age of 12 can request the services without the consent of their parents or legal guardians. Nevertheless, in practice, they are often asked to comply with additional requirements, including reporting the rape to the police or authorization from a Public Prosecutor's Office. They also must overcome unjustified obstacles; for example, insufficient medical staff or equipment to perform the abortion.[8] Violations to the human rights of girls and women seeking the services occur when the authorities are unaware of their legal obligations. Such was the case of Marimar, which showcases the obstacles that many victims of sexual violence face when trying to access abortion services that should be guaranteed by the State.

7 For further information on the patterns identified in cases of denial of abortion for victims of rape that GIRE has recorded, documented, and accompanied, see GIRE, Violence without End, 2nd edition, 2017. Available at http://aborto-por-violacion.gire.org.mx/en/assets/pdf/violence-without-end.pdf.

8 For more data on abortion in cases of rape in Mexico, see the chapter on "Criminalization of Abortion" in the above report.

MARIMAR*

MORELOS, 2015

In 2015, Marimar, then 17, became pregnant as a result of rape. Together with her parents, she went to the Dr. José G. Parres General Hospital in Cuernavaca. After a medical examination performed at the hospital, they told her that the fetus had a congenital malformation, which meant that she had a high-risk pregnancy. Marimar requested an abortion.

To process her request, the hospital's Bioethics Committee convened to determine if the abortion was justified. This action was evidence of their complete ignorance of current norms, which guarantee access to abortion in cases of rape without having to comply with any requirement other than a sworn statement declaring that the pregnancy was the result of rape.

Marimar and her parents received notification of the Committee's resolution, which stated, "Having examined the clinical file compiled in accordance with the Official Mexican Norm, we have concluded that the pregnancy of the patient is developing normally and that although the fetus has a congenital malformation, the mother's life is not at risk. There is no evidence or indication to terminate the pregnancy."

Marimar and her parents, accompanied by GIRE, filed a legal stay to challenge the Bioethics Committee's resolution. They requested that a federal judge should corroborate that the service denial had resulted in human rights violations; order issuance of a new resolution; and award reparation.

The violations to Marimar's human rights are clear. The abortion was justified because the pregnancy had been the direct result of rape. It was also justified because Article 119, paragraph IV, of the Morelos Penal Code states that in the case of the crime of abortion, a congenital malformation of the product will be construed as an absolutory cause, which means that the only necessary requirement for the abortion was the pregnant woman's consent. In the case of Marimar, the attending physicians' diagnosis was that the fetus had a serious congenital malformation and, moreover, based on medical evidence, Marisol faced a high-risk pregnancy—another indication provided for in the state legislation.

Since the lawsuit was not satisfactorily resolved, an appeal for review was filed with the Mexican Supreme Court (SCJN). At a session held on April 4, 2018, the Justices of the Second Chamber of the Supreme Court unanimously decided to grant Marimar's legal stay. With this decision, they acknowledged that Marimar and her parents had been victims of human rights violations. Consequently, they ordered the Morelos Executive Commission for Attention and Reparations for Victims (CEARV) to customize reparations in accordance with the specific needs of the case.

GIRE prepared a proposal that included all the measures necessary to obtain comprehensive reparation, which cover economic compensation, satisfaction, rehabilitation, and measures of non-repetition. The proposal was met with a favorable decision by the CEARV, and is being enforced.

Marimar's is the first case of denial of abortion after rape that won a favorable ruling before the SCJN, which sets an important precedent to improve access to abortion in Mexico. The Court stated, "Health authorities approached by women who have suffered sexual violence and subsequently become pregnant as the result of the attack will comply with their request efficiently and immediately to spare them the consequences—physical, psychological, etc.—derived from the sexual attack. To that end, not only will they provide the necessary medical care and monitoring but also the legal termination of their pregnancy." The Court also stipulated that the authorities will not implement mechanisms or internal policies that prevent the exercise of the rights of women who have been the victims of rape and wish to terminate the pregnancy resulting from such crime.[9]

* Her name was changed to protect her privacy.

9 SCJN, Second Chamber. "Legal Stay in Revision 601/2017. Complaint and Appellant: *****." Justice José Fernando Franco González Salas," April 4, 2018. Available at: https://www.scjn.gob.mx/sites/default/files/listas/documento_dos/2018-02/AR-601-2017.pdf [Accessed on October 24, 2018].

Photo: Cuartoscuro

RECOMMENDATIONS TO THE MEXICAN STATE BY THE CEDAW[10] COMMITTEE

In July 2018, the CEDAW Committee analyzed the Mexican State's obligations in matters of women's human rights. Regarding abortion in cases of rape, the Committee noted that, at the state level, there are:

- Provisions in the criminal legislation that restrict access to legal abortion and continue to force women and girls to resort to unsafe abortion at the risk of their health and life;

- Inconsistencies between different state criminal codes that hinder the effective implementation of Article 35 of the General Law for Victims, as well as NOM-046-SSA2-2005, which allows for abortion after rape.

10 Convention on the Elimination of All Forms of Discrimination against Women.

B. CONTRACEPTIVE ACCESS

Access to contraceptive methods is an essential component for the exercise of reproductive rights. The CEDAW Committee, in General Recommendation number 24 (Women and Health), asserted that States should carry out actions to address all aspects of healthcare for women and girls, including access to contraception and family planning resources.[11] In Mexico, promotion of contraception is a step toward compliance with Article 4 of the Mexican Constitution: every person has the right to decide in a free, responsible, and informed manner on the number and spacing of their children.

Access to information and contraceptive services are fundamental in providing care for the large number of adolescent pregnancies. In that regard, the Committee on Economic, Social, and Cultural Rights (CESCR), in General Comment No. 22, on the Right to the Highest Attainable Standard of Health, states, "The realization of the right to health of adolescents is dependent on the development of youth-friendly health care, which respects confidentiality and privacy and includes appropriate sexual and reproductive health services."[12]

In addition, the CESCR Committee, in General Comment No. 22, on the Right to Sexual and Reproductive Health, states the following:

> All individuals and groups, including adolescents and youth, have the right to evidence-based information on all aspects of sexual and reproductive health, including maternal health, contraceptives, family planning, sexually transmitted infections and HIV prevention, safe abortion and post-abortion care, infertility and fertility options, and reproductive cancers.

It also stipulates,

> States are obliged to ensure that adolescents have full access to appropriate information on sexual and reproductive health, including family planning and contraceptives, the dangers of early pregnancy and the prevention and treatment of sexually transmitted diseases (STDs), including HIV/AIDS, regardless of their marital status and whether their parents or legal guardians grant their consent, and respecting their privacy and confidentiality. [13]

Further, the Committee on the Rights of the Child has recommended that States eliminate the requirement for parental consent to gain access to contraceptive methods.[14] In May 2015, the Committee also recommended that the Mexican State ensure adequate and confidential sexual and reproductive health services, including access to contraceptives, for boys and girls.[15]

Despite the above obligations, according to National Population Council (CONAPO) estimates, in 2014 the unmet need for contraceptives among women of reproductive age was 11.4%. That is, an increase of almost two percentage points above the 2009 national average. Nevertheless, an analysis of only women aged 15-24[16] reveals that the national average for the unmet need for contraceptives is as high as 23.5%. Of concern is the high percentage of this indicator in Chiapas (34.3%), Oaxaca (33.9%), and Yucatan (31.6%).

11 United Nations, CEDAW Committee, *General Recommendation 24. Article 12 of the Convention on The Elimination of All Forms of Discrimination against Women — Women and Health, 29th Session*, 1999, paragraph 17. Available at: http://catedraunescodh.unam.mx/catedra/mujeres3/html/cedaw/Cedaw/3_Recom_grales/24.pdf [Accessed on September 15, 2018].

12 United Nations, CESCR Committee, General Comment No. 14 (2000): *The Right to the Highest Attainable Standard of Health (Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESC))* [E/C.12/2000/4], 22nd Session (2000), paragraph 23. Available at: http://www.acnur.org/fileadmin/Documentos/BDL/2001/1451.pdf?view [Accessed on September 14, 2018].

13 United Nations, CESCR Committee, *General Comment No. 22 (2016) on the Right to Sexual and Reproductive Health (Article 12 of the ICESC)*. Available at: https://tbinternet.ohchr.org/_layouts/treatybodyexternal/TBSearch.aspx?Lang=es&TreatyID=9&DocTypeID=11 [Accessed on October 19, 2018].

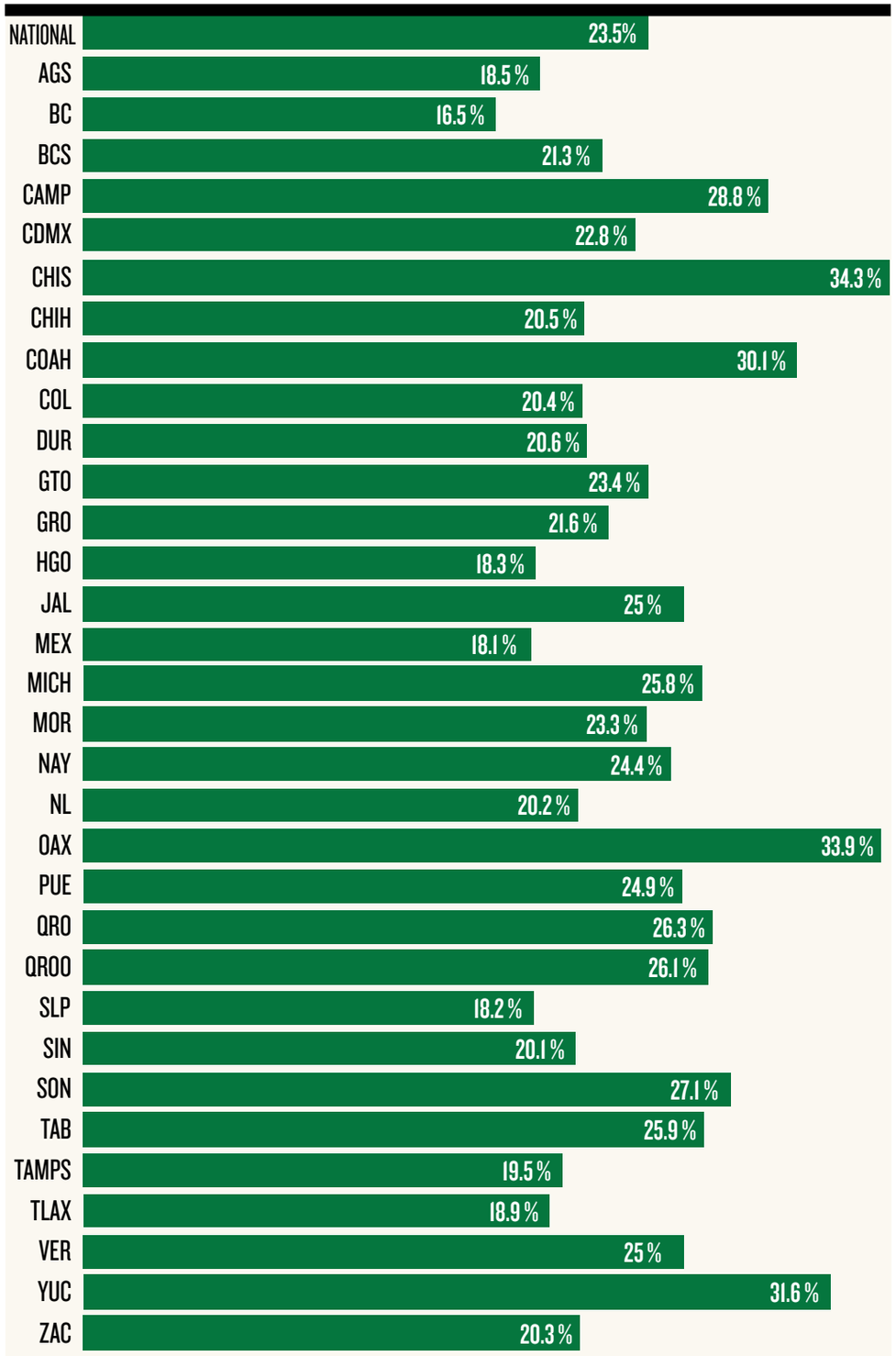
14 United Nations, CEDAW *Committee, Concluding Remarks of the Committee on the Elimination of Discrimination against Women: Mexico* [CEDAW/C/MEX/CO7-8], 52nd Session (2012), paragraph 31. Available at: http://bit.ly/1hhCf09 [Accessed on September 14, 2018].

15 United Nations, Committee on the Rights of the Child, *Concluding Observations on the combined fourth and fifth periodic reports of Mexico* [CRC/C/MEX/CO/4-5], 69th Session (2015), paragraph 46. Available at: http://www.refworld.org/docid/566fc4d14.html [Accessed on September 14, 2018].

16 CONAPO does not make a distinction between adolescents (10 to 19 years of age) and young people (up to 29 years of age) for this data.

UNMET NEED FOR CONTRACEPTIVE METHODS

2014 / WOMEN AGED 15 TO 24



Source: GIRE'S graph based on data from the 2014 ENADID.

On August 12, 2015, the Official Gazette of the Federation published NOM-047-SSA2-2015, On Health Care for the Age Group 10 to 19 (NOM 047). This Norm allows adolescents to request counseling on family planning, sexual and reproductive health, contraceptive methods, unplanned pregnancy prevention, and prevention of sexually transmitted infections (STIs). Adolescents can receive counseling regardless of whether they are accompanied by their parents or legal guardians or representatives.[17]

In the General Law on the Rights of Children and Adolescents,[18] of special significance is Article 50, on the rights to enjoy the highest attainable standard of health and receive free quality health services. Paragraph VI[19] of this Article states that measures will be implemented to prevent pregnancy in girls and adolescents, and paragraph VII states that they will be advised and counseled in matters of sexual and reproductive health.

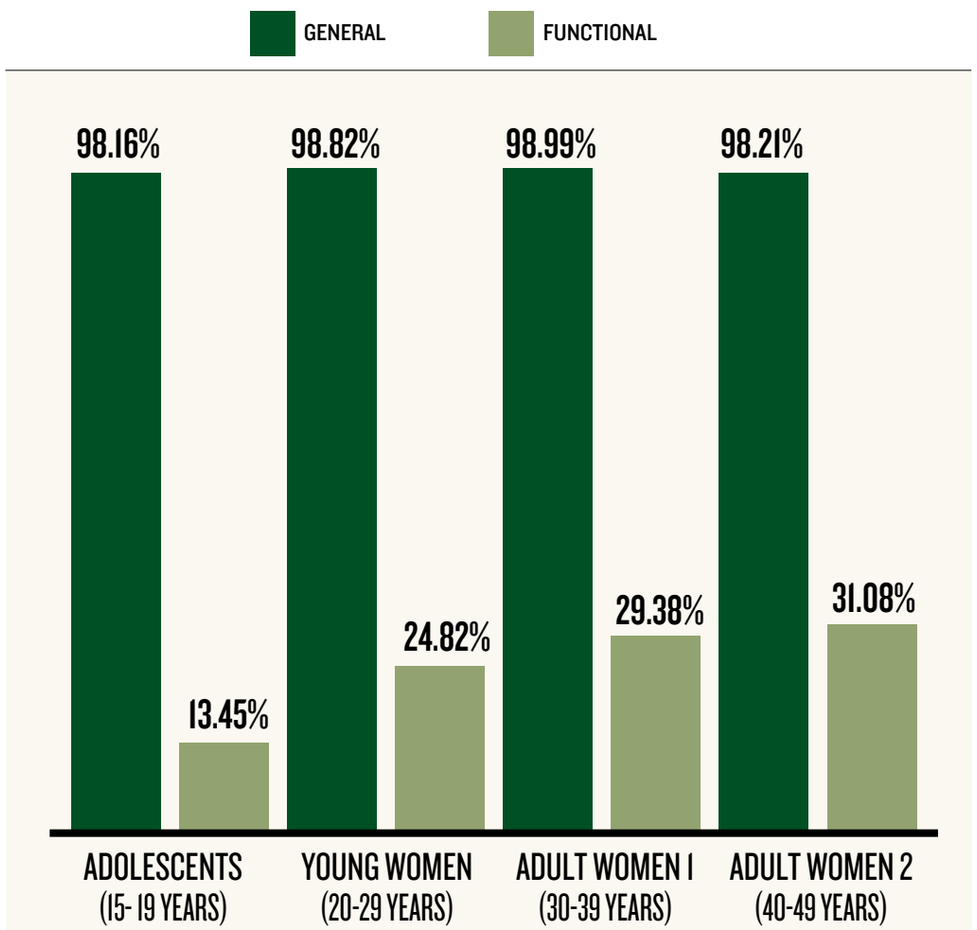
GIRE submitted requests for public information to the federal MOH, IMSS, ISSSTE, and the 32 state MOHs to find out whether individuals under 18 must meet any requirements to request information regarding contraceptive methods. At the federal level, the Women's Hospital reported that to provide contraceptive information to persons under 18, "emancipated girls will request it and in the case of non-emancipated girls, their parents will sign a consent form to meet the minors' contraceptive needs."[20] This is of concern because according to the current NOM, neither this nor any other requirement has to be met to receive contraceptives or contraceptive counseling.

The response from the Women's Hospital is evidence of a complete lack of knowledge of the normative framework that stipulates the State's obligation of ensuring the rights of adolescents to sexual and reproductive health information and services, as well as unrestricted and unconditional provision of preventive supplies for self care. At the state level, there seems to be knowledge of the normative framework among authorities. Statistics notwithstanding, although 98.16% of adolescent girls know about a contraceptive method, only 21.5% reported having used one for pregnancy prevention.[21] Moreover, there is a clear gap between general and functional knowledge of the methods, particularly among younger girls.

17 NOM 047, paragraphs 6.8.5 and 6.8.6.
18 Published in the Official Gazette of the Federation on December 4, 2014.
19 Paragraph amended, published in the Official Gazette of the Federation on June 23, 2017.
20 Request for Information. File Number 0001200375317.
21 ENADID, 2014.

GENERAL VS FUNCTIONAL KNOWLEDGE OF CONTRACEPTIVE METHODS

2014



Source: GIRE'S graph based on data from the 2014 ENADID.

According to existing evidence, there is a considerable lack of knowledge regarding use of contraceptives to prevent STIs and unwanted pregnancies. In addition, due to discrimination, some populations—indigenous groups, people with disabilities—face obstacles in accessing contraceptive information and the methods themselves.

Photo: Chiaroscuro

COUNSELING FOR INDIGENOUS PEOPLE

Ensuring non-discriminatory access for people of indigenous descent to contraceptive information and services is a major human rights challenge for the Mexican State. Specifically, indigenous women in Mexico have suffered serious and systematic violations to their reproductive rights—from forced sterilizations to abuse at health facilities and a lack of access to health information and services in their language and from an intercultural perspective.

According to the 2014 National Survey of Demographic Dynamics (ENADID), 50% of indigenous women of reproductive age gave birth during adolescence. This percentage is higher than that of women who do not speak an indigenous language (45.9%). With regard to contraceptive use among sexually active adolescents, six in ten speakers of an indigenous language did not use contraceptive methods.[22]

22 INEGI 2014, *op. cit*.

According to the 2016 National Survey on the Dynamics of Household Relations (ENDIREH), 20.08% of teenagers that identified themselves as indigenous had been pregnant at least once. This percentage is higher than that of adolescents that did not identify themselves as such (16.15%).

GIRE filed requests for public information with state and federal health institutions to learn whether health centers used interpreters during counseling on reproductive health and contraceptive methods in indigenous languages. Of concern is that, at the federal level, no health institution reported having personnel trained to provide counseling in languages other than Spanish.

The Women's Hospital reported that, given the lack of personnel who speak indigenous languages or trained interpreters, the hospital requests that the women come accompanied by a family member who speaks Spanish, to whom the information is given. Similarly, the IMSS reported that family planning counseling in primary care health centers is conducted in Spanish, and on a state level, they rely on those who accompany the patients for interpretation or translation.[23]

This evidence demonstrates a serious problem in public health services, which transfer responsibility to the patients and their families, instead of guaranteeing access without discrimination to these services as part of the State's obligation.

Sixteen Mexican states reported not having interpreters to provide contraceptive counseling and information in indigenous languages. It is alarming that the Zacatecas health authorities responded that they do not require interpreters since there are no indigenous groups in the state, despite the fact that, according to the National Institute of Statistics and Geography (INEGI), 7.61% of its population identifies as such.[24] Other cases that stand out are the states of Guerrero and Oaxaca, both of which have significant indigenous populations: the first does not have trained personnel to interpret for patients in languages other than Spanish, and the second does not report the requested information.

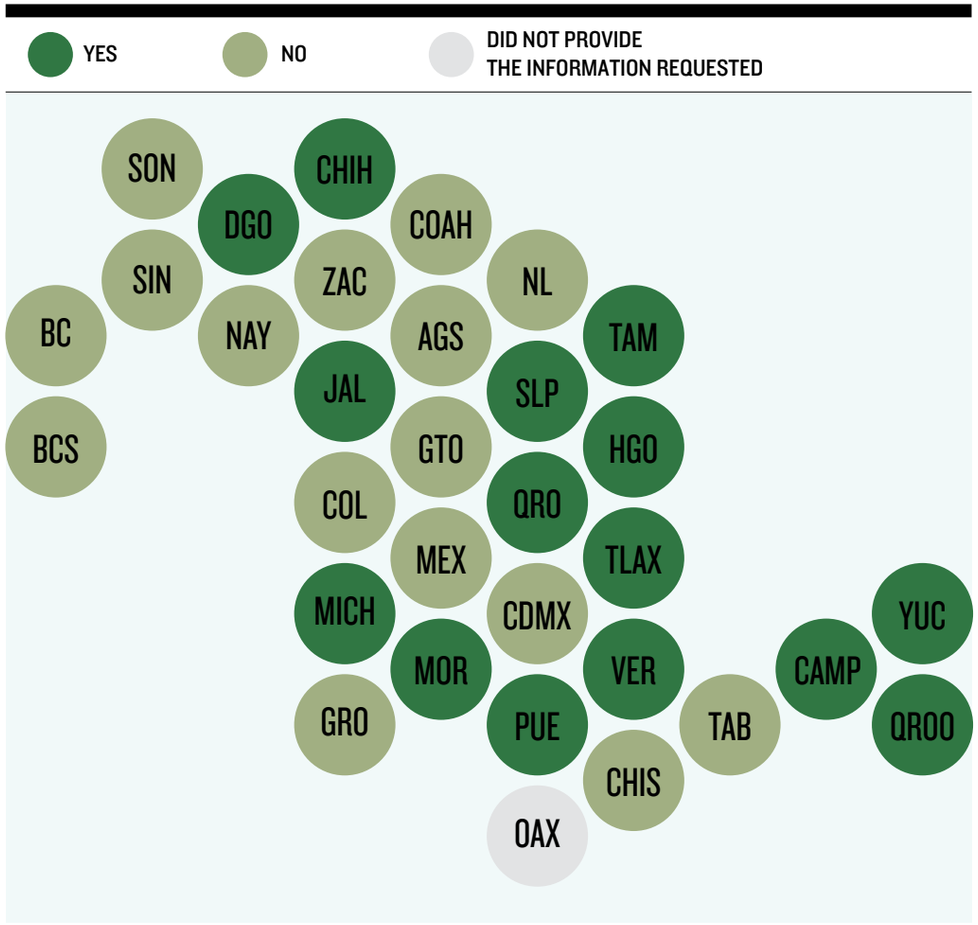
In addition, the 15 states that claimed to have interpreters in their health centers did not provide information about the number available, their training or the languages they speak, so it is impossible to infer whether they are sufficient to meet the demand of people who could require these services.

23 Request for Information. File Number: 0064102851817, "the Coordinating Department for Comprehensive Healthcare at the Primary Level, which belongs to the above Directorate, family planning counseling is provided in Spanish at health facilities under the Mexican Institute of Social Security's Ordinary Scheme.
Locally, there may be service providers or user companions who can speak other languages and may act as interpreters/translators for the women but data on the matter is non-existent because such services are not provided in a consistent manner."

24 INEGI, *Sociodemographic Panorama of Zacatecas*, 2015. Available at: http://internet.contenidos.inegi.org.mx/contenidos/Productos/prod_serv/contenidos/espanol/bvinegi/productos/nueva_estruc/inter_censal/panorama/702825082444.pdf [Accessed on September 16, 2018].

INTERPRETERS FOR CONTRACEPTIVE COUNSELING IN INDIGENOUS LANGUAGES

STATE-LEVEL MINISTRIES OF HEALTH



Source: GIRE'S graph based on data obtained through requests for public information.

NO FEDERAL HEALTH INSTITUTION REPORTED HAVING INDIGENOUS LANGUAGE INTERPRETERS

COUNSELING FOR PEOPLE WITH DISABILITIES

Based on 2014 INEGI data, in Mexico, 6.4% of the population—roughly 7.65 million people—lived with a disability.[25] The information also shows that of all the children (0-17 years of age) in the country, 1.9% have a disability of some kind.[26]

In 2014, 52.7% of people with disabilities reported using institutional social security (IMSS, ISSSTE, Pemex or ISSFAM). Of this group, 50.5% were also beneficiaries of a social program (Universal Health Insurance Program or IMSS-Oportunidades). In terms of the type of facility where they usually sought medical care, 34.9% of the persons with disabilities received care at a MOH health center or hospital; 32.1% at IMSS; 6.2% AT ISSSTE; and the rest at another public or private health service.[27]

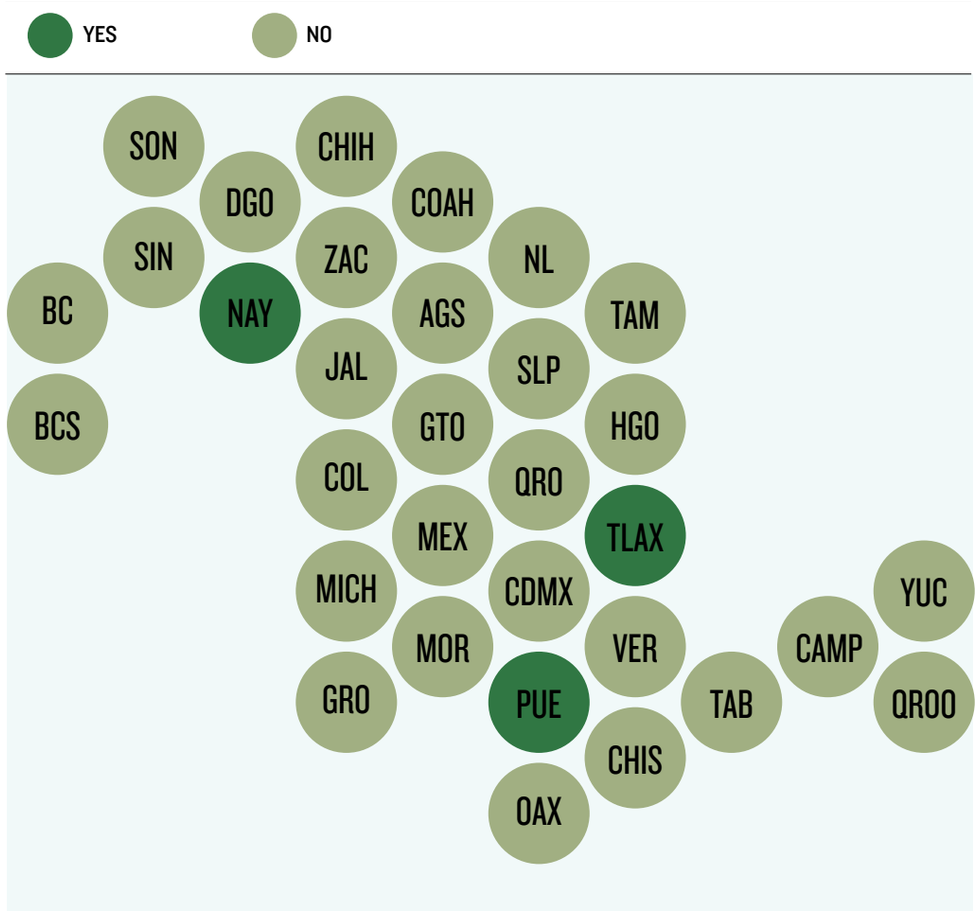
Among the instruments that ensure the respect and exercise of the rights of individuals living with a disability are the General Law for the Inclusion of Persons with Disabilities and its counterparts in each state. Despite the normative framework that protects their human rights, it is necessary to effectively harmonize the Mexican legal system with the Convention on the Rights of Persons with Disabilities to provide these persons with specialized support for decision-making and adopt mechanisms to give them information on sexual and reproductive health and enable them to exercise their human rights in a full, free, and informed manner.

Ensuring the rights of persons with disabilities presupposes, among other things, that counseling services and contraceptive provision consider their needs and characteristics. GIRE submitted requests for public information to find out whether local and federal health institutions had trained personnel and materials—for example, visual materials—specifically designed for this population. No federal health institution reported having such specialized personnel or materials. The IMSS informed that people with disabilities are asked to "come with a person they trust." In contrast, ISSSTE representatives merely reported not having trained personnel, although "staff assigned to the Office of the Deputy Director for Prevention and Health Protection offers care to the general population, corroborating that the insured and uninsured seeking the service can receive it in a direct and easy-to-understand manner, regardless of whether they are hearing, visually or otherwise impaired, by providing them with direct tools to make up for their disabilities that enable them to understand recommendations on reproductive health and contraceptive methods."[28]

25 INEGI, "Diagnostic on the situation of persons living with disabilities in Mexico", May 2016. Available at: www.gob.mx/publicaciones/articulos/diagnostico-sobre-la-situacion-de-las-personas-con-discapacidad-en-mexico?idiom=es.
26 INEGI, "Statistics on the Day of the Child (30 de abril)." Available at: http://www.inegi.org.mx/saladeprensa/aproposito/2017/niño2017_Nal.pdf.
27 INEGI, "Disability in Mexico, Data before 2014," Available at: http://internet.contenidos.inegi.org.mx/contenidos/Productos/prod_serv/contenidos/espanol/bvinegi/productos/nueva_estruc/702825094409.pdf.
28 Request for Information. File Number: 0063700667417.

PERSONNEL TRAINED TO PROVIDE CONTRACEPTIVE COUNSELING TO PERSONS WITH DISABILITIES

STATE-LEVEL MINISTRIES OF HEALTH



Source: GIRE'S graph based on data obtained through requests for public information.

NO FEDERAL HEALTH INSTITUTION REPORTED HAVING SPECIALIZED PERSONNEL.

At the state level, based on the information that GIRE received, only the states of Nayarit, Puebla, and Tlaxcala had staff trained to provide counseling to persons with disabilities. Specifically, Tlaxcala reported not having materials of any kind for visually impaired individuals.

Moreover, a concerning 91% of state-level MOHs lack trained providers to serve individuals with disabilities. Some authorities informed not having specialized personnel but "they're trained to serve this population to the best of their abilities." For the hearing impaired, counseling requires the presence of a companion.

The states of Chiapas, Guerrero, and Tamaulipas reported that although they do not have staff trained for this population, the service that they provide "complies with relevant existing norms." The Morelos MOH informed that nobody living with a disability has sought care at their facilities; they can, however, make information as easy to understand as possible for the user if needed. Evidently, health institutions lack both providers and inputs to ensure provision of services that can meet the needs of persons with disabilities.

The above is a clear example of the forms of discrimination that persons with disabilities face when trying to access reproductive health services. Such discrimination worsens when the users are girls and adolescents. Moreover, Official Mexican Norm 005-SSA2-1993, on Family Planning Services (NOM 005), stipulates that "intellectual disability" is an indication for "bilateral tubal ligation," and thus it assumes that women with mental disabilities must not reproduce. This provision should be eliminated as it is clearly discriminatory and contrary to the human rights that the Mexican State is obligated to ensure. Similarly, it is essential to eliminate all obstacles that individuals living with disabilities face. This means that facilities, services, materials, and contraceptive and reproductive health information should be made as accessible to them as to the rest of the population.

1.2
PUBLIC POLICY

A. NATIONAL STRATEGY FOR THE PREVENTION AND CARE OF ADOLESCENT PREGNANCY

On January 23, 2015, President Enrique Peña Nieto announced the launch of a National Strategy for the Prevention of Adolescent Pregnancy (ENAPEA). This effort seeks to reduce the number of pregnancies among girls aged 15-19 by 50% and eradicate pregnancy among girls under 15 by 2030. To that end, the Strategy proposes five specific objectives, 19 lines of action, and 91 activities, to be implemented by an Institutional Group for Adolescent Pregnancy Prevention.

One of the most important aspects of the Strategy is the fact that the Mexican State has acknowledged that this phenomenon broadens social and gender gaps. Adolescent pregnancy has an impact on the life plan, education, and health of adolescents, especially their human rights, freedom, and personal development.

Although the Strategy acknowledges sexual violence as a cause of child pregnancy, it does not ensure access to emergency contraception and legal abortion for rape among its priority actions, which is contrary to the NOM 046 and the General Law for Victims. As already mentioned, it is essential that the Mexican State acknowledges that adolescent pregnancy is not always the result of a deliberate decision or a lack of contraceptive information.

Several civil society organizations have identified shortcomings in the implementation of actions contemplated by the ENAPEA, specifically those related to a lack of budget and mechanisms for transparency and accountability. In addition to budgetary issues, although one of the pillars of the Strategy is a gender perspective, its analysis of male shared responsibility in reproductive health is limited, which promotes the reproduction of gender roles and stereotypes.[29]

The ENAPEA seeks to reduce the number of pregnancies among adolescents between 15 and 19 years of age by 50% and eradicate pregnancies in girls under 15 by 2030. As shown in the following graph, at the national level, there has been a slight decrease in the number of adolescent pregnancies since the implementation of the Strategy. It is, however, too early to assess its outcomes.

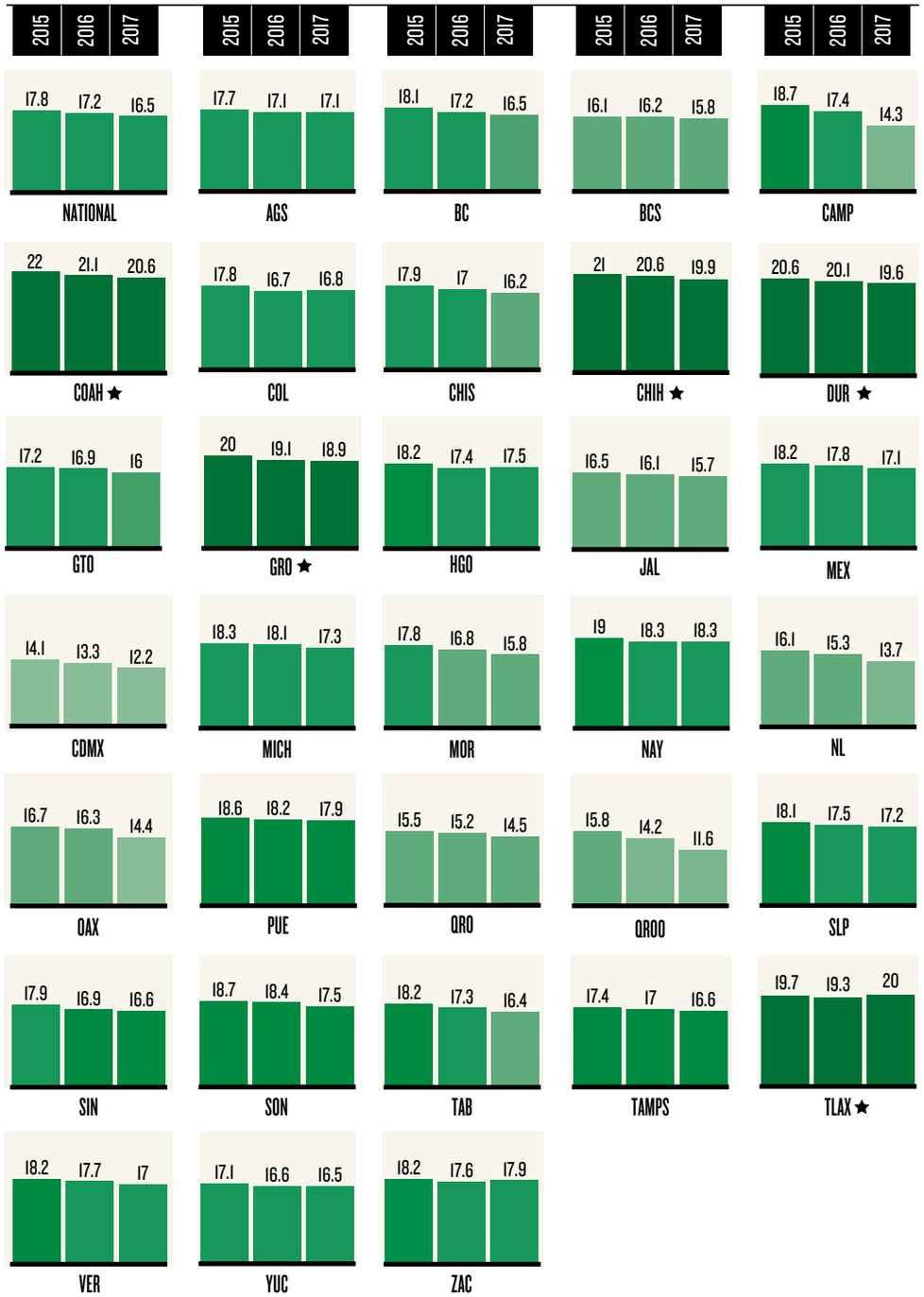
In 2017, five states reported the highest rates of adolescent pregnancies in Mexico. These were: Coahuila (20.6%), Tlaxcala (20%), Chihuahua (18.9%), Guerrero (19.9%), and Nayarit (18.3%). At the national level, there were more than 9,000 births to girls aged 10 to 14. That same year , an average of two girls aged 10-11 gave birth every day.

29 ILSB Género, Innovación y Liderazgo. Situación del embarazo en adolescentes en México, "Increased Transparency and Budget for ENAPEA". Available at: http://www.ilsb.org.mx/embarazoenadolescentes/enapea. "Findings of Social Watchdogs on Male Shared Responsibility". Available at: https://ilsb.org.mx/embarazoenadolescentes/corresponsabilidad.

30 INEGI. Birth Statistics. Available at: http://www.inegi.org.mx/sistemas/olap/Proyectos/bd/continuas/natalidad/nacimientos.asp?s=est&c=23699&proy=nat_nac [Accessed on October 24, 2018].

ADOLESCENTS WHO GAVE BIRTH

2015 - 2017 / PERCENTAGE BY YEAR AND STATE



★ States with the highest rates of adolescent pregnancy.

Source: GIRE's graph based on data from Birth Statistics, INEGI (live births).

In addition to launching the ENAPEA, the Mexican State has bet on the elimination of exceptions to the minimum legal age for marriage to prevent and address teen pregnancy. There is, however, no evidence at the national level that supports the existence of a direct relationship between both phenomena. Moreover, an absolute ban on underage marriage may have other human rights implications that would be questionable from the perspective of the obligations of the Mexican State.

Eliminating the exceptions to underage marriage, even when the partners are already living together, may have an unwanted effect as young women would be more vulnerable. Regarding adolescent pregnancy, country-level evidence suggests that an absolute ban on marriage would not be effective in achieving the intended objective, to say the least. In fact, in Mexico, more young women become pregnant when they live in informal unions than when married: of young women who have been pregnant, only 13% were married, 64% became pregnant while living in informal unions, and 23% were single. The elimination of exemptions would have no significant impact on the reduction of adolescent pregnancies. On the contrary, it may promote an increase in informal unions, which are not eligible for social security benefits related to childcare. [31]

To address adolescent pregnancy, comprehensive measures that consider the multifactorial nature of the phenomenon should be implemented, especially those concerning the prevention and care of sexual violence, such as ensuring access to emergency contraception and legal and safe abortion. Measures like the elimination of marriage exemptions are not only insufficient, but they may also hinder the attainment of the objectives, while neglecting those whose implementation is urgent from a gender and human rights perspective. Although early pregnancy has decreased since the launch of the ENAPEA, it is important to determine whether the decrease has been enough, as well as the pertinence of the proposed strategies, and the factors underlying the regional differences detected.

BETWEEN 2015 AND 2017, THE STATES WITH THE HIGHEST RATES OF BIRTHS TO ADOLESCENT MOTHERS INCLUDED COAHUILA, CHIHUAHUA, DURANGO, GUERRERO AND TLAXCALA.

31 To learn more about the situation of adolescent marriage in Mexico, see GIRE's report, Prohibition without Protection: Adolescent Marriage in Mexico, 2017. Available at: http://matrimonio-adolescente.gire.org.mx.

B. ADOLESCENT PREGNANCY CARE

Complications during pregnancy and delivery are the second cause of death among adolescents 15-19 years old worldwide. Specifically, in Latin America, the risk of maternal death for teenagers under 16 is four times higher than that of women in their twenties.[32] Perinatal death is 50% higher among babies born to mothers aged between 20 and 29.[33] The most common complications among young women include hemorrhage, infection and rupture of membranes, low weight during gestation, prematurity, late fetal mortality and malnutrition.[34] Therefore, this population requires special attention and care from health providers.

According to the 2016 ENDIREH, however, 31.24% of young pregnant women between 15 and 19 years of age reported suffering obstetric violence. This finding reveals that far from receiving specialized care due to the risk inherent in early pregnancy or the special protection owed to minors, pregnant girls and teenagers experience systematic violence at health facilities.

The case of Lupita exemplifies some of the problems girls and adolescents face whose pregnancy should be considered high risk because of their age. Hers, however, is not the only case. From January 2012 to September 2018, GIRE registered 36 cases of obstetric violence (including a collective case); documented 12; and provided legal accompaniment to 46. Of all the cases, four were minors. Also during that period, GIRE provided legal accompaniment to 17 cases of maternal mortality, five of which were underage girls.

32 WHO, *The second decade: Improving adolescent health and development*, Geneva, 2001. Available at: http://www.who.int/maternal_child_adolescent/documents/frh_adh_98_18/en/ [Accessed on October 1, 2018].

33 WHO, *Preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries: what the evidence says*. Available at: https://apps.who.int/iris/bitstream/handle/10665/70813/WHO_FWC_MCA_12_02_eng.pdf?sequence=1 [Accessed on October 1, 2018].

34 Mejía R., Christian, Delgado, Milagros, et. al., "Abuse during adolescent pregnancy: A descriptive study in pregnant women treated in a public hospital in Lima", Chilean Journal of Obstetrics and Gynecology, vol. 83, no. 1, Santiago, February 2018. Available at: https://scielo.conicyt.cl/scielo.php?pid=S0717-75262018000100015&script=sci_arttext [Accessed on October 2, 2018].

LUPITA*

QUERETARO, 2018

Lupita was 15 years old and according to her prenatal control, her pregnancy was progressing well. She was expected to deliver vaginally, although the pregnancy was considered high risk because of her age and the fact that she was overweight. In January 2018, at 39 weeks of gestation, Lupita began to experience cramps and decided to seek care at the Child and Mother Hospital in Queretaro. After having been in labor for some time, her doctors decided to perform a Cesarean section without explaining why. The next day, she was discharged together with her baby, who had been born in perfect health.

Since her pain continued and she had a fever, she returned to the same hospital, where she received another operation. According to the doctors, she had pieces of a retained placenta in her uterus, causing an infection but her file stated that there were few pieces of placenta and that she did not have an infection. Further, the informed consent that was used for the procedure did not have the attending doctor's data—medical license number, name, signature—nor had it been signed by Lupita's witnesses. She stayed in the hospital for several days but her condition did not improve. On the sixth day, she was operated on again, this time to perform a hysterectomy and remove an ovary.

After the second surgery, she underwent two additional procedures. One of them because she had internal bleeding and another because there was fluid in her abdominal cavity. In the days that followed, her fever did not subside, and a doctor ordered a tomography, which was never carried out because the equipment was out of order.

Because of the many complications that she experienced, ten days later she was transferred to the IMSS Century 21 National Medical Center, in Mexico City (CDMX), where she had to be operated on again due to liver damage. Almost a month later, she was discharged but she continues to receive follow-up care at the IMSS facility in Zumpango, Queretaro. She needs special care because as the result of the surgeries, and despite being 15, she must take measures to prevent intestinal occlusion and, moreover, she lives with vaginal prolapse.

On behalf of Lupita, her mother filed a complaint with the Queretaro Office for the Defense of Human Rights that is still being processed. Currently, Lupita receives psychological and medical accompaniment facilitated by GIRE. In addition, GIRE accompanied Lupita to file a legal stay for human rights violations. It is also monitoring the handling of the complaint with the Office mentioned above.

* Her name was changed to protect her privacy.

1.3
CONCLUSIONS

For girls and adolescents, pregnancy, in addition to being a public health concern, is a reproductive justice issue. As such, it stems from a series of actions and omissions by the State that affect several human rights, including the rights to health, a life free of violence, and free development of personality. At present, Mexico ranks first among OECD countries for adolescent pregnancy rates. The State must strive to prevent and address early pregnancy from a gender and an intercultural perspective, while complying with its human rights obligations. The landscape in Mexico shows that girl and adolescent pregnancy stems from a variety of factors, including high rates of sexual violence and a lack of access to services for victims, as well as the gap between general and functional contraceptive knowledge among young people. Even though the relevance of the issue was recognized by the previous administration when it formulated a National Strategy to specifically address this phenomenon, the plan has shortcomings that should be evaluated and corrected if it is to be effective.

Therefore, the State needs to develop specific actions to prevent and address early pregnancy, ensuring access to not only comprehensive sexuality education, contraceptive methods and specialized obstetric care. It also needs to ensure emergency services for victims of sexual violence, particularly legal abortion, without any requirements and obstacles. Further, the Mexican State should make sure that adequate policies are implemented from the perspective of non-discrimination, considering existing barriers so that populations that have been historically discriminated against, such as indigenous women and persons with disabilities, can access health services under a framework of freedom and justice.

Photo: GIRE archive

2

CRIMINA-LIZATION OF ABORTION

CRIMINALIZATION OF ABORTION

WORLDWIDE

99 MILLION

UNINTENDED PREGNANCIES EVERY YEAR

56%

END IN ABORTIONS

2010—2014

56

MILLION INDUCED ABORTIONS

Latin America and the Caribbean has the highest abortion rate[1]

8–11%

maternal deaths are associated with unsafe abortions.[2]

→

6.9 MILLION

Women receive care for unsafe abortion-related complications every year.[3]

OF ALL THE COUNTRIES IN THE WORLD:

6%

BAN ABORTION
IN ALL CASES

21%

ALLOW ABORTION
TO SAVE THE WOMAN'S LIFE

11%

ALLOW ABORTION
TO SAFEGUARD THE WOMAN'S HEALTH

37%

ALLOW ELECTIVE ABORTION

IN MEXICO

UNSAFE ABORTION IS THE FOURTH LEADING CAUSE OF MATERNAL DEATH

Source: Maternal Mortality Observatory, 2015.

Only Mexico City (CDMX) and Oaxaca (as of October 2019) allow elective abortion within the first 12 weeks of gestation. In the rest of the country, women can have an abortion in cases of rape and, depending on the state, for other reasons, including when the woman's life or health is at risk, serious fetal abnormalities, and socioeconomic reasons.

UP TO SIX YEARS IMPRISONMENT FOR HAVING AN ABORTION
for reasons not stated in the law.

1 Bearak J. *et al*., "Global, regional, and subregional trends in unintended pregnancy and its outcomes from 1990 to 2014: estimates from a Bayesian hierarchical model," in Lancet Global Health, 2018, 6(4):e380–e389.
2 Data tables from Say et al., "Global causes of maternal death: a WHO systematic analysis," in *Lancet Global Health*, 2014, 2(6):e323–e333, http://dx.doi.org/10.1016/S2214-109X(14)70227-X.
3 Singh S and Maddow-Zimet I, "Facility-based treatment for medical pregnancy termination in the developing world, 2012: a review of evidence from 26 countries," in BJOG, 2016, 123(9):1489–1498 http://dx.doi.org/10.1111/1471-0528.13552.


Photo: Carlos Quijo

In Mexico, state-level penal codes stipulate the indications or circumstances when a woman can have an abortion without breaking the law. This, in practice, is legal discrimination because women have more or fewer legal abortion rights depending on which state of the country they live. Numerous bills have been submitted to decriminalize abortion at the state level, though none have been passed to date, except for Mexico City in April 2007 and Oaxaca in October 2019. The Mexico City Program for the Legal Termination of Pregnancy (the ILE Program) has been an example—at the national and regional level—of how to provide access to legal, safe, and free abortion services to women living in Mexico City (CDMX) and other states in the country and even from other countries.

Despite the normative framework, access to legal abortion in Mexico is very limited or non-existent. Authorities and health providers are largely unaware of their obligations. They impose requirements that are not stated in the legislation and thus hinder access to legal abortion services; allow antichoice groups to disseminate misinformation; violate professional confidentiality; and criminalize women experiencing obstetric emergencies.

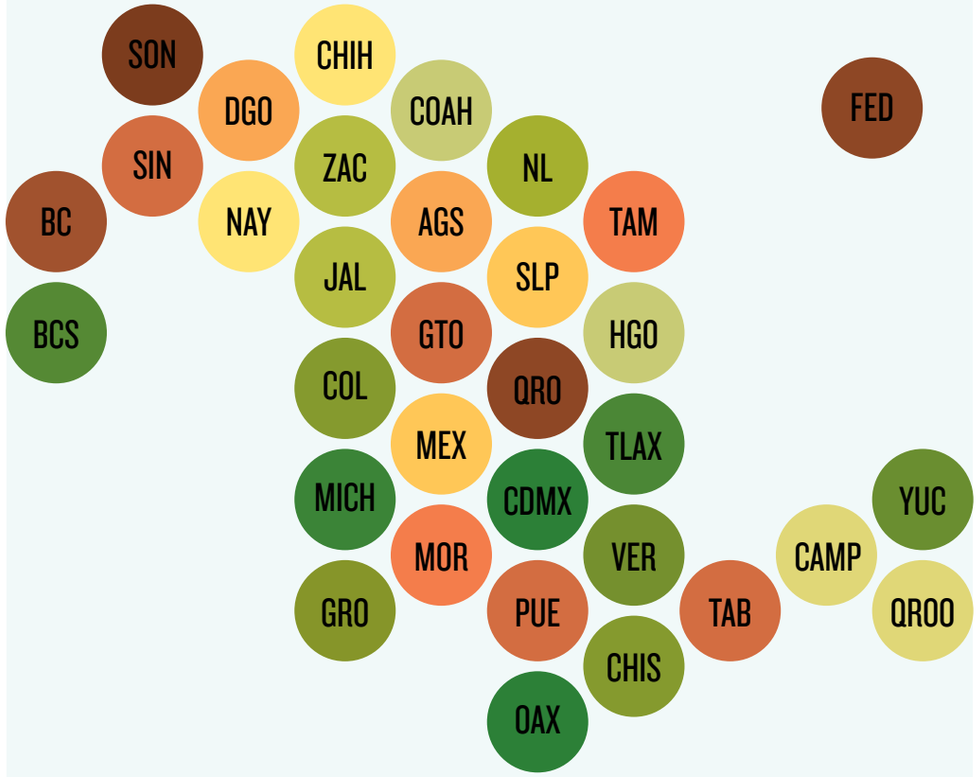
2.1
SITUATION IN MEXICO

A. LEGAL INDICATIONS

Regulated on a state-by-state basis, abortion is considered a crime for which there are exculpatory circumstances or situations where it is not punishable. In other words, there are cases where abortion is not punished or is not considered a crime. In the last decade, some Mexican states have increased the number of legal abortion indications in their penal legislation, thus making it less restrictive. Of note is the inclusion of the indication for the risk to the woman's health in Colima (2011), Guerrero (2014), and Coahuila (2017), as well as the exemption of responsibility when the woman lives in a precarious financial situation in Michoacan (2016). Currently, all penal codes consider that abortion for rape is not punishable or is grounds for exculpatory circumstances; 29 states allow abortion for imprudent or negligent behavior; 23 when the pregnant woman's life is at risk; 15 when the woman's health is at risk; 16 when the fetus has severe genetic or congenital anomalies; 15 when the pregnancy is the result of non-consensual artificial insemination; and two under financial hardship. The Federal Penal Code stipulates that abortion will not be punishable only when it is unintended, the result of rape, and the woman's life is at risk. The above restrictions have been obstacles to women seeking abortion services at federal health institutions, even in states whose legislation includes a larger number of legal indications. In contrast, Mexico City and Oaxaca are the only states that allow elective abortion within the first 12 weeks of gestation.

THE CRIME OF ABORTION IN MEXICO

GIRE CLASSIFIED THE NORMATIVE FRAMEWORKS ON ABORTION IN PENAL CODES BASED ON 1) NUMBER AND TYPE OF INDICATIONS AND 2) SEVERITY OF THE PENALTIES (IF ANY).



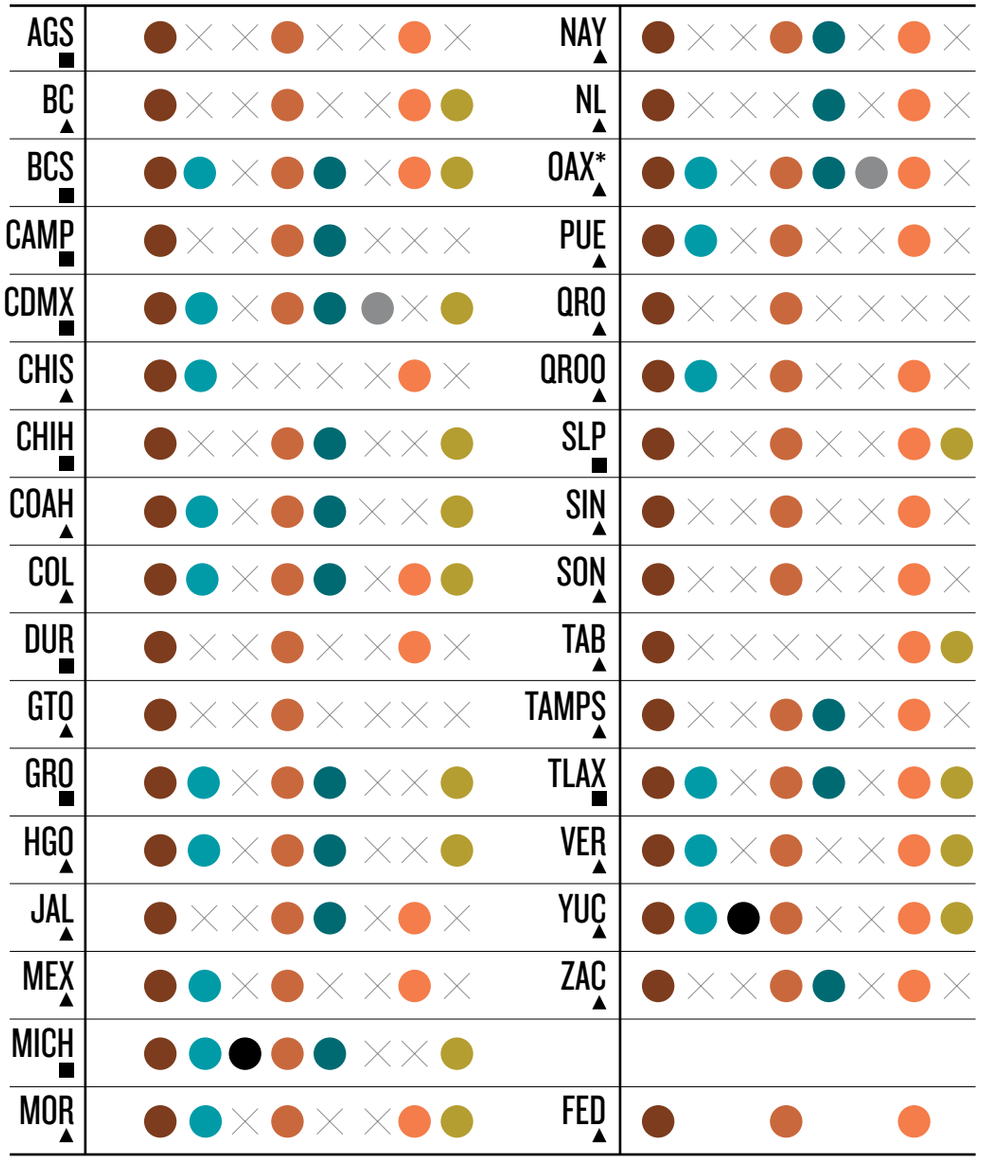
SONORA	22.8	CAMPECHE	48.5
QUERETARO	27.1	QUINTANA ROO	48.5
FEDERAL	27.1	COAHUILA	50
BAJA CALIFORNIA	30	HIDALGO	50
GUANAJUATO	35.7	JALISCO	51.4
PUEBLA	35.7	ZACATECAS	51.4
SINALOA	35.7	NUEVO LEON	52.8
TABASCO	35.7	COLIMA	54.2
MORELOS	38.5	CHIAPAS	54.2
TAMAULIPAS	38.5	GUERRERO	55.7
AGUASCALIENTES	41.4	VERACRUZ	60
DURANGO	41.4	YUCATAN	64.2
MEXICO	44.2	BAJA CALIFORNIA SUR	68.5
SAN LUIS POTOSI	44.2	TLAXCALA	76.4
CHIHUAHUA	47.1	MICHOACAN	77.1
NAYARIT	47.1	CDMX	80.7
		OAXACA	80.7

Source: GIRE, November 2019.

ABORTION INDICATIONS

IN PENAL CODES

- RAPE(33)
- UNINTENDED/NEGLIGENT (30)
- RISK TO THE MOTHER'S LIFE (24)
- SERIOUS FETAL GENETIC/CONGENITAL ABNORMALITIES (16)
- HEALTH(16)
- NON-CONSENSUAL INSEMINATION (15)
- FINANCIAL REASONS (2)
- WOMAN'S CHOICE (UP UNTIL 12 WEEKS GESTATION) (2)



Source: GIRE, November 2019.

*As of October 2019.

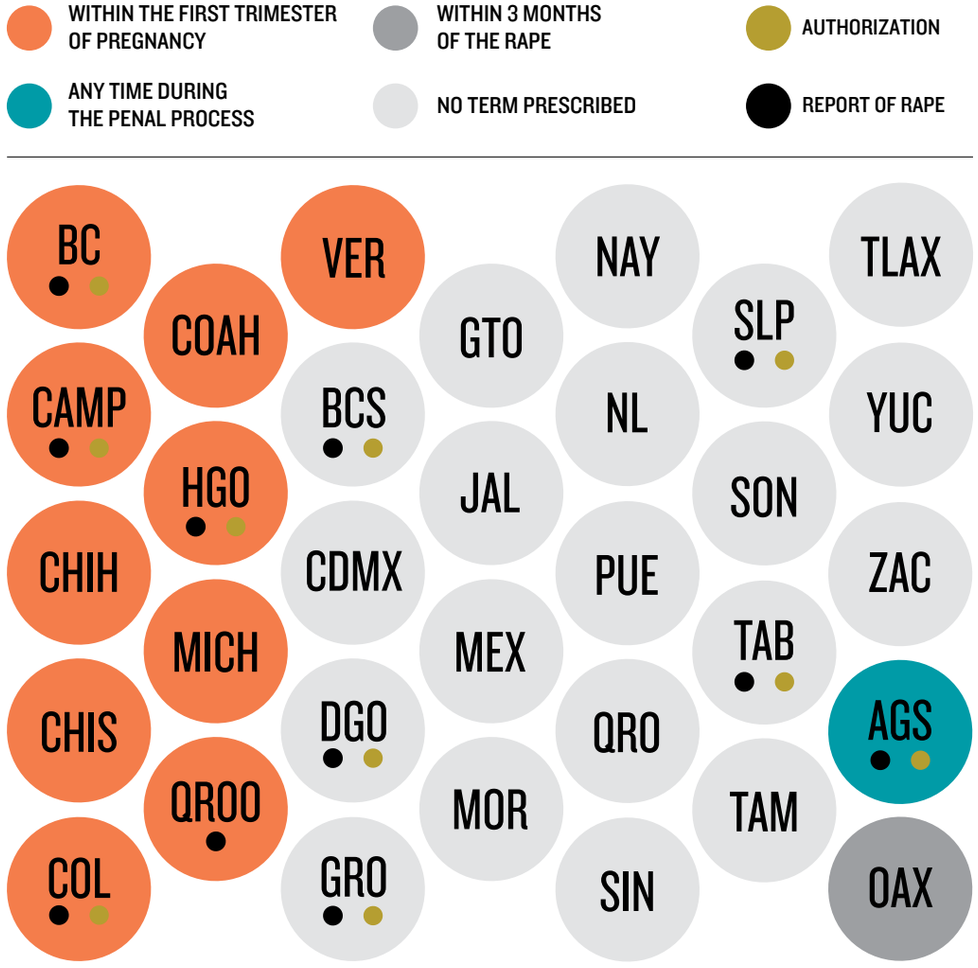
■ EXCULPATORY CIRCUMSTANCE

▲ NON-PUNISHABLE

ACCESS TO ABORTION — CASES OF RAPE

The only legal indication for abortion accepted in every state in Mexico is when the pregnancy is the result of rape. The General Law for Victims and Mexican Official Norm 046-SSA2-2005, On Domestic and Sexual Violence and Violence against Women, Criteria for Prevention and Care (NOM 046), stipulate that access to the service must be ensured for all women and that no requirement other than a sworn statement that the pregnancy is the result of rape will be imposed. No report or authorization is necessary. Further, women aged 12 or older can request the service without having to be accompanied by their parents or legal guardians. In practice, however, the authorities hinder or deny access to abortion by requesting compliance with additional requirements, including reporting the rape to the police or obtaining authorization from a Public Prosecutor's Office. This reveals a lack of knowledge of their obligations, as well as a lack of harmonization of protocols, administrative guidelines, and penal codes with current legislation regarding victims of sexual violence.

REQUIREMENTS TO ACCESS ABORTION IN CASES OF RAPE, AS STATED IN PENAL CODES



10 STATES STIPULATE AUTORIZATION IS REQUIRED

12 STATES ESTABLISH A TERM FOR THE ABORTION

11 STATES REQUIRE REPORTING THE RAPE

Source: GIRE, October 2018.

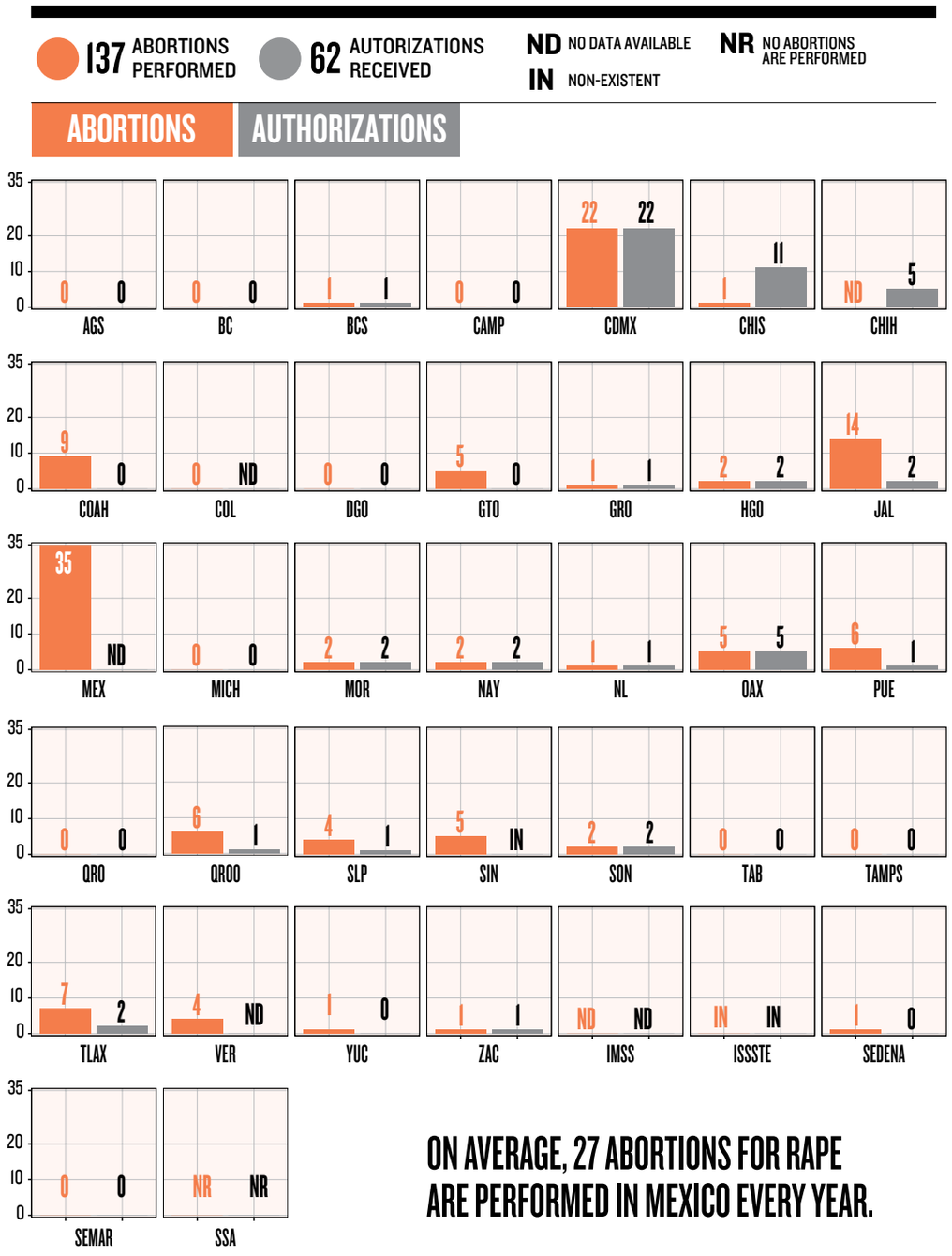
The lack of harmonization of legislation on the care of victims with the penal codes of some states in Mexico places women living those states at a disadvantage. They must overcome greater obstacles to receive abortion services. Consequently, modifying the norms is a pressing need, just as it is essential that health workers know and comply with their obligation to provide services of abortion for rape without imposing any additional requirements. They must also become sensitized to issues facing the victims to prevent behaviors such as verbally abusing women seeking a legal abortion.

Although rape is the only legal indication for abortion accepted in all the country, access to abortion services, as documented by GIRE, is very limited or non-existent. Because there are no available public statistics on the matter, GIRE submitted requests for information to federal and local health institutions and Attorney General Offices. In total, the health services reported having performed 137 abortions for rape from December 2012 to October 2017 and having received 62 service authorizations. This means that they performed an average of 27 abortions a year in the country. Of the 137 abortions, 52 were provided to underage girls, some of whom were 10 years old.

In general, it is striking to see how little information federal health institutions provide. Either they are unaware of the number of abortions they perform or they fail to report them despite being obliged to do so. Further, based on the responses GIRE received, the case of Chiapas stands out: the number of authorizations is greater than that of procedures reported. To date, it is still not clear why not all abortions were performed.

ABORTIONS IN CASES OF RAPE REPORTED BY HEALTH INSTITUTIONS

DECEMBER 2012 - OCTOBER 2017



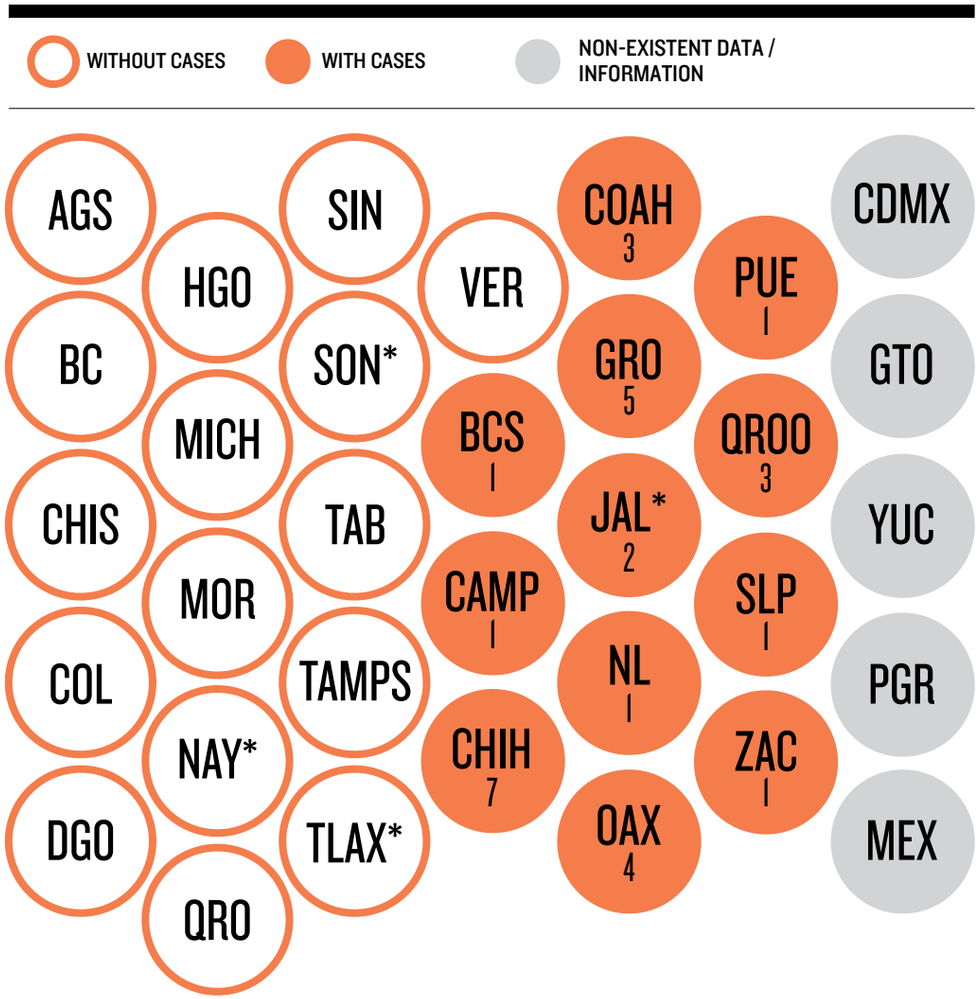
ON AVERAGE, 27 ABORTIONS FOR RAPE ARE PERFORMED IN MEXICO EVERY YEAR.

Source: GIRE's graph based on data from requests for public information.

AUTHORIZATIONS TO PERFORM ABORTIONS FOR RAPE REPORTED BY STATE PUBLIC PROSECUTOR'S OFFICES

DECEMBER 2012 - OCTOBER 2017

30 AUTHORIZATIONS



* They recognize that with the reform to NOM 046, it is no longer necessary to obtain an authorization to have an abortion after rape.
Source: GIRE's graph based on data from requests for public information.

According to the graph shown, between December 2012 and October 2017, as reported by Attorney General or Public Prosecutor's Offices, there was a total of 30 authorizations for abortion after rape. In some cases, the information provided was not disaggregated as requested or the figures did not match the number of authorizations detailed by state MOHS for the same period. In addition, when asked to give information about the time elapsed between submitting a request and obtaining an authorization, most states informed that the response time was less than a week. Nevertheless, some states revealed that it could take months to give women an authorization, which hinders their effective access to what is considered an emergency service. Such is the case of Nuevo Leon; after three and a half months, an authorization was not granted because the doctor had reported that the termination "was risky for the victim."[1]

Positive cases are Jalisco, Nayarit, Sonora and Tlaxcala, where the authorities themselves recognized that authorizations are not needed in accordance with general legislation and referred to information that predated the changes. Nevertheless, 11 penal codes still stipulate the requirement of reporting the rape, and ten still require an authorization from a judge or a Public Prosecutor's Office.[2] Thus, there is a lack of clarity among authorities regarding their obligations, which ultimately translates into obstacles to services that the General Law for Victims and NOM 046 regard as emergency care.

ACCESS TO ABORTION — OTHER LEGAL INDICATIONS

Regarding other indications for access to abortion, there is little information in Mexico to determine whether indeed health institutions provide the services. To obtain relevant data, GIRE submitted requests for information in accordance with the legal indications in each state. In most cases, however, the agencies legally bound to provide information only reported the total number of "medical abortions" in their records—without information on the specific legal indications or distinction between a miscarriage and an abortion induced by the woman or a health provider—or, once again, the cases of abortion for rape. Only two states provided the information that GIRE requested: Morelos, which reported performing four abortions because the women's life was at risk, and San Luis Potosi, which registered one case but without mentioning the indication.[3]

The absence of data on legal indications for abortion is a major hindrance to the identification of obstacles to abortion services in different parts of the country or the development of a profile of the woman who requests the services. In addition to the medical abortions registered in the Health Information System, vital statistics produced by INEGI distinguish between miscarriage, induced abortion, and therapeutic abortion.[4] According to these figures, at the country level, a total of 610 induced abortions and 2,149 therapeutic abortions were performed between 2012 and 2016. Nonetheless, as with the data obtained from the Health Information System, GIRE was unable to determine if the above were either incomplete abortions (either miscarriages or induced abortions) attended to by health workers or legal abortions performed, for example, due to health reasons or because the woman's life was at risk or the fetus had severe anomalies. Moreover, the information was only about women seeking hospital care after or for an abortion. Hence, the total number of induced abortions is under-registered in Mexico, particularly because medication is increasingly used to induce abortions.[5]

1 Request for Information. File Number: 01260917.
2 As of August 2018, the penal codes of Aguascalientes, Baja California, Baja California Sur, Campeche, Colima, Durango, Guerrero, Hidalgo, San Luis Potosi, and Tabasco required an authorization and a report of the rape. Quintana Roo only required reporting the rape.
3 Request for Information. Health Services. File Numbers 00650118 (Morelos) and 00686217 (San Luis Potosi).
4 A therapeutic abortion is the procedure performed by medical indication.
5 In Mexico, of all the abortions in 2007, an estimated third was performed with medication, specifically misoprostol. See: Juarez F. et al., *Unintended Pregnancy and Induced Abortion in Mexico: Causes and Consequences*, New York: Guttmacher Institute, 2013. Available at https://www.guttmacher.org/report unintended-pregnancy-and-induced-abortion-mexico-causes-and-consequences.

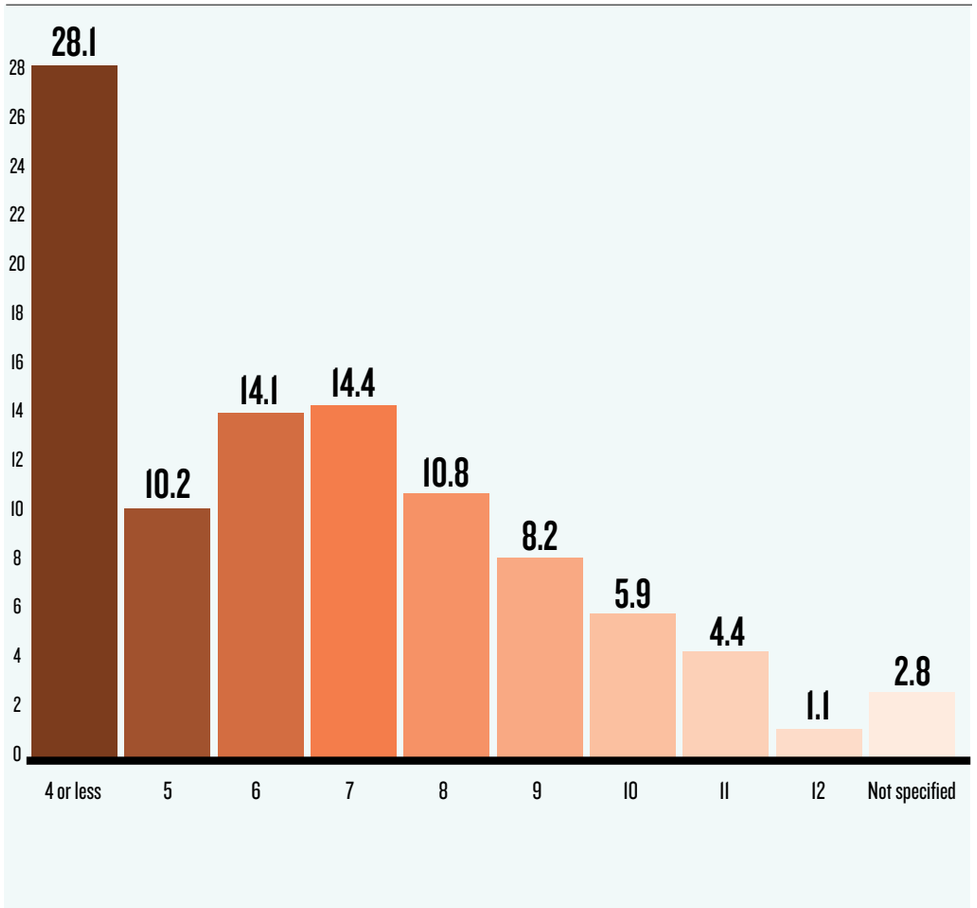
B. THE MEXICO CITY LEGAL ABORTION PROGRAM

On April 26, 2007, a reform to the Mexico City Penal Code and Health Law was published, thereby decriminalizing abortion within the first 12 weeks of gestation. In addition, it decreased the penalties for those who terminate a pregnancy at a later gestational age or for reasons not stipulated in the law. In those cases, the penalty is now 3-6 months' imprisonment or 100-300 days' community work. Also, because of the reform, the Mexico City government implemented a health service program for women who want to terminate their pregnancy—the Program for the Legal Termination of Pregnancy (the ILE Program).

April 2017 marked the tenth anniversary of the Mexico City ILE Program. A decade of access to legal and free abortion has made it possible to collect statistical information about the profile of women who request it, as well as challenge some of the most common myths surrounding the decriminalization of abortion and its consequences. The data obtained reveal the frequency with which abortions are induced with medication and also that most of them take place at four weeks of gestation or earlier.

NUMBER OF PREGNANCY TERMINATIONS BY WEEKS OF GESTATION

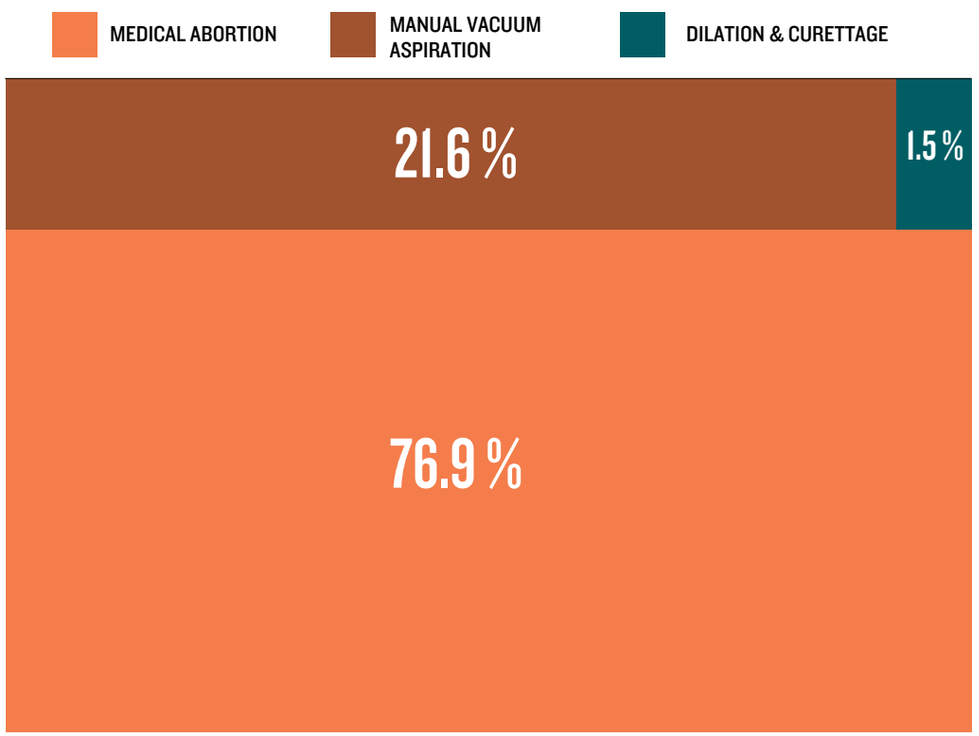
APRIL 2007 — OCTOBER 2018



Source: GIRE's graph based on data from the ILE Information System.

TYPE OF PROCEDURE PERFORMED AT ILE SERVICES

APRIL 2007 — OCTOBER 2018

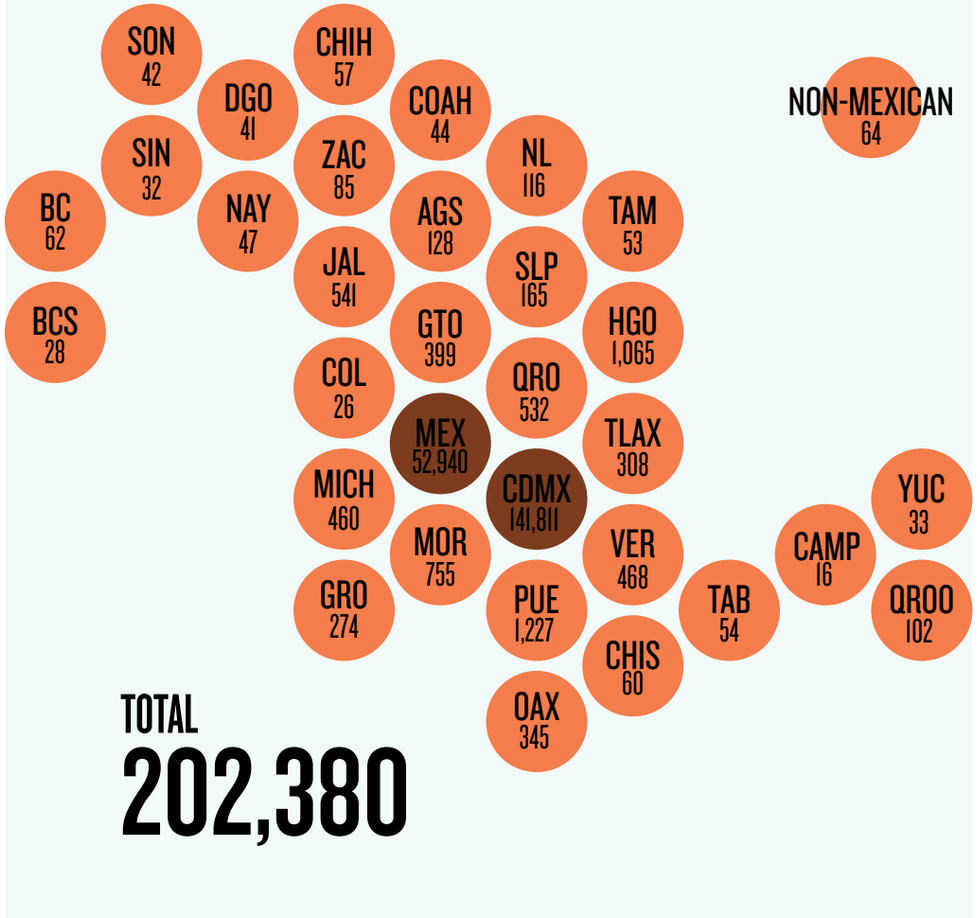


Source: GIRE's graph based on data from the ILE Information System.

Photo: Shutterstock

NUMBER OF WOMEN THAT RECEIVED CARE FROM ILE SERVICES BY STATE OF ORIGIN

APRIL 2007 — OCTOBER 2018



Source: GIRE's graph based on data from the ILE Information System.

Statistics on the ILE Program show that service users live not only in Mexico City but in other states where abortion is criminalized or inaccessible. Slightly over ten years after the implementation of the ILE Program, by October 2018, a total of 202,380 women had received the services. Of these women, roughly 70% live in Mexico City and the rest come mainly from the State of Mexico (26.1%), Puebla, Hidalgo, Morelos and Jalisco.

For women who request an elective abortion outside the term established in the law, the Mexico City penal code provides for the possibility of receiving the services under certain circumstances. On April 25, 2018, an update to the General Guidelines on Health Service Organization and Operation for the Termination of Pregnancy in Mexico City was published. This update includes some worrisome elements. First, it introduces a confusing classification that distinguishes between elective abortions and those performed in accordance with the indications in the penal code, without clarifying that in all cases they are elective and legal abortions. More importantly, the update considers requirements—not stated in the penal code—that must be met to receive an abortion after rape, thus contradicting the stipulations in the General Law for Victims.

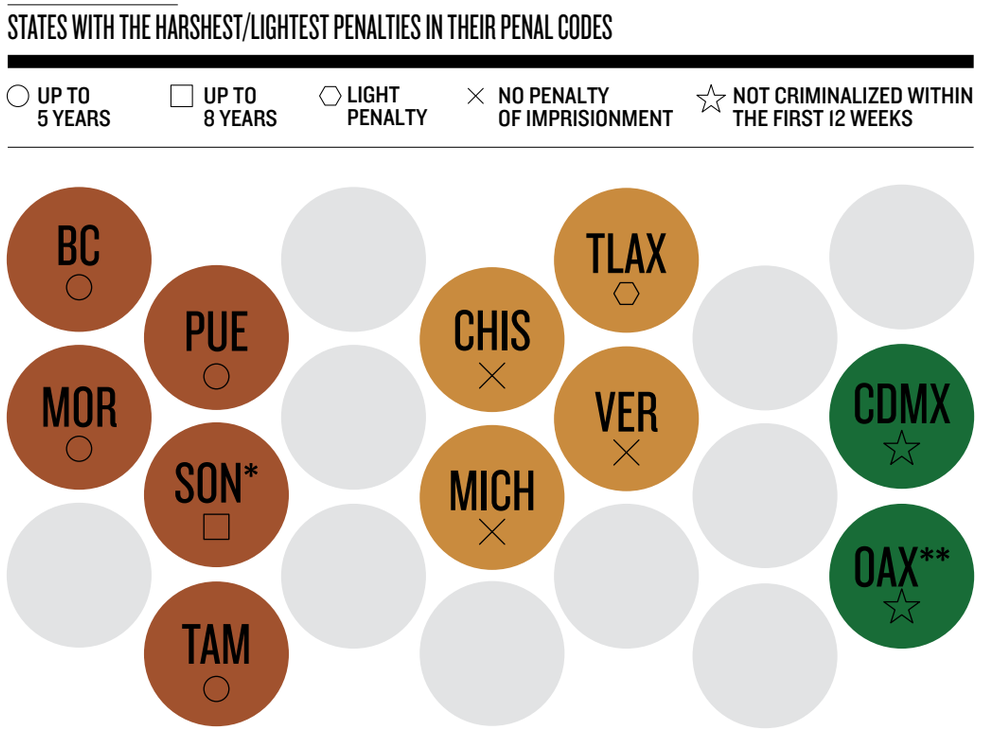
Among the above requirements is the intervention by the Mexico City Office for the Defense of Children and Adolescents to grant adolescents aged 12 and older access to abortion. Another requirement is the obligation of providing information related to the reporting of the facts before a Public Prosecutor's Office. This obligation is disproportionate and contradicts stipulations in the NOM 046: the only requirement is a sworn statement in writing that the pregnancy is the result of rape. In like manner, of concern is the limit to the number of weeks of gestation within which an abortion for rape can be authorized. Besides not being specified in the local penal code, the General Law for Victims, or the National Code of Penal Procedures, this requirement affects the rights of victims of sexual violence.

C. PENALTIES IN MEXICAN PENAL CODES

The crime of abortion in Mexico is not regarded as a felony, due to which, in accordance with Article 155 of the recent National Code of Penal Procedures, the accused can remain free during the criminal process after precautionary measures are enforced such as bail. Despite being deemed a positive change, it is important to consider that paying bail can be a significant burden for most of the women facing criminal processes as they live in financial marginalization and often lack the necessary resources to make bail. The penalties for the crime of abortion range from imprisonment—from 15 days to 6 years—, fines, and community work to different forms of medical or psychological treatment.[6] Interestingly, the following states impose the longest length of imprisonment, as well as the lightest penalties on women.

PENALTIES FOR WOMEN WHO HAVE AN ABORTION

STATES WITH THE HARSHEST/LIGHTEST PENALTIES IN THEIR PENAL CODES



*According to the National Code of Penal Procedures, for penalties longer than five years, there is no possibility of early release. Therefore, women sentenced to the maximum penalty as per the Sonora Penal Code are the only ones who are not eligible for early release in the country.

**As of October 2019.

Source: GIRE, November 2019.

6 For detailed information on the penalties imposed by each state on health providers and women who have induced an abortion, see GIRE, *Maternity or Punishment: Criminalization of Abortion in Mexico*, 2018. Available at: criminalizacionporaborto.gire.org.mx.

The penal codes also criminalize those who help a woman have an abortion. Not only does this situation contribute to stigmatizing abortion but also to restricting access to safe abortion at health services. The codes include similar penalties and, for health workers, they also contemplate suspension of professional license. Consequently, rather than safeguarding women's health, hospital personnel focus on avoiding any potential liability, letting pass their obligation for doctor-patient confidentiality. In fact, most abortion reported in Mexico stem from health providers, who report or threaten to report women who, in their opinion, have undergone an induced abortion.

The Mexican legal framework allows abortion under certain circumstances. Nevertheless, the fact that it is deemed a crime, the lack of knowledge by public servants of normative frameworks in effect, and the confusion created by reforms to some state constitutions influence the performance of authorities, who deny legal services due to fear or prejudice, thus violating the human rights of girls and women who request them. Maritza's case exemplifies this situation.

MARITZA*

CDMX, 2018

In April 2018, Maritza, who was 15 weeks pregnant, started bleeding and decided to go to the IMSS Hospital of Gynecology and Obstetrics Number 4. There, she was told that the bleeding was caused by her cervix, which was opening, and was discharged the following day. Weeks later, she started bleeding again and decided to return to the hospital. This time they told her that she needed a dilation and curettage. Several hours later, her attending physicians told Maritza her pregnancy was still viable and her condition did not require an abortion. Maritza was worried about the care she was receiving because she had been recently operated to remove tumors from her thyroid and was about to start iodine treatment to eliminate potential cancer cells. She voiced her fear of bleeding again.

Therefore, accompanied by GIRE's legal team, she filed a legal stay to ensure that she would receive necessary, sufficient and appropriate health services to safeguard her integrity and life. In response, the judge ordered the health system to provide her with "appropriate medical care."

Maritza stated that she wanted to terminate her pregnancy because of her health status. A visiting doctor replied that her request would be assessed by the Bioethics Council at the hospital to determine whether the abortion was lawful. If that was the case, she would have to undergo a hysterectomy to prevent complications due to her previous bleeding.

Later, the attending doctor said that they would not perform the procedure because Maritza was medically fit to continue the pregnancy. He added that she should have been careful not to get pregnant and that it was "a crime to kill a 15-week-old baby."

The doctor asked Maritza if she wanted to continue her pregnancy because she did not seem "willing" to keep it. He also told her that their assessment was based on the information in her file, that they were unaware of her thyroid cancer, and that she should ask the attending oncologist to write a letter specifying the diagnosis so that an IMSS oncologist could validate it. Only then would they convene the Bioethics Council to review her case again.

On May 13, Maritza started bleeding for the third time. By then, she was seriously afraid for her life. The following day, after a fourth hemorrhage, she finally underwent emergency dilation and curettage.

Maritza said that when she asked if what had happened to the pregnancy could have negatively affected her health, the doctor told her that the important thing was to try to "save her baby's life," and that he was unable to tell her more about her health.

* Her name was changed to protect her privacy.

The criminalization of abortion affects all women, but the ones who suffer the consequences more directly are the women being reported and processed for the crime of abortion and for other offenses related to reproductive processes, such as infanticide and homicide of relatives. To learn about the patterns and magnitude of the criminalization of abortion, GIRE submitted requests for information to attorney general and public prosecutors' offices.

PENAL PROCESSES FOR THE CRIME OF ABORTION[7]

JANUARY 2007- DECEMBER 2016

4,246 REPORTS OF THE CRIME OF ABORTION; ONE REPORT A DAY.

531 CRIMINAL TRIALS, **228** SENTENCES.

83 INDIVIDUALS IN PREVENTIVE DETENTION FOR THE CRIME OF ABORTION, **44 OF WHOM ARE WOMEN.**

53 IMPRISONED INDIVIDUALS, **19 OF WHOM ARE WOMEN.**

Using transparency mechanisms, GIRE obtained public versions of the sentences for women accused of the crime of abortion that revealed an alarming pattern. In most cases, women—among them minors—are reported by hospital staff, who tend to interrogate them in contexts of medical emergencies, driven by prejudice and discriminatory stereotypes, without guaranteeing presumption of innocence or due process. The cases are often based solely on self-incriminatory confessions obtained under duress and in contexts of medical emergencies.

Of concern are the documented cases of women who have an abortion or a miscarriage and are also accused of such crimes as infanticide or homicide. Women who are criminalized for the latter crimes and those who are tried for the crime of abortion come from similar backgrounds: precarious financial situations, lack of access to health services, and contexts of sexual, domestic and institutional violence. Women accused of the crime of abortion are reported by hospital workers or their own relatives, and their criminal processes are ripe with irregularities, violations to due process, and sentences colored by gender stereotypes. Further, they pay harsher penalties and face more adverse circumstances in accessing justice.[8]

7 For more information, see GIRE, 2018, *op. cit.*
8 For more information on some of these stories, see GIRE, 2018, *op. cit.*

D. CONSTITUTIONS THAT "PROTECT LIFE" FROM CONCEPTION

Since 2008, in response to the decriminalization of abortion in Mexico City, conservative groups have promoted a major wave of reforms to state-level constitutions to "protect life from conception." The reforms sought to restrict women's reproductive rights and prevent access to legal and safe abortion, as well as hinder future attempts to include more indications or decriminalize abortion.

Nevertheless, in Artavia Murillo *et al.* v. Costa Rica, in 2012, the Inter-American Court of Human Rights (the Court) conclusively interpreted protection of prenatal life by redefining it as protection of women's reproductive rights. Thus, the Court resolved that

a) Conception refers to the implantation process; that is, when the fertilized egg adheres to the lining of the uterus (endometrium).
b) The fetus cannot be considered a person.
c) The protection of prenatal life is gradual and incremental.
d) Only by exercising women's rights can prenatal life be protected.

Thus, despite their initial objective, the above constitutional reforms are not a legal obstacle to abortion in the cases stated by law or to future reforms seeking to decriminalize abortion in other states in the country. Nonetheless, they have helped to promote an environment of confusion and legal uncertainty for health and law enforcement personnel and for the women themselves as to the legality of abortion in the circumstances stipulated by law.

Because of the above reforms, in Veracruz, an unconstitutionality claim submitted by the National Human Rights Commission (CNDH) is pending review at the SCJN. GIRE hopes that after reviewing the case, the Supreme Court rules that protection of prenatal life is compatible with the legal indications for abortion, based on the decision by the Inter-American Court in the case Artavia Murillo *et al.* v. Costa Rica.

On September 28, 2018, the Sinaloa Congress passed a reform to Constitutional Article 4 to include the protection of life from conception. In March 2019, the Nuevo Leon legislature approved a similar reform. Including this latest reform, currently 20 Mexican state constitutions contain protection of life from the moment of conception provisions.

STATE CONSTITUTIONS THAT "PROTECT LIFE FROM CONCEPTION"

2008 - 2019

*Chihuahua reformed its constitution in October 1994. Therefore, it is not included in the set of reforms carried out during the 2008-2019 period.

Source: GIRE, November 2018.

E. CONSCIENTIOUS OBJECTION

The right to freedom of conscience is recognized in Article 24 of the Mexican Constitution, the International Covenant on Civil and Political Rights, and the American Convention on Human Rights. Conscientious objection is considered an expression of said freedom. In the medical field, it means that health workers can abstain from carrying out activities that they view as contrary to their personal—including religious—beliefs. Recognition of conscientious objection, however, should consider potential limitations stipulated by law to prevent obstacles to the exercise of the rights of others, including the right to health. In this regard, conscientious objection poses an individual exception that is conditional on specific circumstances, but in no way does it assume that the State will no longer be obliged to provide services regarded as "objectionable."

Both the CESCR and CEDAW[9] Committee have pointed out that an absolute application of conscientious objection may have a negative impact on the availability and accessibility of safe abortion services. Therefore, they specify requirements for the exercise of conscientious objection, including referral to providers—located within a reasonable distance—willing to perform the procedures. In like manner, the special United Nations bodies specify conditions with which the State must comply so that conscientious objection does not become an obstacle to reproductive health services. The conditions include the personal—never institutional—nature of conscientious objection and that only those directly involved in the procedure can exercise it.[10]

In Mexico, on May 11, 2018, a reform to the General Health Law on the exercise of conscientious objection by health providers came into effect. The reformed text reads as follows:

> Article 10 bis: Medical and nursing staff of the National Health System can exercise conscientious objection by recusing themselves from participating in the provision of the service established in this law. When a patient's life is at risk or in the case of a medical emergency, conscientious objection will not be invoked; otherwise, their refusal to participate will be deemed grounds for professional liability. The exercise of conscientious objection will not result in any form of labor discrimination.

The reform incorporates the following elements:

1. Exception to participate in the provision of health services established by law.
2. Conscientious objection.
3. It applies only to medical and nursing staff.
4. It does not apply in two cases: when the life of the person requiring care is at risk and in the case of a medical emergency.

Nevertheless, since it does not specify the type of procedure to which the above applies, ambiguous interpretation is possible. This may represent an obstacle to services like abortion and a legal possibility that could open the door to different forms of discrimination against some groups.

At present, an unconstitutionality claim filed by the CNDH against the reform to the General Health Law in matters of conscientious objection is pending resolution by the Supreme Court. GIRE hopes that with its resolution, the SCJN will contribute to informing health personnels' interpretation of the content of conscientious objection, specifically 1) that this right is not used as justification to hinder access to abortion services; 2) that an effective system of referral to non-objecting practitioners is implemented; 3) that those who request abortion services receive clear information, even from objecting providers; 4) that the right is always exercised at the individual—not at the institutional—level; and 5) that it applies only to those directly involved in the procedure.

9 Committee on Economic, Social and Cultural Rights and the Committee on the Elimination of Discrimination against Women, respectively.

10 See UN, Working Group on the issue of discrimination against women in law and in practice, *Report of the Working Group on the issue of discrimination against women in law and in practice,* A/HRC/32/44, April 8, 2016, paragraphs 82, 93, 94, and 100, and UN, Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, *Interim report of the Special Rapporteur of the Human Rights Council on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover, in accordance with resolutions 15/22 and 6/29 of the Human Rights Council,* A/66/254, August 3, 2011, paragraphs 24 and 65.

Photo: GIRE archive

2.2
ACCESS TO JUSTICE

In April 2018, the SCJN granted two legal stays, to Marimar and Fernanda, two victims of sexual violence who were accompanied by GIRE after public health services had denied them an abortion despite it being a right of rape victims throughout the country. The Court stated that the denial was a violation to their human rights; health authorities are obliged to comply efficiently and immediately with the requests of women who had been victims of sexual violence, and subsequently become pregnant, to spare them the consequences—present and future—derived from the sexual attack. This means that relevant health authorities will not implement mechanisms, or internal policies, that limit the exercise of the rights of women who have been victims of rape and want to terminate the pregnancies resulting from the crime.[11]

With these resolutions, the SCJN dispelled any doubt over health providers' legal obligation of ensuring access of rape victims to abortion and, hence, of all other women who request the service on the grounds established in penal codes. The dissemination and implementation of the decision is a critical pending issue in Mexico, which might prevent the occurrence of episodes like the case of Pilar, a minor who not only suffered abuse but also had to overcome obstacles to request an abortion for rape.

11 SCJN, Second Chamber. "Legal Stay under Review 601/2017. Complaint and Appellant: *****. Justice José Fernando Franco González Salas," April 4, 2018. Available at: https://www.scjn.gob.mx/sites/default/files/listas/documento_dos/2018-02/AR-601-2017.pdf [Accessed on: October 24, 2018].

PILAR*

CDMX /PUEBLA, 2018

In May 2018, Pilar, then 15, and her mother visited a clinic to have a blood test because her period was late and they wanted to find out if she was pregnant. In March, while on vacation in Cuetzalan, Puebla, her paternal uncle had raped her. When she learned that she was pregnant, she decided to tell her mother about the rape, and together they went to a public prosecutor's office in CDMX, where they live, to file a report. At the office, an employee told them that they could not see her because the attack had taken place in another state. She was also informed, however, that since she had been a victim of rape, she had the right to decide whether to carry the pregnancy to term and an abortion would not be considered a crime. Pilar and her mother returned to the clinic for an ultrasound and found out that Pilar was 10.2 weeks along. They then traveled to Puebla to report the crime.

At the Public Prosecutor's Office in Puebla, Pilar underwent some tests, and some officials visited the place where the attack had taken place. In the end, they denied her request to terminate her pregnancy arguing that abortion was not legal in Puebla. Not only did the authorities fail to inform her about the emergency service to which she was entitled—particularly because she was a minor and her number of weeks' gestation, but they also gave her false and incorrect information. Moreover, they told Pilar and her mother that no one in Puebla would grant her an authorization to have the abortion, thus making them fear that, should she have the termination in Mexico City, a judge could question her decision and might even criminalize her.

Because of the service denial, Pilar and her mother decided to return to Mexico City to seek an abortion; her gestational age was still within the limit established by law to request a pregnancy termination. Afterward, accompanied by GIRE, they went to the Puebla Human Rights Commission to file a complaint for the violations to Pilar's human rights committed by the Public Prosecutor's Office in Teziutlan, Puebla. The violations originated from a lack of information about the rights of Pilar as a victim of rape and the refusals to terminate her pregnancy, and from the fact that she was asked to have a DNA test to provide evidence to accompany the report of the rape. The complaint is pending resolution. The Commission issued a conciliatory settlement but it included insufficient reparations. Therefore, gire is accompanying Pilar and her family to file a claim based on the principle of State patrimonial liability.

* Her name was changed to protect her privacy.

Pilar's case shows that, as long as abortion is considered a crime rather than a health service, the State will continue to convey a message that can influence beliefs, prejudices and fears among society at large and particularly public servants, while providing them with tools to exercise power against women who are suspected of self-inducing an abortion. Pilar's situation is not unique: from 2012 to September 2018, GIRE registered, documented, and accompanied cases of denial of abortion for rape and other indications and of women criminalized for the crime of abortion. Some of them have been brought before the SCJN, whereas others await resolution by the Court.[12] Still others were resolved by filing a second legal action.

CASES REGISTERED, DOCUMENTED, AND ACCOMPANIED BY GIRE / 2012 - 2018

	Registered	Documented	Accompanied	Total
Abortion for rape	10	10	38	58
Other indications	11	—	11	22
Criminalization	39	3	15	57
				137

Access to justice in cases of abortion means ensuring due process and presumption of innocence for all women reported for having an abortion or for other crimes related to reproductive processes. It also implies ensuring comprehensive reparations for human rights violations for women who were denied an abortion for rape and other legal indications stated in penal codes, according to what was stipulated by the Second Chamber of the SCJN in decisions regarding the legal stays 601/2017 and 1170/2017. In both cases, the Executive Commission for the Care of Victims—and in the first case, its Morelos counterpart—issued a ruling that included the measures of comprehensive reparation requested by direct and indirect victims accompanied by GIRE. Among those measures are proposals for compensation for material and immaterial damages, rehabilitation measures, public apologies, and guarantees of non-repetition to ensure the implementation of the NOM 046 and the LGV in Mexico.

A mechanism available to women confronted with the denial of legal abortion services or any other form of abuse while trying to access services is the filing of complaints before human rights commissions, on a state level and nationally. Through requests for information, GIRE sought to find out how many of those cases had been registered, how they have been resolved, and whether recommendations have been emitted to the involved authorities. In total, commissions reported 15 complaints for denial of abortion, of which only one—in Baja California Sur—offered a recommendation.[13] One possible reason for having so little information may be the way in which the authorities register cases of rape and not the lack of complaints per se.

12 For more information about the type of cases, see GIRE, *Women and Girls without Justice: Reproductive Rights in Mexic*o, 2015. Available at: informe2015.gire.org.mx.

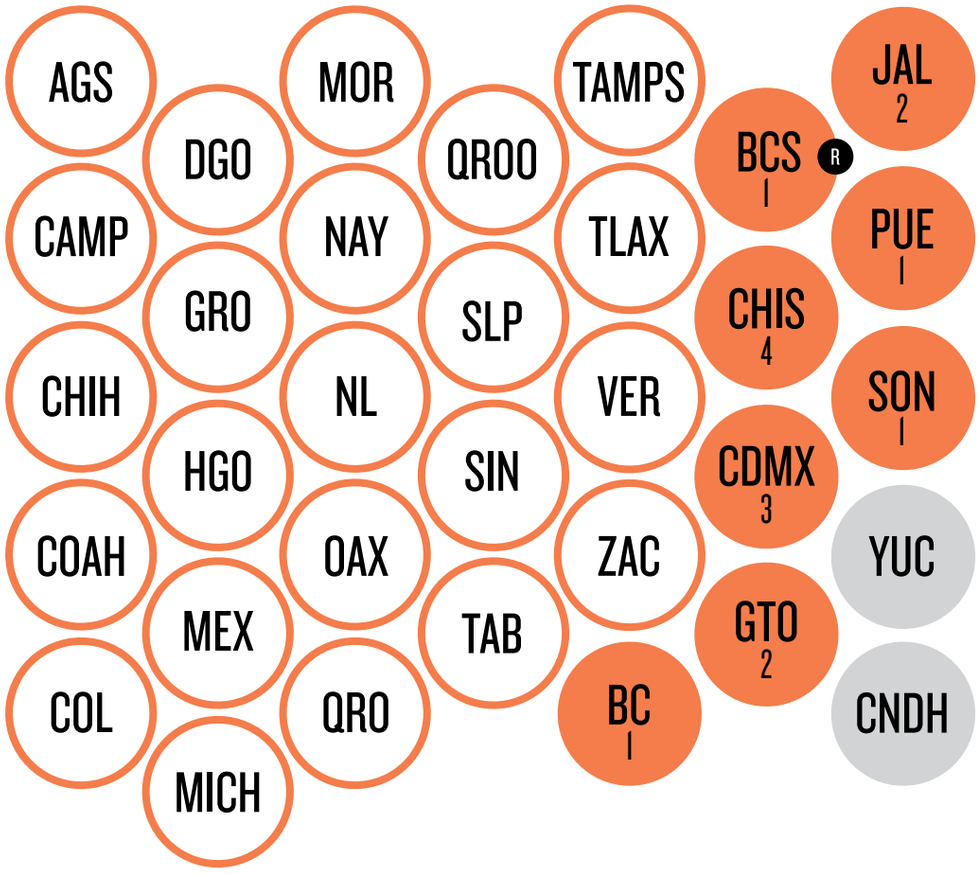
13 See Baja California Human Rights Commission, Recommendation 15/16. Available at: http://www.ced- hbcs.org.mx//recomendaciones/2016/recomendacion15-16.pdf.

COMPLAINTS OF DENIAL OF LEGAL ABORTION SERVICES FILED BEFORE HUMAN RIGHTS COMMISSIONS

DECEMBER 2012 - OCTOBER 2017

15 COMPLAINTS

WITH CASES | WITHOUT CASES | NON-EXISTENT INFORMATION / RECORD NOT FOUND | R RECOMMENDATION



Source: GIRE's graph based on data from requests for public information.

2.3 CONCLUSIONS

Between 2000 and 2017, 28 countries changed their abortion laws. Except for Nicaragua, which prohibits abortion in all cases, the legal changes were, in general, either an increase in the number of legal indications or decriminalization. The safety of induced abortions has increased in the last decade because of changes in legislation and broader access to medical abortion.

In Mexico, respect for human rights obligations means ensuring access to abortion for existing legal indications, especially rape, which is included in the penal codes of all states and the federal penal code. This indication is also stipulated in general legislation for victims of sexual violence, according to which health institutions are to provide abortion services without imposing additional requirements other than a sworn statement by the woman that the pregnancy is the result of rape. Since the decriminalization of abortion in Mexico City in 2007, some states in the country have increased the number of indications for abortion. Others, however, have passed reforms that despite not legally limiting the indications or the possibility of decriminalizing abortion, have fostered an environment of uncertainty among authorities regarding their obligations, a setting that can promote the persecution of women who are suspected of having induced an abortion and hinder access to legal services.

For as long as abortion continues to be considered a crime rather than a health service, women will continue to suffer violations to their reproductive rights, even when they seek access to terminations in cases permitted by law. The Mexican State owes it to women to decriminalize abortion. It is especially indebted to those women who are the most marginalized and who more frequently live with the consequences of being persecuted or allowed to die by the State.

3

OBSTETRIC VIOLENCE

OBSTETRIC VIOLENCE

A specific form of institutional violence that women may experience during pregnancy, delivery, and postpartum care.

EXPRESSIONS

PHYSICAL	PSYCHOLOGICAL
Invasive practices	Dehumanizing treatment
Unjustified use of medication	Discrimination
Delays in emergency care	Humiliation
Disregard for the stages of labor	

33.4% → 13.1%

women experienced obstetric violence by their health providers.

of those women reported being forced to receive contraception or sterilization.

Source: ENDIREH, 2016.

8 700 000

WOMEN

delivered at least once between 2011 and 2016 in Mexico.

3 700 000 = 42.5%

UNDERWENT A CESAREAN SECTION

37.8%

of all women who received obstetric care at public facilities had a cesarean delivery.

10.3%

of them were not told why

79%

of all women who received obstetric care at private facilities had a cesarean delivery.

9.7%

of them did not consent to the procedure.

Source: SINAC, 2011-2016.

Source: ENDIREH, 2016.

Photo: Cuartoscuro

Obstetric violence is a specific form of violence against women that violates their human rights. It occurs at public and private facilities during pregnancy, delivery, and postpartum care. It is any act or omission by health personnel that causes physical or psychological harm to women, expressed by a lack of access to reproductive health services, in cruel, inhuman or degrading treatment, or in overmedication, all of which undermine women's ability to make free and informed decisions over their reproductive processes.[1]

Expressions of this sort of violence include invasive practices and unjustified use of medication, denial of treatment or delay in the provision of care, disregard for the stages of labor, scolding, mocking, insults, manipulation of information, lack of privacy and coercion to obtain women's "consent," as well as other forms of discriminatory and humiliating treatment.2 These forms of violence may result in a maternal death—the death of a woman from preventable causes related to pregnancy, labor and childbirth, and the postpartum.

1 GIRE, *Obstetric Violence: A Human Rights Approach*, 2015, p. 13. Available at: https://gire.org.mx/en/wp-content/uploads/sites/2/2015/11/ObstetricViolenceReport.pdf.

2 Villanueva-Egan, Luis Alberto, "El maltrato en las salas de parto: reflexiones de un gineco-obstetra", Revista CONAMED, 2010, 15(3), p. 148. Available at: https://dialnet.unirioja.es/servlet/articulo?codigo=3393251 [Accessed on: September 9, 2018].

3.1

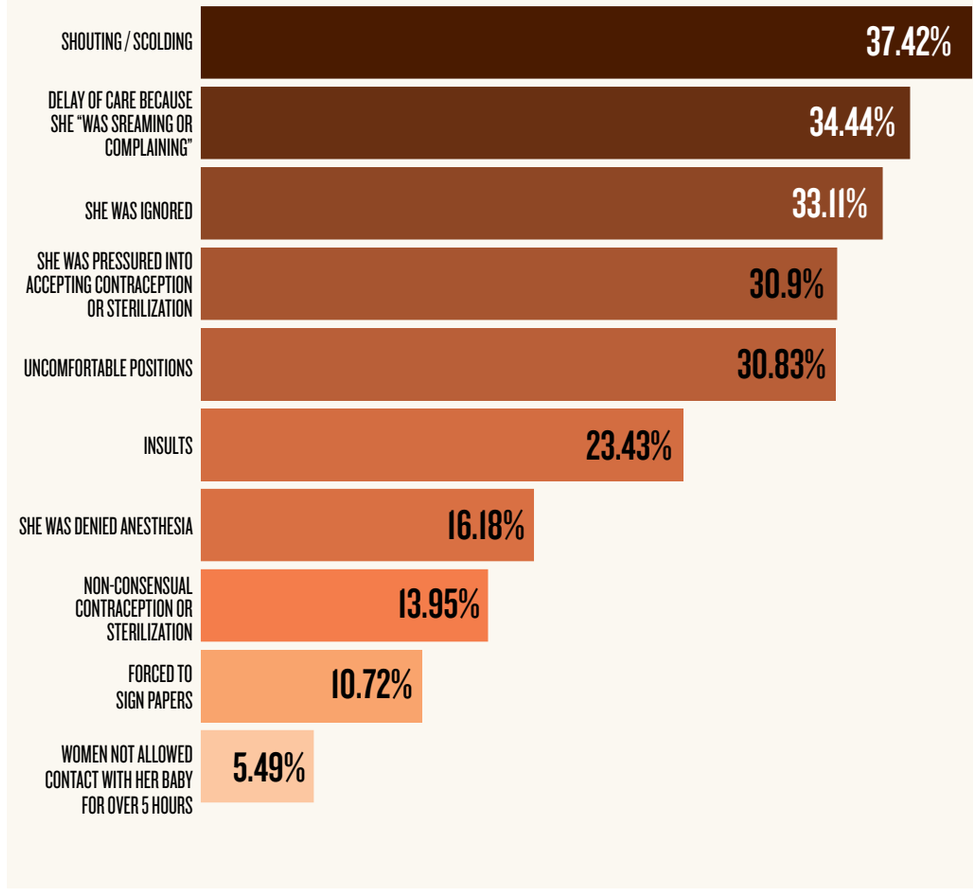
SITUATION IN MEXICO

In 2016, for the first time, the National Survey on the Dynamics of Household Relationships (ENDIREH) included questions to explore aspects of women's experiences regarding their most recent deliveries. The Survey allows for a more complete assessment of the magnitude and variables associated with obstetric violence in the country. It also helps the State recognize the existence and importance of using the term 'obstetric violence.' In general, data collected by the Survey and previous research show that obstetric violence is a violation of women's human rights at health care facilities, not an exceptional or sporadic occurrence.[3]

The term is not new. There is, however, considerable reluctance to accept its implications, particularly among medical personnel. Nevertheless, the concept of obstetric violence—as opposed to others such as abuse or negligence during obstetric care—helps to underline that it is a specific form of violence against women. GIRE believes that a response to violence of this sort implies changing the structural conditions of the health system at all levels rather than individualizing the problem by punishing individual health providers, particularly in view of the obstacles that hinder their ability to work in optimal circumstances. Hence, GIRE considers that the penalization of obstetric violence overlooks the underlying problem and may thwart its objectives. According to the 2016 ENDIREH, of the 8.7 million women who delivered at least once between 2011 and 2016 in Mexico, 33.4% reported having suffered abuse by their health providers.[4]

EXPRESSIONS OF OBSTETRIC VIOLENCE IN MEXICO

2016 / WOMEN WHO REPORTED EXPERIENCING AT LEAST ONE FORM OF OBSTETRIC VIOLENCE



Source: GIRE's graph based on data from the 2016 ENDIREH.

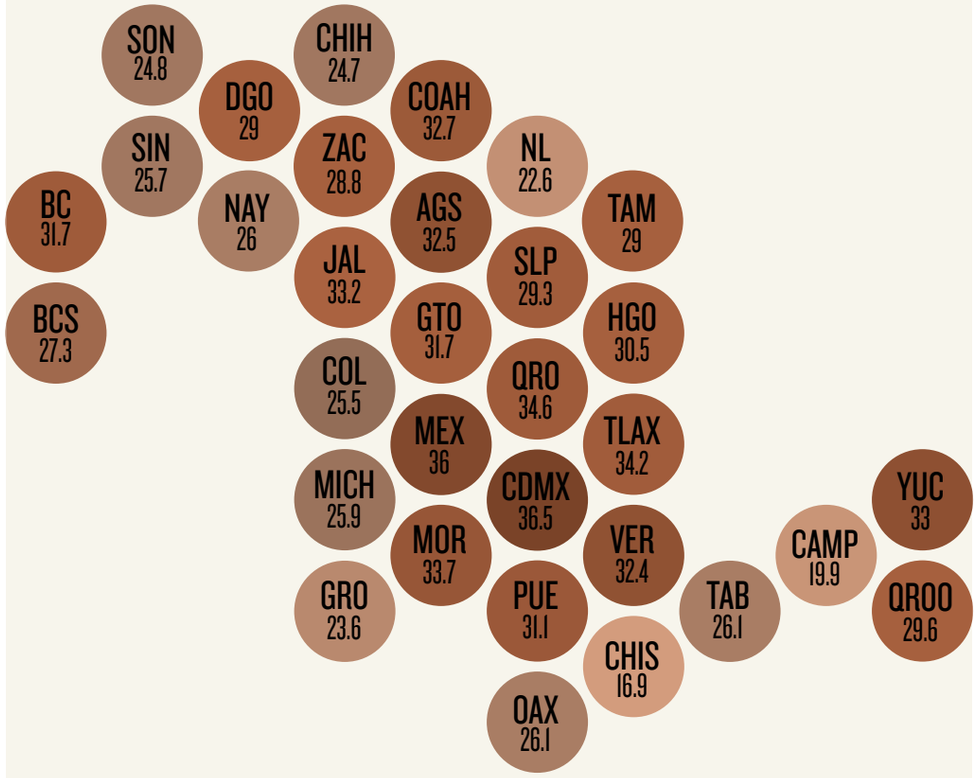
3 Castro, Roberto, Erviti, Joaquina. "25 años de investigación sobre violencia obstétrica en México", CONAMED, 2014, vol. 19, No. 1, pp 37-42.

4 ENDIREH 2016. Available at: http://www.beta.inegi.org.mx/contenidos/proyectos/enchogares/especiales/endireh/2016/doc/endireh2016_presentacion_ejecutiva.pdf [Accessed on: September 9, 2018].

The Survey findings reveal a problem experienced by millions of women in Mexico, though they also show significant variations in both their profile and their geographical distribution. In that regard, the states with higher percentages of women who suffered a form of obstetric violence are Mexico City (CDMX) (36.5%), the State of Mexico (36%), Queretaro (34.6%), Tlaxcala (34.2%) and Morelos (33.7%). This data—the first of its kind—is a significant starting point to propose evidence-based public policies for specific settings to prevent and address these forms of violence.

WOMEN WHO EXPERIENCED AT LEAST ONE FORM OF OBSTETRIC VIOLENCE

2011 - 2016 / PERCENTAGE OF WOMEN WHO BECAME PREGNANT AT LEAST ONCE IN THE LAST FIVE YEARS, BY STATE



Source: GIRE's graph based on data from the 2016 ENDIREH.

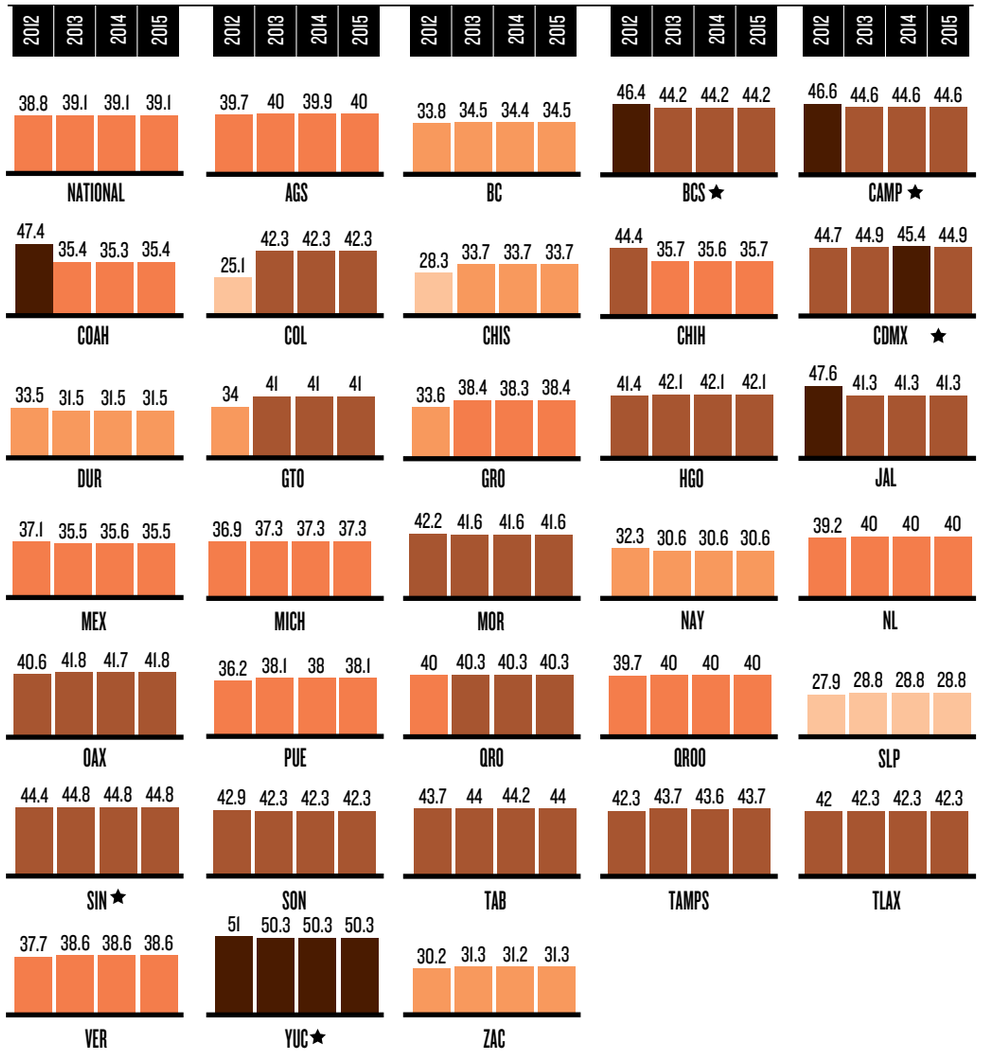
5 WHO, *WHO Statement on Cesarean Section Rates*, 2015. Available at: https://apps.who.int/iris/bitstream/handle/10665/161442/WHO_RHR_15.02_eng.pdf;jsessionid=6B01087001B76C30D6CFEAF49A9BF371?sequence=1 [Accessed on: September 9, 2018].
6 Ministry of Health. DGIS. Statistical Information Bulletin No. 35, Vol. lll. 2015. Mexico 2015.
7 WHO, *Caesarean sections should only be performed when medically necessary*, April 10, 2015. Available at: https://www.who.int/mediacentre/news/releases/2015/caesarean-sections/en/ [Accessed on: September 9, 2018].

The elements of obstetric violence include overmedicalization during childbirth and the implementation of routine procedures without justification or the women's consent. Among those procedures are cesarean sections that are seldom medically indicated, thus posing a health risk to the women, particularly those with limited access to comprehensive obstetric care.[5]

In 2015, as many as 39.1% of births in Mexico were cesarean births.[6] The World Health Organization (WHO) has underscored the importance of focusing on the needs of women on a case by case basis and has discouraged the use of maximum quotas of C-section rates. Nevertheless, the number of actual procedures substantially exceeds the percentage (10-15%) recommended by both international agencies and NOM-007-SSA2-2016, On Providing Care for Women during Pregnancy, Labor and Delivery, and the Puerperium, and for the Newborn (NOM 007). This suggests that there is a high prevalence of unnecessary C-sections in Mexico.[7]

CESAREAN SECTIONS BY STATE

2012 - 2015 / PERCENTAGE OF TOTAL NUMBER OF BIRTHS



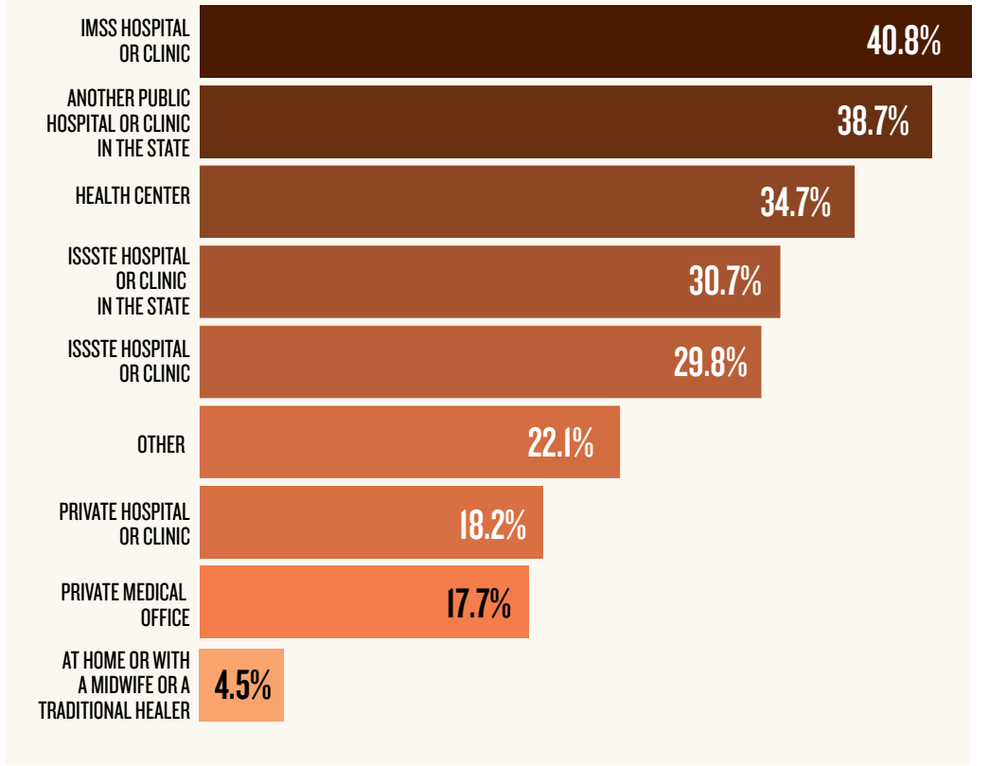
★ States with the highest percentages of C-sections.
Source: GIRE's graph based on data from the Ministry of Health.

Photo: GIRE archive

In general, the information provided by the women matches that reported by the Ministry of Health. According to 2016 ENDIREH data, 42.8% of the women surveyed had experienced a cesarean in their last birth. Of these, 10.3% were never told the reason for the procedure, and 9.7% were not asked for their consent to perform it—a blatant violation of their reproductive rights. In addition, the Survey reveals that prevalence of abuse during obstetric care is higher at IMSS hospitals and clinics and is lower when care is provided by midwives.

WOMEN WHO EXPERIENCED OBSTETRIC VIOLENCE, BY HEALTH FACILITY

2016



Source: GIRE's graph based on data from the 2016 ENDIREH.

Another expression of obstetric violence is forcing women to adopt a reversible or a permanent contraceptive method without previously obtaining their free and informed consent. The 2016 ENDIREH shows that 13.95% of women who experience a form of obstetric violence also received a contraceptive method or an operation or permanent sterilization without previously asking or informing them. The case of Sandra exemplifies these types of practices and how health personnel do not consider relevant factors when obtaining the woman's informed consent, particularly for obstetric emergency procedures.

SANDRA

JALISCO, 2017

Sandra was 31 and had her prenatal control visits at the IMSS Family Medical Unit No. 33 in Tonila, Jalisco. During the seventh month of her pregnancy, she began to have sporadic high blood pressure. When she was 38 weeks, she decided to go to the Medical Unit because she had labor pains and high blood pressure again. The health providers referred her to the General Area Hospital in Guzman City, Jalisco, where she was admitted to the emergency room and asked to stay the night. The following day, she was informed that her pregnancy was going well and that she was not due yet.

Two days later, the morning shift doctor noticed that Sandra no longer had any amniotic fluid but it was not until the afternoon shift that she was taken to an operating room. At that moment, the doctor told her that she would perform a C-section and asked her if she had already discussed with her husband the possibility of not having any more children. When Sandra told her that they had not talked about it yet, the doctor called her "irresponsible." She added, "I'm going out to talk to your husband. All I hope is that he's not one of those macho men who don't understand. What's more, if he doesn't agree, you'll stay here until you eventually give birth."

Afterward, the doctor informed Sandra's family that for health reasons, it was no longer convenient for her to get pregnant again and assured them that Sandra had agreed with this and had signed a consent for a bilateral tubal ligation (BTL)—a permanent contraception procedure. Therefore, her husband signed an authorization, which Sandra could not read carefully because she had had contractions for more than four days and was very tired. She signed the document in a context of pressure and intimidation while she was being taken to the operating room for an emergency C-section.

In October 2017, Sandra, accompanied by GIRE, filed a complaint with the National Human Rights Commission because, in her opinion, the treatment she had received from her health providers was inadequate. She never received previous and appropriate counseling and was asked to give her consent for the BTL at an unsuitable moment. Because of her complaint, the IMSS Directorate for Beneficiaries launched an investigation into the events. The complaint is pending resolution.

In addition, Sandra, also accompanied by GIRE, filed an indirect legal stay with the District Judge in Jalisco, requesting specialized medical and psychological care, as well as information on the procedure that she underwent and the possibility of reversing it. The legal stay was dismissed. In May 2018, GIRE submitted an appeal against the dismissal but it has not been resolved yet.

On July 30, the IMSS Bipartite Commission decided that the complaint was medically inadmissible. Therefore, compensation was not awarded as there was no liability.

Recently, the Inter-American System of Human Rights has found precedents related to obstetric violence, specifically obtainment of informed consent in cases of sterilization or permanent contraceptive methods such as BTL. Importantly, the judgements by the Inter-American Court of Human Rights are legally binding for the Mexican legal system.

INTER-AMERICAN COURT OF HUMAN RIGHTS CASE OF I.V. V BOLIVIA[8]

In its ruling of November 30, 2016, the Court declared the State of Bolivia internationally responsible for the tubal ligation performed on Mrs. I.V. at a public hospital without her informed consent.

To that end, the Court examined the treatment and development of informed consent and its elements, at the international level, in cases of female sterilization.

Because of the nature and seriousness of the procedure, which permanently deprives a woman from her reproductive capacity, the Court states that special factors are to be considered by health providers when obtaining informed consent prior to a sterilization. Therefore,

- It should be obtained before any medical action, except in cases of emergency. Tubal ligation will not be deemed an emergency procedure;[9]
- It should be given freely, voluntarily, autonomously, without any pressure, without using it as a condition to receive other procedures, without coercion, threats, or misinformation;
- Consent will not be regarded as free if it is requested when the woman is not in condition to make a fully informed decision due to stress or vulnerability, among other factors, or during labor or in the immediate postpartum or after a cesarean section;[10]
- The woman should be guaranteed a reasonable time for reflection, which may vary according to the conditions of each case and her individual circumstances. This is an effective guarantee to prevent non-consensual involuntary.[11]

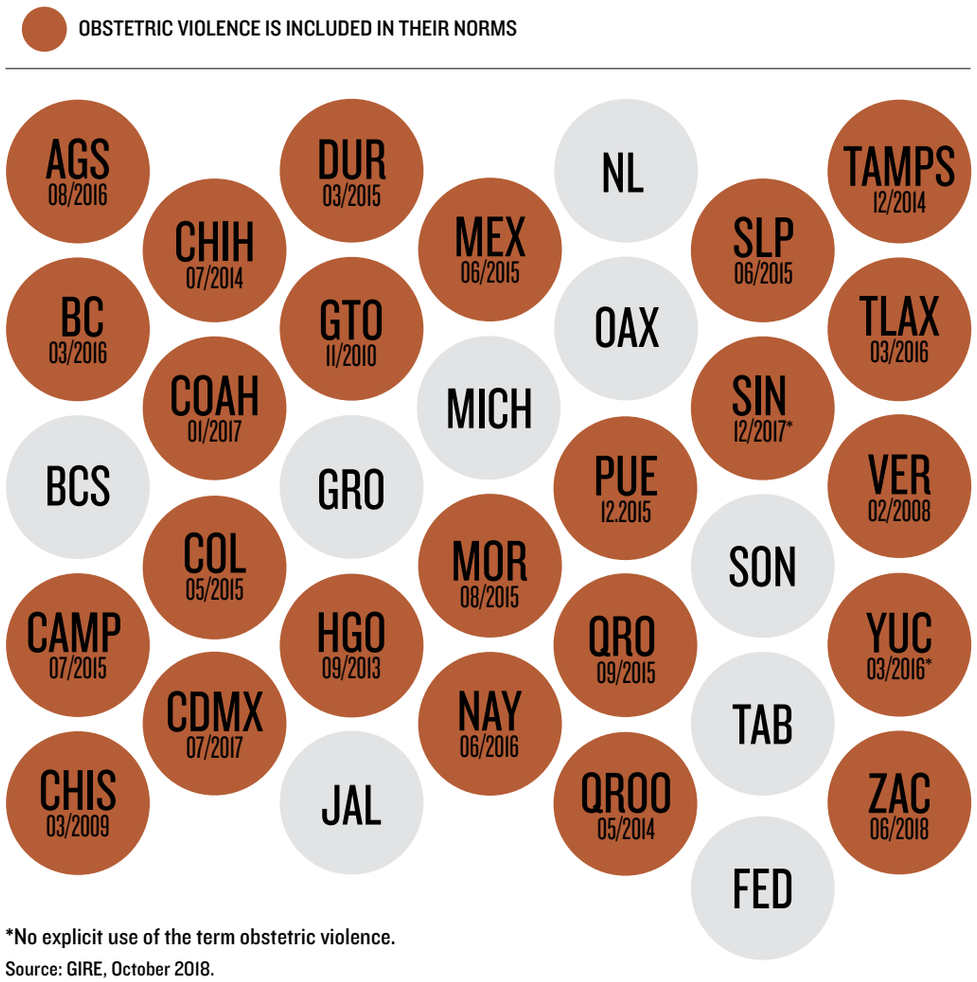
8 Inter-American Court of Human Rights, *Case of I.V. v Bolivia. Preliminary Objections, Merits, Reparations and Costs*. Judgment of November 30, 2016. Available at: http://www.corteidh.or.cr/docs/casos/articulos/seriec_329_esp.pdf [Accessed on: September 9, 2018].
9 *Ibid*, paragraphs 176-178.
10 *IIbid*, paragraphs 181-188.
11 *Ibid*, paragraphs 189-194.

A. NORMATIVE AND PUBLIC POLICY FRAMEWORK

Up until November 2019, the General Law for Women's Access to a Life Free of Violence, published in 2007, did not expressly state obstetric violence as a form of violence against women. Nevertheless, the inclusion of psychological, physical, and institutional violence provided an adequate framework to categorize behaviors that constitute obstetric violence.

To date, 24 states have incorporated definitions of obstetric violence into their laws on women's access to a life free of violence. This contributes to recognizing that obstetric violence is a specific form of institutional violence against women and a human rights violation.

OBSTETRIC VIOLENCE IN LEGISLATION ON WOMEN'S ACCESS TO A LIFE FREE OF VIOLENCE



*No explicit use of the term obstetric violence.

Source: GIRE, October 2018.

NOM 007 establishes the criteria for providing care to women during pregnancy, labor and the postpartum and to the newborn. The Norm's application and observance is mandatory for all National Health System facilities. In April 2016, an update to the Norm was published to improve obstetric care services.[12] The implementation of the Norm is an urgent pending issue as it is needed to ensure women's access to quality obstetric services in Mexico.

The saturation of the Mexican health system, particularly secondary and tertiary level hospitals, has a significant impact on the quality of healthcare and the response to obstetric emergencies, and thus on the number of cases of obstetric violence and maternal deaths. To address the problem, some countries have opted to refer uncomplicated deliveries to the primary care level, thus freeing higher level facilities to deal with complicated cases. This initiative requires mid-level health professionals, such as midwives and obstetric nurses, which has sparked new interest in their training. In Mexico, according to the National Center for Gender Equity and Reproductive Health, in the third quarter of 2017, there were 248 active midwives in 16 states.[13]

The General Health Law and its regulations govern the provision of health care services, including the persons authorized to provide obstetric care and contraceptive services.[14] In Article 64, Section IV, the Law establishes that health authorities will train the above personnel to strengthen their technical competences. Further, the NOM 007 stipulates that all health institutions will train obstetric nurses and technical and traditional midwives to identify pregnancy, labor/delivery, and puerperium complications and will facilitate referral and accompaniment of pregnant women requiring health care at other facilities.[15] Thus, low-risk deliveries can be managed by obstetric nurses, technical midwives, and traditional midwives[16] that have received training.[17]

Although this represents a promising beginning, considerable challenges to obstetric care and midwifery persist in Mexico. Among them are the lack of clarity of the legal framework as to accreditation and training of midwives, a lack of recognition of the value of traditional midwifery, and the reluctance of physicians to include trained mid-level providers into obstetric services.

12 The update to the Norm changed, among other things, the definition of pregnancy. In the past, pregnancy was "a woman's physiological state that starts with fertilization and ends in labor and the birth of a full-term child." Currently, the NOM 007 defines pregnancy as "the part of the human reproduction process that begins with the implantation of the 'conceptus' in the endometrium and ends in birth." This change is based on medical science and distinguishes between fertilization and implantation; it considers pregnancy a woman's physiological state that begins at the moment of implantation. For more details on the points included in the update to the NOM 007, refer to *Diagnóstico sobre la victimización obstétrica en México, op. cit.*, pp. 131-134.

13 The 248 midwives included 89 perinatal nurses, 98 obstetric nurses, 27 general registered nurses, 25 professional midwives and 9 general nurses. Sixth National Technical Meeting on Maternal and Neonatal Health, February 15-16, 2018.

14 General Health Law, Article 48. It is the responsibility of the Ministry of Health and state-level governments, within the purview of their respective competences and in coordination with education authorities, to oversee the performance of health professionals, technicians, and auxiliary staff during provision of their respective services.

15 Paragraph 5.1.1. All health institutions will train obstetric nurses and technical and traditional midwives to identify pregnancy, labor/delivery, and puerperium complications and will facilitate timely referral and accompaniment of the pregnant woman requiring health care at other facilities, when needed. Low-risk term deliveries can be managed by obstetric nurses, technical midwives, and trained traditional midwives.

16 According to paragraph 3.30 of NOM 007, traditional midwives are non-professional personnel authorized to provide medical services.

17 General Health Law Regulations on Medical Service Provision (RLGSMPSAM), Article 102. For the ends and purposes of these regulations, non-professional personnel authorized to provide medical services will be persons who have received relevant training and have authorization from the Ministry to practice as such. The authorization will be renewed every two years.

Further, NOM-035-SSA3-2012, On Health Information (NOM 035),[18] tates that only midwives certified by the National Health System can issue a birth certificate. The legislation, however, does not mention the procedure whereby health institutions can authorize a midwife to issue the certificates; it leaves the decision in the hands of each state. Such legal insecurity also makes women less likely to choose to give birth with a midwife despite policy efforts to include midwifery personnel into the National Health System.

The professionalization of midwives would be optimal, and efforts should include their training and certification, as well as their input in decision-making regarding customs to overcome unjustified obstacles. Finding alternatives to reduce the burden imposed by labor care on the health system and recognize the value of midwifery at the community level is indispensable.

18 NOM-035-SSA3-2012, On Health Information. Available at: http://dof.gob.mx/nota_detalle.php?codigo=5280848&fecha=30/11/2012 [Accessed on: September 9, 2018].

3.2

ACCESS TO JUSTICE

The State has the obligation to promote legislation and public policies designed to transform the health system to ensure the provision of quality obstetric care to eliminate obstetric violence and reduce maternal deaths. In addition, it is obligated to guarantee that victims have access to effective resources and judicial protection, including comprehensive reparations. To that end, it is fundamental that the State assume its responsibility in cases of obstetric violence instead of limiting its response to attributing individual responsibilities to health personnel.

In cases of obstetric violence, useful procedures include administrative responsibility lawsuits and filing of complaints with public human rights agencies, when the events involve public health providers. Medical arbitration is also useful when the episodes involve public and private services. These mechanisms, despite their limitations, shed light on the structural nature of the problem, offering solutions that are not based only on individual actions, and imposing measures of comprehensive reparation for the victims.

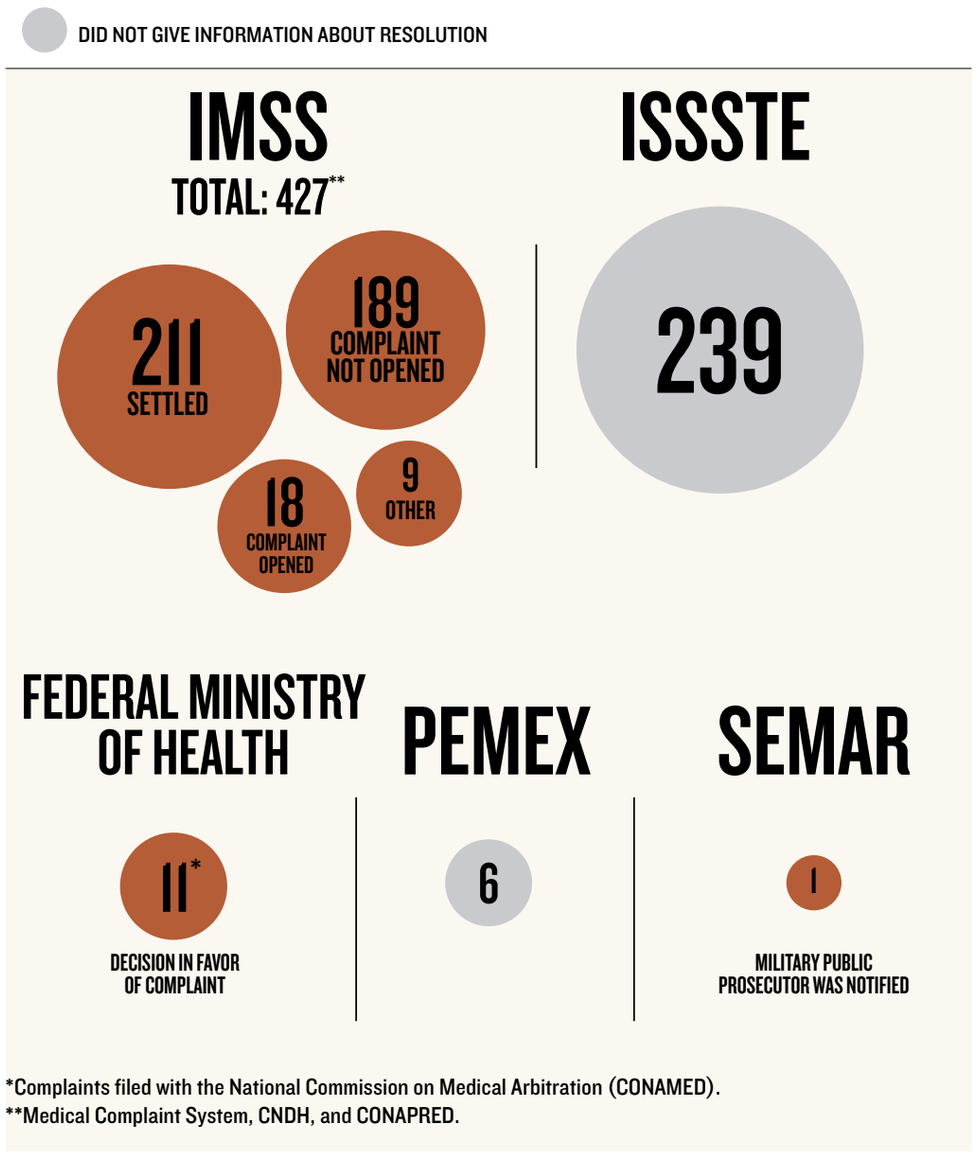
A. ADMINISTRATIVE COMPLAINTS

The most immediate resource for women who have been victims of obstetric violence is a written complaint filed with the internal comptroller of a health institution, whereby an investigation of the events is launched. Each health institution determines the procedure to file a complaint, which constitutes an important obstacle to justice as it creates uncertainty in those experiencing these types of violations. Moreover, filing a complaint with the very institution that committed the violations creates a conflict of interest, particularly if the woman and her family routinely seek care at its facilities.

To determine how the mechanism was used, GIRE filed requests for public information with federal and state health institutions on the number of registered complaints of obstetric violence or abuse by gynecological and obstetric services. Nevertheless, despite the progress in the recognition of the concept and practices that constitute this type of violence at the normative and public policy level in Mexico, there was a significant lack of specific records. Of note, according to the 2016 ENDIREH, Tlaxcala and Morelos ranked fourth and fifth, respectively, among the states with the highest rates of obstetric violence; their health ministries, however, reported having received zero administrative complaints. This may be an indication that internal control bodies fail to keep relevant records; the mechanisms to file complaints are not clear; and the victims are unaware of the actions or omissions that constitute obstetric violence and a violation to their human rights.

OBSTETRIC VIOLENCE COMPLAINTS FILED WITH INTERNAL CONTROL BODIES OF FEDERAL HEALTH INSTITUTIONS

DECEMBER 2012 — SEPTEMBER 2017



*Complaints filed with the National Commission on Medical Arbitration (CONAMED).
**Medical Complaint System, CNDH, and CONAPRED.

Source: GIRE's graph based on data from requests for public information.

OBSTETRIC VIOLENCE COMPLAINTS FILED WITH INTERNAL CONTROL BODIES OF STATE HEALTH INSTITUTIONS

DECEMBER 2012 — OCTOBER 2017

867 COMPLAINTS

WITH COMPLAINTS | WITHOUT COMPLAINTS | UNFOUNDED | ? DID NOT GIVE INFORMATION ABOUT RESOLUTION

AGS 12*
3 Ongoing
8 Lack of elements
1 Public admonishment

QRO 103
97 Conciliation agreement
6 Archived for lack of elements

MEX 175
98 Archived
52 Administrative resolution
25 ?

SLP 25
6 Settlement
6 Administrative resolution
13 ?

*Complaints filed with a local commission on medical arbitration.
** Complaints and suggestions box.
*** Complaints in the Unified Management System.

Source: GIRE's graph based on data from requests for public information.

B. APPEALS FILED WITH THE NATIONAL COMMISSION ON MEDICAL ARBITRATION

The National Commission on Medical Arbitration (CONAMED) is a decentralized agency of the federal Ministry of Health. Its main responsibilities include advising users of medical services, dealing with complaints or irregularities in health care, mediating and settling disputes between health providers and users, and providing technical opinions on general issues.

GIRE submitted a request for public information to CONAMED to find out how many appeals on obstetric violence cases had been filed from December 2012 to October 2017. CONAMED reported having received 11 complaints that were resolved by arbitration against gynecological service providers. Among the complaints, there were two against ISSSTE, one against the Federal Hospital of the Ministry of Health, one against state-level health services, six against "medical offices," and one against a "hospital." Data on the latter two did not specify if they were public or private health facilities. Of note, although CONAMED provided GIRE with public versions of the 11 arbitration awards, it was impossible to read the contents of the documents because the agency censored almost all the information, and not only that which was confidential. This constitutes a significant obstacle to information.[19]

C. CRIMINAL PROCESSES

GIRE believes that disproportionately resorting to criminal law to deal with such structural social problems such as obstetric violence is not in itself compatible with democratic rule of law. The criminal approach individualizes the problem, attributing responsibility to physicians and nurses who often work in settings that undermine their abilities and the quality of care they provide. Moreover, it can hardly contribute to the prevention of obstetric violence that is structural in nature.[20] Therefore, administrative measures and public policies that strengthen the normative and the human rights framework should be implemented at obstetric services. Accordingly, specific forms of non-compliance or human rights violations could be punished by means of administrative or civil processes.

Some states in the country, however, have chosen to define obstetric violence as a crime in their penal codes. Such is the case of Chiapas, the State of Mexico, Guerrero, Quintana Roo, Veracruz[21] and Yucatan as of July 2019.

19 Request for public information. File Number 4220700024218. These documents are available at: justiciareproductiva.gire.org.mx.
20 GIRE, *Obstetric Violence: A Human Rights Approach, op. cit.*, pp 53, 54.
21 Aguascalientes (June 11, 2018); Chiapas (December 24, 2014); State of Mexico (March 14, 2016); Guerrero (August 1, 2014); Quintana Roo (July 4, 2017); Veracruz (April 2, 2010). On May 2, 2018, the governor of Coahuila submitted a bill to reform several provisions in the penal code to define obstetric violence as a crime. The bill is still under review. Available at: http://congreso-coahuila.gob.mx/portal/iniciativas-2018 [Accessed on: September 9, 2018].

In June 2018, the Aguascalientes Congress reformed its penal code[22] to include behaviors that constitute obstetric violence, though the concept is not used as such. The reform has some worrisome aspects; particularly, some actions or omissions that, though likely to be seriously harmful or even fatal to women or their infants, are not accurately described. This may cause significant legal insecurity for medical practitioners without solving the structural problem that allows obstetric violence to prevail. Importantly, before the reform, the local penal code already included several accurate descriptions of actions or omissions regarded as crimes in order to safeguard those objects of legal protection that could be affected by expressions of obstetric violence—that are indeed the direct responsibility of health providers.

Of greater concern is a provision in Section IV of Article 158 that defines as a crime a delivery that occurs in an "inappropriate" place, without specifying the conditions that make a place appropriate. Thus, an appropriate space could be a hallway, an unhealthy area, and even a room with no privacy. Although this situation should be addressed, it should not necessarily be attributed to one specific person as stated in the code. Deficiencies in infrastructure and equipment at hospitals and health centers should be remedied by the state by creating the necessary conditions for the effective enjoyment of human rights. This will hardly be achieved by attributing criminal responsibilities to medical personnel.

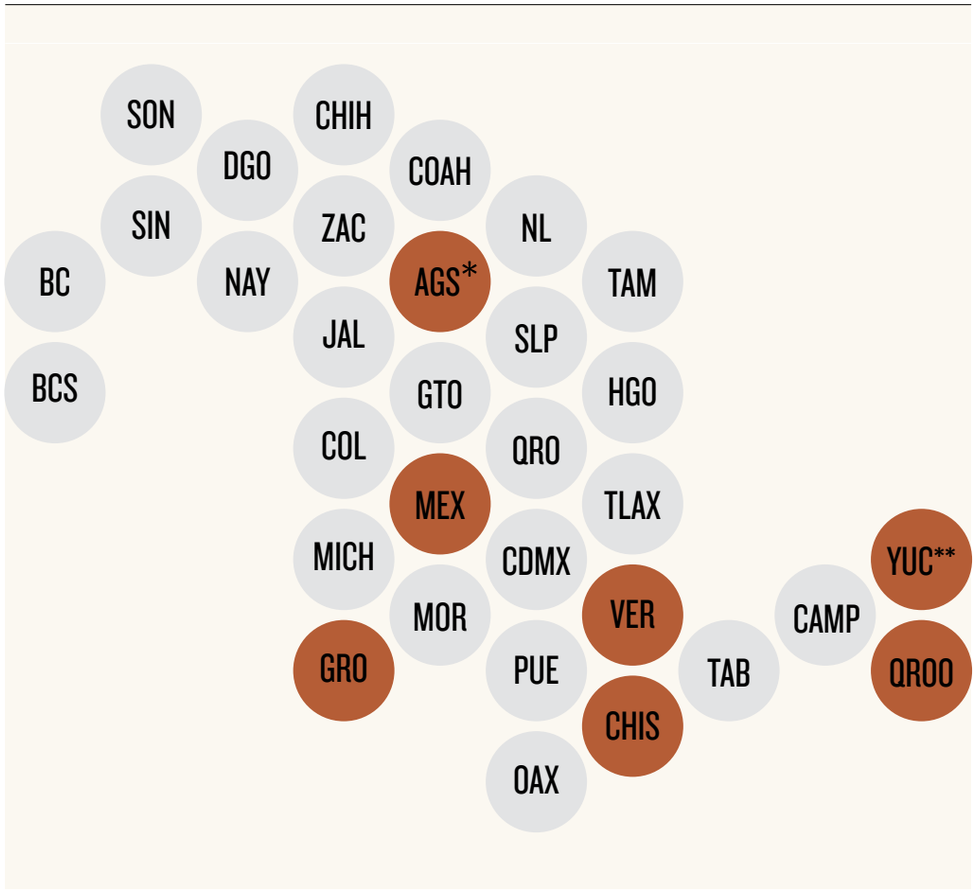
> Article 158. Medical liability. Health facility directors, heads, or administrators will incur medical liability when during the provision of a medical service, they
> iii. Deny or restrict access of a pregnant woman to the hospital or health center when her health or physical integrity or that of the product of conception is at risk; or
> iv. Fail to provide the pregnant woman with an appropriate place to give birth, without any justification.
> …
> The person responsible for the aforementioned liability will be imprisoned from six months to two years, fined 20 to 50 days, liable to pay damages in full, and suspended from three months to one year.

To find out how the above mechanisms were being used, GIRE submitted requests for information on the number of reports, criminal trials, and sentences in states where obstetric violence is defined as a crime. The requests were made to state public prosecutors and judicial branches. The responses received showed that there had been seven reports of obstetric violence—but no criminal trials or sentences—in Veracruz. Quintana Roo reported one criminal trial but the Public Prosecutor's Office informed GIRE that obstetric violence is not defined as a crime in the state, which means that local authorities are evidently unaware of their normative framework.

22 Reform published in the Official Journal of the State of Aguascalientes on June 11, 2018.

Photo: GIRE archive

OBSTETRIC VIOLENCE IN PENAL CODES



*Does not explicitly use the term obstetric violence.
** As of July 2019.

Source: GIRE, November 2019.

D. COMPLAINTS FILED BEFORE HUMAN RIGHTS COMMISSIONS

The presentation of complaints before human rights commissions seeks to obtain reparations for human rights violations. Nevertheless, complainants may need to wait years for a resolution. In GIRE's experience with the CNDH, complaints have not always been an effective legal recourse to protect women.[23] Influencing factors include the limited participation allowed to the aggrieved during the processing of the complaint; little consideration for the victim's requests when formulating recommendations that ensure comprehensive reparation in accordance with human rights principles; and the restrictions and obstacles facing the victims and their legal representatives when trying to access complaint files. Usually, the authorities accept the recommendations but their adoption is not closely monitored, nor evidence of their enforcement is collected. Sometimes, the CNDH considers that a recommendation has been satisfactorily implemented, even when the relevant authorities do not carry it out. All the CNDH does is exchange official documents with the authorities. Therefore, in recent years, GIRE started using a strategy to promote legal stays for cases of obstetric violence in an attempt to ensure access to health services, particularly emergency care, to prevent an obstetric violence event from developing into a maternal death, for example.

In response to the request for information submitted by GIRE, the national and state human rights commissions provided inconsistent information. In some cases, they did not even recognize the term obstetric violence or they claimed that they do not classify information in that manner. In other cases, the information provided is limited or incomplete. According to the state human rights commissions, they had registered 1,109 complaints of *obstetric violence*, 147 recommendations, and 84 accepted complaints. The CNDH reported having 567 complaints of obstetric violence, of which most were closed during the process because of a lack of subject-matter jurisdiction or of interest.

23 Non-governmental organizations have reported that the CNDH has failed to ensure the protection of a victim's human rights. Human Rights Watch. The National Human Rights Commission: A Critical Evaluation. Mexico, 2008. Available at: https://www.hrw.org/sites/default/files/reports/mexico0208sp_1.pdf.

COMPLAINTS OF OBSTETRIC VIOLENCE FILED BEFORE THE NATIONAL HUMAN RIGHTS COMMISSION

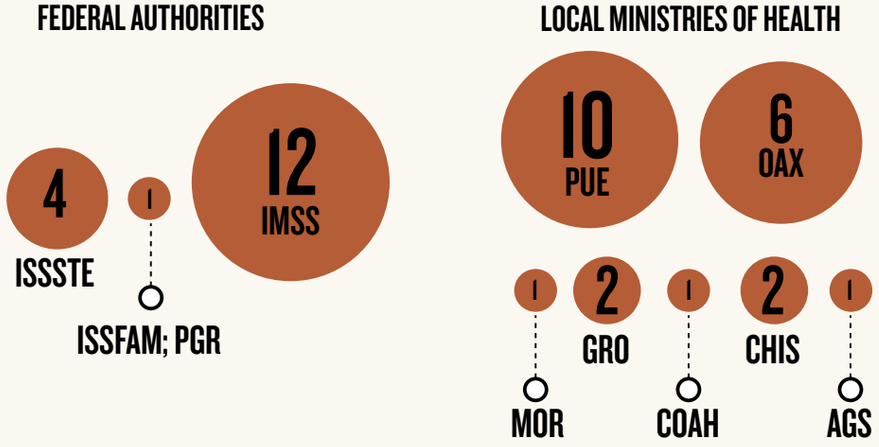
DECEMBER 2012 — SEPTEMBER DE 2017

567 COMPLAINTS*

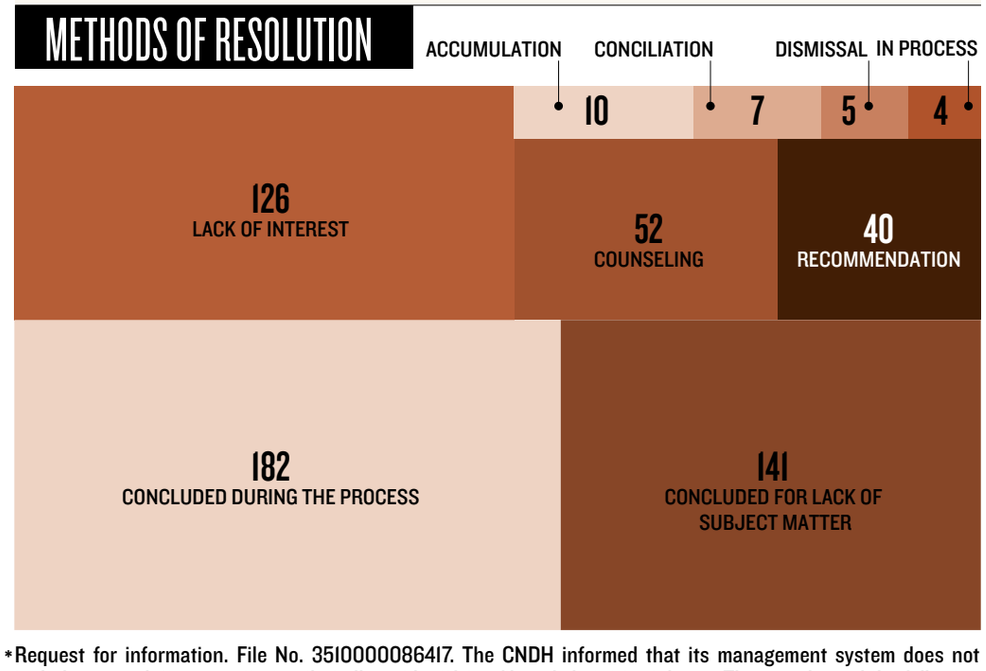
7 CONCILIATIONS

40 RECOMMENDATIONS

RECOMMENDATIONS



METHODS OF RESOLUTION



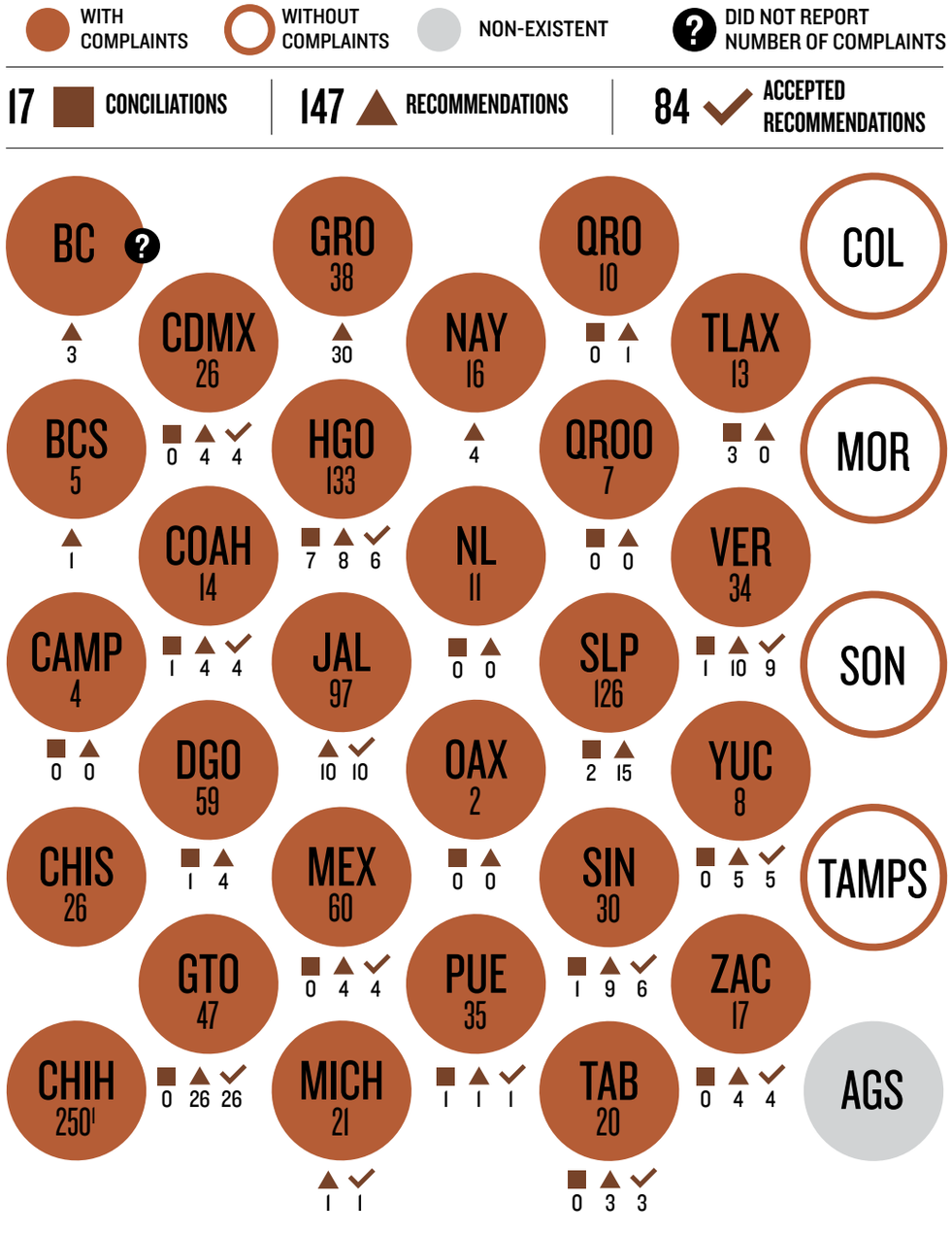
*Request for information. File No. 3510000086417. The CNDH informed that its management system does not include a search item or criterion that allows identifying files of obstetric violence. The search used the following filters: right violation "medical negligence," authority sector "health sector;" account of the events and violations: pregnancy, medical negligence, abuse, failure to provide special medical care and in case of maternity and infant care, failure to provide medical care, labor, and gynecology. In the cases where the CNDH's search produced duplicates and even quadruplicates, GIRE counted them as one item to determine the actual number of complaints.

Source: GIRE's graph based on data from requests for public information.

COMPLAINTS OF OBSTETRIC VIOLENCE FILED BEFORE HUMAN RIGHTS COMMISSIONS

DECEMBER 2012 - OCTOBER 2017

1109 COMPLAINTS



[1] The Chihuahua Human Rights Commission reported the number of complaints of "medical negligence" but did not specify if the events had occurred during pregnancy, labor/delivery, or the puerperium.

Source: GIRE's graph based on data from requests for public information.

The recommendations by the CNDH and state human rights commissions regarding cases accompanied by GIRE include comprehensive reparations such as compensation, rehabilitation, and measures of non-repetition. The monitoring of their implementation by the commissions, however, has been inadequate in terms of prevention of future cases and access to justice for women who have survived obstetric violence.

In July 2017, the CNDH offered General Recommendation 31/2017 on Obstetric Violence in the National Health System (SNS) to give visibility to women's experiences in the context of obstetric care at health institutions and to help to identify and eradicate obstetric violence. In general, the recommendation is in line with GIRE's position in that it proposes that the solution does not lie in criminalizing obstetric violence and recognizes the importance of incorporating midwifery into the National Health System. Nevertheless, it also recommends actions such as the implementation of awareness raising workshops for health providers, which do not include evaluation mechanisms to determine their effectiveness or propose changes in the professional training of health personnel from a gender and an intercultural perspective. In that regard, it is essential not only that the CNDH monitors compliance by the institutions to which the recommendation was made but also that there are elements to evaluate the activities that they carry out so that it truly becomes a driver of change in obstetric care in Mexico.

From January 2012 to September 2018, GIRE registered 36 cases of obstetric violence, documented 12, and accompanied 46. In 19 of these cases, the newborn died as the result of abuse experienced by women at obstetric services in Mexico. The case of Elizabeth is another example of these patterns of human rights violations.

CASES REGISTERED, DOCUMENTED, AND ACCOMPANIED BY GIRE / 2012—2018

RECOMMENDATIONS TO THE MEXICAN STATE BY THE CEDAW COMMITTEE AND THE CESCR.[24]

In March and July 2018, the CESCR and the CEDAW Committee, respectively, examined the compliance of the Mexican State with its human rights obligations. Both Committees expressed concern for the structural situation of the National Health System, specifically as it relates to obstetric violence.

The CESCR expressed concern for the structural inadequacy and problems accessing health services.

b) There are significant disparities among regions in terms of accessibility, availability, and quality of health services that are partly due to a lack of adequate infrastructure and medical equipment, shortage of medicines, and insufficient medical personnel.

The CESCR recommended that the Mexican State

a) Step up efforts to ensure that all the population, especially low-income individuals, has access to adequate, affordable, and quality health services;
b) Allocate enough resources to the health sector and continue working to ensure accessibility, availability, and quality of health care in all regions, particularly rural and remote areas, including improving the infrastructure of the primary health care system, and ensure that hospitals have enough and adequate medical personnel, infrastructure, and supplies, as well as the necessary medicines for emergencies.

The CEDAW Committee expressed the following concerns:

— The reports of incidents of obstetric violence by health personnel during labor and delivery;
— The reports of forced sterilization of women and girls and limited access to reproductive health services, particularly for women and girls with intellectual and other disabilities.

The Committee recommended that the Mexican State

— Harmonize federal and state-level laws to classify obstetric violence as a form of institutional and gender-based violence, in accordance with the General Law for Women's Access to a Life Free of Violence, and ensure effective access to justice and comprehensive reparations to all women who have been victims of obstetric violence;
— Ensure that medical personnel request a woman's fully informed consent before performing a sterilization, that practitioners who perform sterilizations without such consent face penalties, and that women that had non-consensual sterilization receive monetary reparation and compensation.

24 The Committee of the Convention on the Elimination of All Forms of Discrimination against Women and the Committee on Economic, Social, and Cultural Rights, respectively.

ELIZABETH

MORELOS, 2016

Elizabeth, who lives in Jiutepec, Morelos, was 25 years old at the end of January 2016, when she received confirmation that she was pregnant and started her prenatal control at the imss Family Medicine Unit No. 3. Later that year, in September, she visited the IMSS Family Medicine Unit No. 1 at the General Regional Hospital, where she was admitted to the labor ward because she was 41 weeks along and her water had broken. She had no labor pains and was two centimeters dilated and in good health.

At the hospital, after several pelvic exams, they induced labor. She was attended to by a resident who performed an episiotomy without informing her and without supervision from the attending doctor. Because of this procedure, Elizabeth had a fourth-degree laceration that resulted in a fistula. The attending doctor, while repairing the laceration, ignored and downplayed Elizabeth's pain and, thus, did not give her any anesthesia. The intervention failed and she had to undergo two additional surgeries.

It was not until May 12, 2017, when she had reconstructive surgery at the IMSS Century 21 Medical Center. Once again, she did not receive clear information about her condition or her short-, medium-, and long-term prognosis.

Elizabeth turned to different officials at the IMSS to complain about the events and then filed a formal complaint with the Morelos Human Rights Commission, which referred it to the CNDH on the grounds of institutional competence. With GIRE's accompaniment, she filed an extension of the complaint, which is still in process despite the time that has elapsed.

In addition, in July 2017, GIRE accompanied Elizabeth to file a legal stay against the IMSS Family Medicine Unit No. 1 at the General Regional Hospital and the IMSS Century 21 Medical Center to request specialized urgent medical care to restore the damage to her health resulting from the deficient services she had received. A judge granted the legal stay so that Elizabeth could have her health and physical integrity fully restored. He also ordered that she receive comprehensive medical care. The resolution, however, was challenged by the IMSS and the appeal is pending.

In April 2018, GIRE found an agreement signed by the IMSS Bipartite Commission for Beneficiaries, whereby it acknowledged that, during labor care, Elizabeth was not properly examined (which resulted in the fourth-degree laceration) and declared the complaint medically admissible. The Commission also ordered the Internal Control Body to review her case. Further, it required the implementation of a training program in human rights with emphasis on humanizing care for pregnant women and an information campaign for women's human rights at the Regional General Hospital.

3.3 CONCLUSIONS

Women's human rights violations during pregnancy, labor and delivery, and postpartum care present common patterns. They stem from structural and systemic problems, whose resolution requires both legislation and public policies that provide women with quality health care services and mechanisms to access justice and comprehensive reparations, including measures of non-repetition, for violations to their human rights.

Obstetric violence is an issue of justice and human rights that requires measures to produce systemic changes in the conception of women's health care. Although Mexico has made progress in relevant legislation, such as including the concept of obstetric violence in most state-level normative frameworks, the country still needs strategies and mechanisms to broadly and continuously disseminate information about the problem from a human rights perspective. In other words, this effort calls for a permanent policy, not merely contextual actions.

Consequently, it is necessary to formulate—from a gender and an intercultural perspective—and implement public policies to eliminate and prevent the actions or omissions that constitute obstetric violence. Urgent measures, in that regard, include prioritizing provision of low-risk labor care at primary care facilities and improving hospital equipment and infrastructure with emphasis on remote and socially marginalized areas, as well as institutionalizing health provider involvement in women's care during pregnancy, labor and delivery, and the postpartum. If the current situation remains unchanged, the *continuum* of violence facing women, which sometimes results in preventable deaths, will be a permanent reality.

4

MATERNAL MORTALITY

MATERNAL MORTALITY

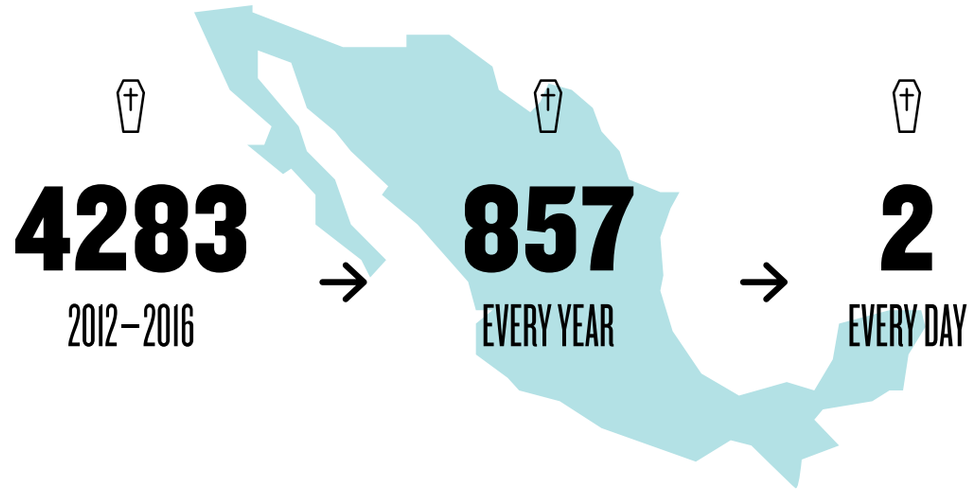
The death of a woman from preventable causes during pregnancy, labor/delivery, and the postpartum—within 42 days of childbirth.

At the international level, maternal deaths are measured by Maternal Mortality Ratios (MMRs).

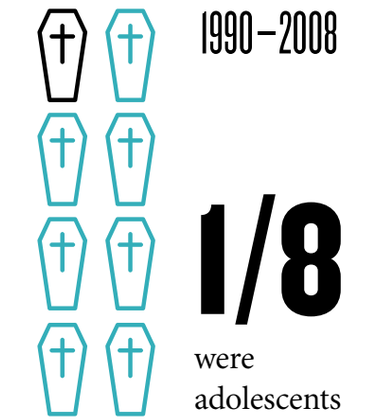
Maternal mortality is associated with structural flaws in the health system. These include limited human, technical, and infrastructure-related resources; saturation of personnel and existing services; and inadequate management of the health budget expenditure, among others.

830 PREVENTABLE DEATHS WORLDWIDE EVERY DAY

Source: WHO.



Source: Maternal Mortality Observatory and INEGI.



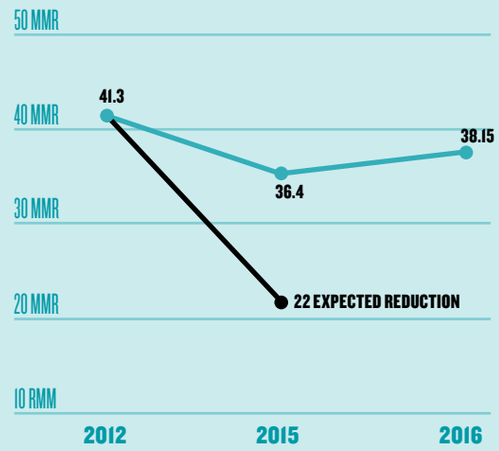
2015

11.2%

were indigenous

Source:
Maternal Mortality Observatory.

MEXICO DID NOT REACH THE MILLENNIUM DEVELOPMENT GOAL OF REDUCING MATERNAL MORTALITY BY 2015



Source: Maternal Mortality Observatory and INEGI.

Photo: Cuartoscuro

Maternal mortality is the death of a woman from preventable causes during pregnancy, labor/delivery, and the postpartum. A maternal death represents a violation of the rights to life, health, equality and non-discrimination, private life, and information, as well as the rights to be free of cruel and inhuman treatment and enjoy the benefits of scientific and technological progress. In Mexico, maternal deaths disproportionately affect the poorest women, as well as women who lack access to social security and indigenous women. The latter suffer multiple forms of discrimination: the lack of access to health services, of interpreters to enable them to give their informed consent to the medical procedures that they undergo, as well as abuse and ill-treatment.[1]

1 GIRE, *Women and Girls without Justice: Reproductive Rights in Mexico*, 2015, page 164. Available at: informe2015.gire.org.mx.

4.1
SITUATION IN MEXICO

Preventable maternal deaths are closely linked to structural flaws in the National Health System. The Organization for Economic Cooperation and Development (OECD) has noted that the Mexican government allocates insufficient funds to health, which results in a negative impact on health care access and quality and a heavy financial burden. The out-of-pocket expenses by health service users amount to 41%, the second highest among OECD countries.[2]

In Mexico, the labor force in health care is not enough to satisfy the demand for services. There are 2.8 professional nurses per 1,000 people, compared to nine, which is the OECD average. Further, the geographical distribution of health workers is not homogenous: whereas Mexico City (CDMX) has 3.9 doctors per 1,000 population, other states have between 1.3 and 2.2. The OECD average is 3.4.[3]

The lack of human, technical, and material resources in the Health System is, according to the CNDH, a structural obstacle to women's care during pregnancy, labor/delivery, and the postpartum. Overuse of health personnel not only compromises their labor rights but also has a negative impact on the timeliness and quality of care provided. Moreover, medical residents often attend women without supervision.[4]

The intersectional discrimination experienced by women in Mexico becomes evident in the differentiated effect of maternal mortality on some groups. The structural flaws in the health system have a specific impact on women from indigenous communities. They often need to travel long distances to reach a health center, which is usually in poor condition, does not have permanent staff or interpreters of local languages, and the health providers discriminate against them.[5]

In 2015, 6% of the Mexican population was indigenous women. Nevertheless, 11.2% of all maternal deaths in the country were indigenous women—evidence of how maternal deaths disproportionately concentrate in this population group. In addition, particularly girls and adolescents are at risk of becoming pregnant. Compared to adult women, according to the WHO,[7] their risk is two to five times higher, a fact that is not usually considered by their health providers. In Mexico, between 1990 and 2008, roughly one in eight maternal deaths were adolescents under 19 years of age.[8] In 2015, of all maternal deaths 10.9% were minors under 19.[9] The case of Anita, an indigenous girl from Puebla, is a clear but appalling example of intersectional discrimination.

2 OECD, *Health at a Glance 2017: OECD Indicators*. Available at: https://www.oecd.org/mexico/Health-at-a- Glance-2017-Key-Findings-MEXICO-in-Spanish.pdf.
3 *Ibid*.
4 CNDH, General Recomendación No. 31/2017 on obstetric violence in the National Health System, paragraphs 216 and 218. Available at: http://www.cndh.org.mx/sites/all/doc/Recomendaciones/generales/RecGral_031.pdf.
5 *Ibid*, paragraph 167.
6 Maternal Mortality Observatory, *Numeralia 2015*.
7 I/A Commission H.R., *Access to Maternal Health Services from a Human Rights Perspective.* [OEA/Ser.L/V/II.Doc. 69, Jun 7, 2010], Washington, 2010, paragraph 15. Available at: https://www.oas.org/en/iachr/women/docs/pdf/saludmaternaeng.pdf.
8 Schiavon, R., Erika Troncoso, and Gerardo Polo, "Analysis of maternal and abortion-related mortality in Mexico over the last two decades, 1990-2008," in *International Journal of Gynecology and Obstetric*s, vol. 188, supplement 2, September 2012, pages S78-S86. Available at: http://bit.ly/12lqxIm.
9 Maternal Mortality Observatory, *op. cit*.

ANITA

PUEBLA, 2018

Anita used to live near the highway, 20 minutes away from the center of Huehuetla, Puebla. She was a high school student and worked at her godparents' store. Her father died five months before the events occurred and, currently, her siblings are the family providers.

At 16, Anita became pregnant. When she was approximately 37 weeks pregnant, her contractions started so together with her mother, Rosa, Anita went to the Huehuetla Community Hospital. Upon arriving, a doctor examined her and said that it was still too early for her to give birth; that she should return in the afternoon for a second exam. Anita and her mother went back home and, in the afternoon, returned to the hospital, where the doctor told her again that it was early for her to be in labor, that she should go for a walk.

Anita was admitted to the hospital around 10 pm. The doctor examined her and told her that everything was going well. Nevertheless, an hour later, Anita asked for her mother; she told her that she was feeling very bad and wanted to be transferred to the Ixtepec Hospital for a C-section, as had been indicated due to her age during her prenatal control. Anita's mother asked the doctor to transfer her daughter but angrily, the doctor replied that Anita was not a physician and, thus, unable to make such a decision; that she was to have a vaginal delivery. Around 4:00 am, they took her to the delivery room and an hour later, the doctor asked Rosa to come and see Anita. Anita was unconscious and there was a lot of blood on the floor and on the doctor and nurse's clothes. Rosa started cleaning Anita and asked the doctor to stop hurting her. The doctor and the nurse made signs to each other and then told Rosa to leave.

Nobody informed the family about Anita's health status until 8:00 am, when the doctor told them that she had died. She also said that they had not taken the fetus out because they had seen that Anita "didn't want it" and "hadn't made an effort" to have a successful delivery.

Rosa did not sign the hospital's documents to acknowledge receipt of the remains because she wanted to find out what had happened. Officials of the Zacatlan health jurisdiction came to talk to the family and assured them that the medical staff had acted appropriately. Afterward, representatives of the Puebla Prosecutor's Office also came to ask the family to authorize the transfer of Anita's body to Zacatlan.

Anita and her baby were buried by their family on August 6, 2018. GIRE learned about the case through conversations with Anita's godfather and will accompany the family in their pursuit of justice.

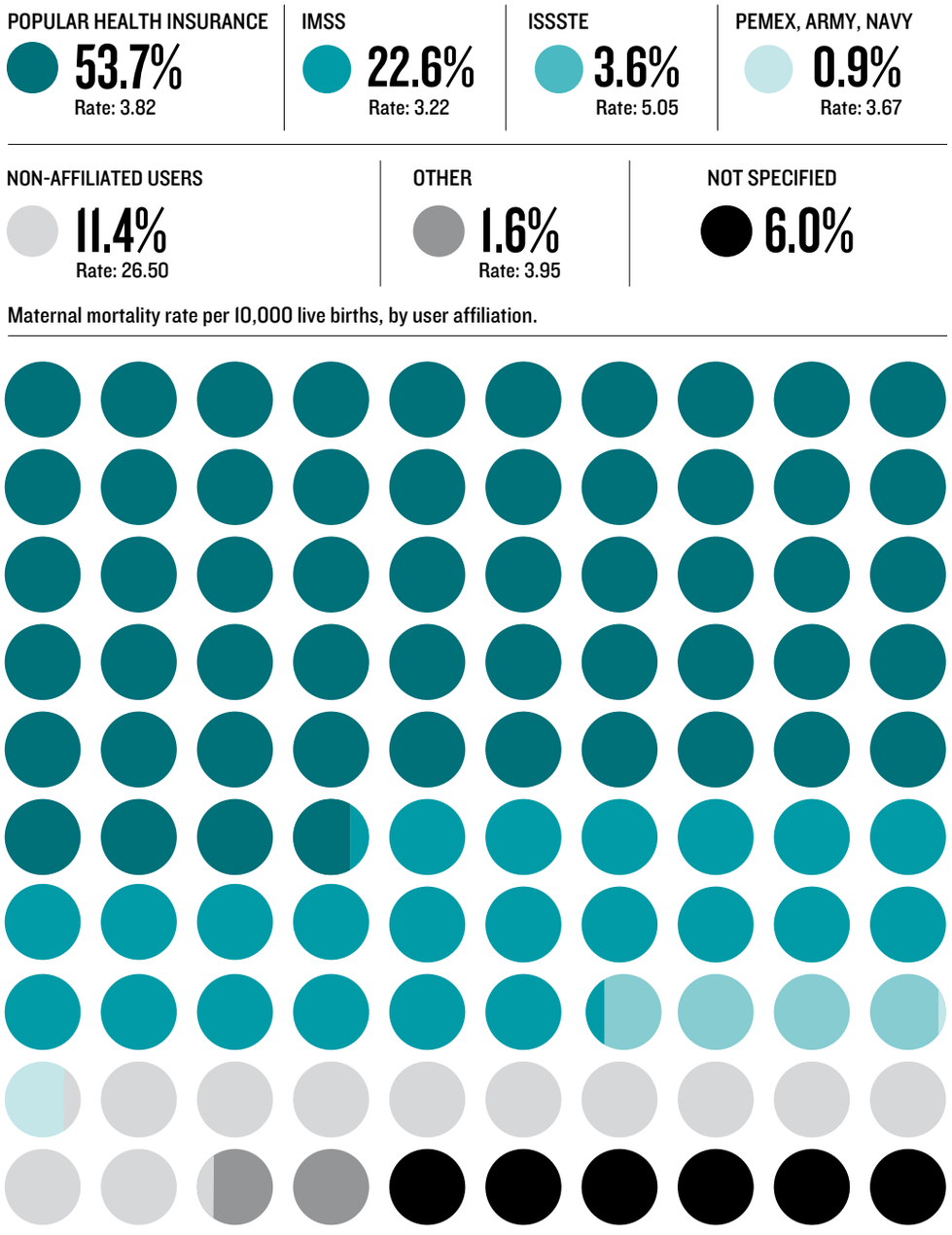
The emphasis on increasing the coverage of universal access to health services has lowered the priority on the need for addressing low quality services and deficiencies in infrastructure and equipment that affect health service provision during pregnancy, labor/delivery, and the postpartum, at public institutions. Further, the fragmentation of the National Health System has resulted in users receiving unequal care at varying costs depending on their affiliation, if any.

Despite the fast pace of affiliation to programs such as the Universal Health Insurance Program, in recent years it has become evident that in terms of service provision, they have bigger problems than the IMSS and ISSSTE, and their service package, personnel and infrastructure cannot satisfy the demand for care.[10] In 2015, according to the Maternal Mortality Observatory, 53.7% of the maternal deaths in the country were Universal Health Insurance Program affiliates. Although the Universal Health Insurance Program serves a larger sector of the general population, an analysis of the number of women that receive health care from each institution reveals that the ISSSTE has the highest rate of maternal deaths compared to the IMSS, the Universal Health Insurance Program, and other agencies offering social security like Pemex, the Ministry of National Defense (SEDENA), and the Navy (SEMAR).

10 Laurell, Asa Cristina, *Impacto del Seguro Popular en el sistema de salud mexicano*, Buenos Aires, CLACSO, 2013, page 114.

MATERNAL DEATHS BY AFFILIATION[11]

2015



Maternal mortality rate per 10,000 live births, by user affiliation.

Source: SINAC, 2015.

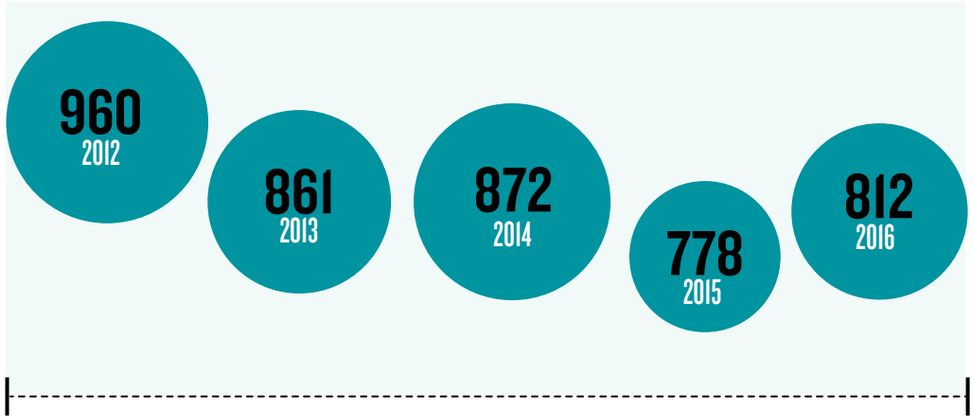
11 For further information, see justiciareproductiva.gire.org.mx.

A. MATERNAL DEATH TRENDS IN MEXICO, 2012-2016

At the international level, maternal deaths are measured by the Maternal Mortality Ratio (MMR). This value indicates the number of women who die from preventable pregnancy- or childbirth-related causes per 100,000 live births. In 2016,[12] the states with the highest MMRs were Campeche (46.3), Chiapas (45.7), Oaxaca (44.3), Guerrero (43.7) and Hidalgo (43.6). From 2012 to 2016, a total of 4,283 women died from preventable causes related to pregnancy, labor/delivery, and postpartum in Mexico. In other words, on average, 857 women died every year or two each day. Their deaths reflect the gross injustices that persist in the country, as well as the human rights violations that women experience every day that result in deaths that could have been avoided.

MATERNAL DEATHS IN MEXICO

2012-2016



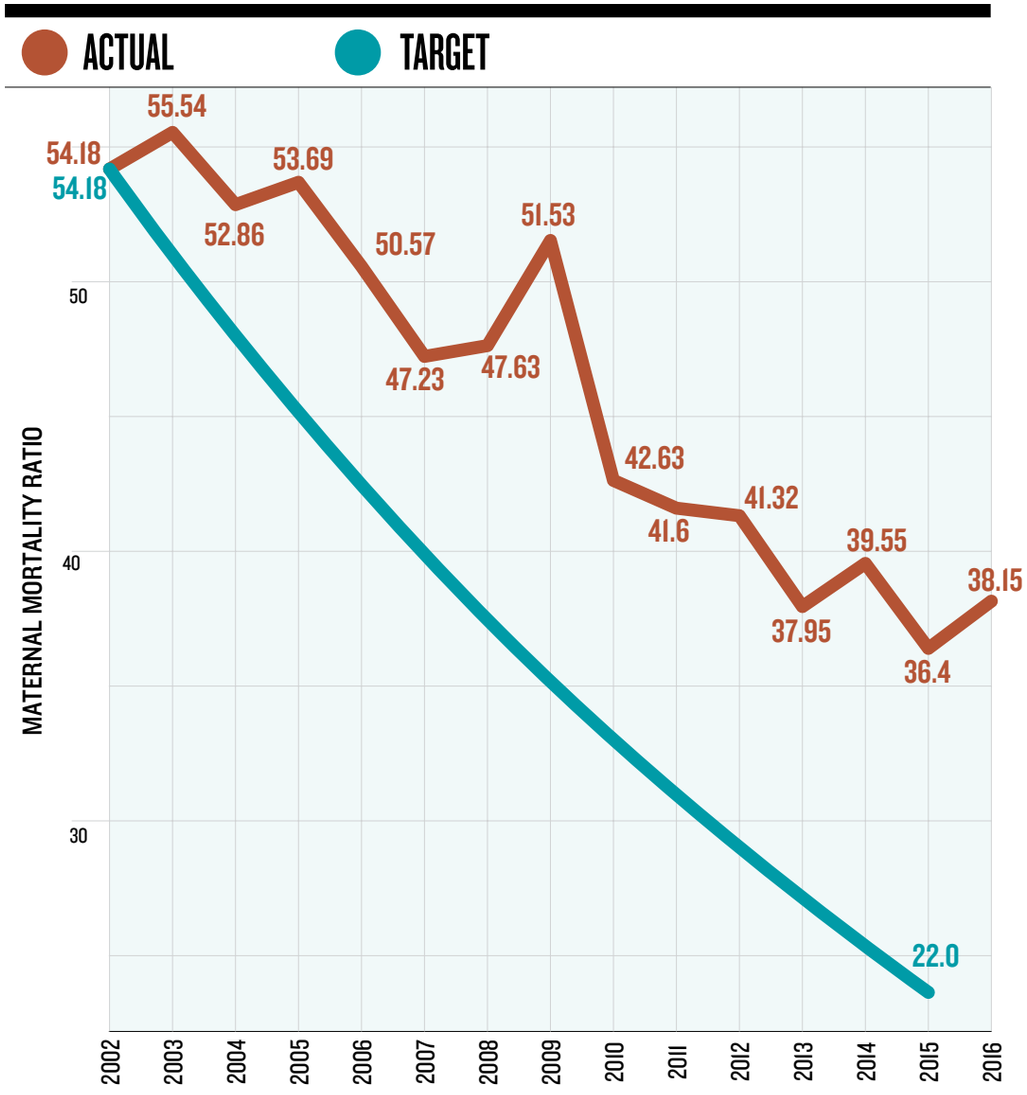
Source: GIRE's graph based on data from the Maternal Mortality Observatory (2012–2015) and INEGI (2016).

ON AVERAGE, 857 WOMEN DIED EVERY YEAR OR TWO EVERY DAY.

12 Although the figure is published in the Weekly Epidemiological Surveillance Reports by the Ministry of Health for 2017 and 2018, GIRE decided not to include this information because they tend to under-report maternal mortality. The Reports do not consider women who died from postpartum complications. The data is adjusted by INEGI approximately a year after the occurrence of maternal deaths. Once available, it can be accessed at justiciareproductiva.gire.org.mx.

NATIONAL MATERNAL MORTALITY RATIO

2002 - 2016



Source: GIRE's graph based on data from the Maternal Mortality Observatory.

IN 2016, THE STATES WITH THE HIGHEST MMRS WERE CAMPECHE, MEXICO CITY, GUERRERO, HIDALGO AND OAXACA.

There have been changes in the national MMR. It went from 41.32 in 2012 to 36.4 in 2015 and to 38.15 in 2016. Overall, this decrease was undoubtedly positive but not enough to reach the Millennium Development Goals (MDGS). Pursuant to these Goals, the MMR should have dropped to 22 by 2015.

MATERNAL MORTALITY RATIO BY STATE

2012 - 2016

	2012	2013	2014	2015	2016
NATIONAL	42.3	38.2	38.9	34.6	35.4
AGS	47.7	25.7	22.1	25.8	19.1
BC	31	42.3	28.9	32	27
BCS	23.3	32.1	15.9	24.3	8.1
CAMP	42.8	65.4 ★	18	46.5 ★	46.3 ★
CHIS	60.6 ★	54.8 ★	68.1 ★	68.5 ★	40.1
CHIH	46.7	59.8 ★	56.5 ★	43.1	42.3
CDMX	40.1	41.9	41.9	44.3	45.7 ★
COAH	34.4	27	37	28.3	43.4
COL	23.6	22.5	29.4	22.3	26.2
DUR	52.5 ★	41.2	71.2 ★	31.1	37
GTO	34.8	34.9	27.7	31.2	31.7
GRO	75.9 ★	59.4 ★	58.7 ★	49.5 ★	43.7 ★
HGO	37.8	37.5	65.5 ★	32.3	43.6 ★
JAL	23.4	22.4	34.4	24.7	24.8
MEX	42.7	36.1	33.9	30.9	42.8
MICH	41.7	36.7	47.7	34.3	24.7
MOR	39	44.5	9.1	36.6	30.7
NAY	45.5	36.1	28.5	66.9 ★	37.4
NL	26.6	14.8	17.6	23.5	35.6
OAX	65.3 ★	50.4	46.7	48.6 ★	44.3 ★
PUE	50.6	31.8	37.6	32.3	37.7
QRO	19.8	35	34.5	14.9	35.3
QROO	50.4	46.2	27.8	20.7	32.9
SLP	40.7	31.8	24.1	30.1	25.9
SIN	41.5	26.7	31.4	22.1	39.2
SON	33.2	40.2	33.7	32.2	43.3
TAB	34.2	27.4	40.7	41.7	33.6
TAMPS	26	41.7	28.5	32	35.4
TLAX	59.4 ★	23.2	51.4	20.1	39.9
VER	51	46.4	43.4	29.9	30
YUC	50.1	50.8 ★	42.4	32.6	31.1
ZAC	32	44.2	32.5	32.6	20.8

★ States with the highest annual MMRs.

Source: Maternal Mortality Observatory (2012-2015); INEGI (2016).

Of the states with the highest rates of maternal deaths in 2012, three of them were among the five that ranked worst in 2016. These were Chiapas, Oaxaca, and Guerrero, which despite having had a decrease during the period, their MMRs are still higher than the national ratio. Significantly, according to CONEVAL, in 2016, these three states occupied the first three places of the Social Gap Index for 2000-2015.[13] Of the five states with the highest rates of maternal deaths in 2016, Campeche ranked first among those states that in the last years had reported the highest rates at the national level. Hidalgo also demonstrated a setback in the combat of maternal mortality and closed out 2016 in fifth place nationally.

B. NORMATIVE AND PUBLIC POLICY FRAMEWORK

NORMATIVE FRAMEWORK

The General Health Law establishes the bases and modalities to access health services, as well as the concurrence of the Federation and the states in matters of general health. Chapter V stipulates that mother and child care is a priority and, among other provisions, defines actions aimed at improving access and quality of pregnancy, labor/delivery, and postpartum care.

> According to Article 64 bis 1 of the Law, all health services in the country will provide prompt care to women presenting obstetric emergencies regardless of whether they are beneficiaries or affiliates of an insurance scheme. In other words, the lack of affiliation to a social security scheme will not be grounds for denying women care during pregnancy and labor or delivery.

The Mexican Official Norm 007-SSA2-2016, On Providing Care for Women during Pregnancy, Labor and Delivery, and the Puerperium, and for the Newborn (NOM 007), stipulates minimum criteria for the provision of medical care for women during pregnancy, labor/delivery, and the postpartum, and for the newborn. NOM 007 is binding for all health facilities in the country. The following are some of the criteria that are particularly critical to prevent maternal deaths:

13 *The Social Gap Index* uses information regarding education, access to health services, and household quality, utilities, and other assets. Available at: https://www.coneval.org.mx/Medicion/Documents/Indice_Rezago_Social_2015/Nota_Rezago_Social_2015_vf.pdf.

DURING PREGNANCY

- Health providers will fully inform the pregnant woman and her family about the warning signs and symptoms that require immediate medical attention and will prepare a relevant safety scheme (5.3.1.12).
- All women who have reached 41 or more weeks of pregnancy will be evaluated at a secondary health care level facility (5.2.1.17).
- In all obstetric emergency cases (obstetric hemorrhage, hypertensive disorders during pregnancy, threatened preterm labor, sepsis, or serious concomitant diseases), health providers will ensure provision of timely and quality comprehensive medical care or, if needed, the timely transfer of the user to an adequate referral hospital (5.3.1.13 and 5.3.1.13.3).

DURING LABOR

- Upon admission of the user to obstetric services, a clinical file will be set up as per NOM 004 that will include a partograph. If the user must be transferred to a referral hospital, the safety and timeliness of the transfer will be guaranteed (5.5.2).
- No provider of gynecological or obstetric services will discriminate against the women or inflict on her any form of violence during labor (5.5.3).
- All indications, prescriptions, and procedures will be registered in the clinical file (5.5.13).

DURING THE POSTPARTUM

- Medical monitoring during the postpartum will include, among others, the following procedures:
- Women will be monitored every 15 minutes within the first hour postpartum. Afterward, they will be monitored every 30 minutes until after 2 hours of delivery and subsequently, every 4-8 hours depending on her condition and until her discharge (5.6.1.2).
- The woman and her partner will receive information to identify warning signs and symptoms in a timely manner (5.6.1.5).
- The woman can be discharged 24 hours postpartum provided there are no complications (5.6.1.6).

The Mexican Official Norm 004-SSA3-2012, On Clinical Files (NOM 004), establishes the criteria for the preparation, compilation and confidentiality of medical records, which are a fundamental tool to protect the woman's health. NOM 004—and all other official norms—is mandatory for all personnel working for any institution of the National Health System. The following are some of its most relevant provisions:

> - Medical personnel are under the obligation to provide the woman and her family with verbal information (5.6);
> - All medical notes and reports will include date, time, the provider's full name and signature; the woman's full name, age, sex, bed number, and file number (5.9 and 5.10);
> - The documents that make up the clinical file will be confidential information (5.7).

Nevertheless, GIRE has found that non-compliance with this Norm is a frequent occurrence in the cases that it has registered, documented, and accompanied. Examples of non-compliance include serious contradictions between the notes prepared by medical and nursing staff; failure to provide the woman and her family with information about her health status; and confusing data and corrections to the information in the files, which makes it impossible to accurately determine how the events occurred. This constitutes an obstacle in accessing justice for the families of women who die from causes related to pregnancy, labor/delivery, and postpartum. The CNDH has also stated that the incorrect or deficient compilation of clinical files has been the object of several recommendations.[14]

14 CNDH, *op. cit.*, paragraph 215.

PUBLIC POLICIES

The National Development Plan governs programming and budgeting at all levels of the Federal Public Administration and coordinates the government's strategy to reach social development goals, health among them. Given that the current Plan will end in 2018, GIRE believes that it is essential that its successor considers—at least—the following in matters of maternal mortality:

- Recognize that reducing maternal mortality is a human rights issue.
- Prioritize effective coordination between agencies and institutions to promote universal access to obstetric health services regardless of the woman's affiliation or lack thereof.

The Specific Action Program on Maternal and Perinatal Health is an instrument of the national health policy that was designed to improve access and quality of health services and assets during pregnancy, labor/delivery, and the postpartum for both the woman and newborn child. Like the National Development Plan, the Program will end in 2018. Therefore, it is essential that the new instrument includes the following actions:

- Incorporate the midwifery model into maternal and perinatal health services.
- Consider the diversity of users of reproductive health services—indigenous women, adolescents, people with disabilities—during the design, implementation, and evaluation of the Program.
- Allow for strategies and activities to ensure that more low-risk pregnant, laboring, and postpartum women receive care at the primary health care level.

RECOMMENDATIONS TO MEXICO BY THE CEDAW COMMITTEE

In July 2018, the Committee of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) examined compliance by the Mexican State with its obligations in matters of women's human rights. Among the reasons for concern stated by the Committee were the high rates of maternal deaths that disproportionately affect women from indigenous communities in Mexico.

In line with the content and meaning of women's right to health, the CEDAW Committee recommended that the Mexican State

e) Reduce the incidence of maternal mortality, including through collaboration with traditional midwives and the training of health professionals, especially in rural areas, ensuring that all births are attended by skilled health personnel, in line with targets 3.1 and 3.7 of the Sustainable Development Goals.[15]

15 United Nations, Committee on the Elimination of Discrimination against Women, *Concluding observations on the ninth periodic report of Mexico*, [CEDAW/C/MEX/CO/9], 70th Session, 2018, paragraph 42 (e).

ALYNE DA SILVA PIMENTEL V BRAZIL: THE STATE'S RESPONSIBILITY FOR A MATERNAL DEATH[16]

Alyne da Silva Pimentel was an Afro-descendant woman from a marginalized community in Rio de Janeiro, Brazil. She was the mother of a five-year-old girl. On November 11, 2002, she went to a private health center because she had nausea and abdominal pain; she was in her sixth month of pregnancy. At the facility, they prescribed some medicines and sent her home. The following days, her condition worsened considerably and she returned to the health center. Once there, she had to wait hours to see a doctor. When she was finally examined, the doctor on call told her that he could not detect a fetal heartbeat and, therefore, they induced delivery.

Alyne had to wait an additional six hours to deliver the stillborn. Some 14 hours later, she underwent curettage surgery to remove parts of the placenta and afterbirth. Since her condition continued to worsen, she needed specialized emergency care. The health center staff could not locate her prenatal files and because there was no transportation available, she had to wait eight hours—two of which she was in a coma—to be transferred to a public hospital. Once there, she had to be resuscitated. The hospital placed her in a makeshift area in the hallway. Since the medical providers had not brought her medical files to the hospital, they provided the treating physician with a brief oral account of her symptoms. Alyne died on November 16, 2002, three days after the delivery.

After a trial began, a Brazilian court ordered child support and compensation for moral damages to Alyne's daughter. The court, however, did not rule that the State was responsible for her death because Alyne had been treated at a public clinic. Therefore, her mother, represented by the Center for Reproductive Rights, decided to bring her case before the CEDAW Committee, claiming that the Brazilian State had violated Alyne's rights to life and health, which are protected by CEDAW.

In 2011, the CEDAW Committee published its decision and identified two main elements in the case. First, Alyne's death constituted maternal mortality and, second, she had not received adequate obstetric care.

In conclusion, the Committee observed that failure to provide maternal health services that satisfy women's needs is not only a violation of the right to reproductive health services but also gender-based discrimination and a violation of the right to life. Thus, it recommended that the Brazilian State award reparation for the harm done to Alyne's daughter, reduce the maternal death rate, and implement measures of non-repetition at hospitals and health centers in the country.

Alyne da Silva Pimentel v Brazil is the first case of maternal mortality brought before and decided by an international human rights protection organism. Hence, it has been critical to advance the recognition of women's reproductive rights and the positive obligations of the State to protect them, particularly non-discriminatory access to health services and quality public and private maternal health services.

16 United Nations, CEDAW Committee, [Case of Alyne da Silva Pimentel v Brazil] Communication No. 17/2008, [CEDAW/C/49/D/17/2008], 49th Session (2011).

Photo: Chiaroscuro

4.2
ACCESS TO JUSTICE

Effective resources and judicial protection are the main guarantee for victims of human rights violations and their families to access the justice they are due. Attribution of responsibility in cases of maternal deaths also helps to identify and eliminate the discriminatory practices that perpetuate maternal mortality, as well as award reparation for human rights violations, and enforce guarantees of non-repetition.

A. ADMINISTRATIVE COMPLAINTS

For cases of maternal mortality, the most immediate resource is a written complaint whereby the family can report poor medical care to the internal comptroller of each health institution. With the reports, an investigation of the facts will be conducted and, if applicable, penalties will be imposed. The disadvantages of this mechanism are that each institution determines what procedure to follow in these cases, thus creating uncertainty for the users. Further, the fact that a complaint is filed against the health institution that both allegedly provided poor care and will resolve the complaint may create a conflict of interest when attributing responsibility for the events to a public servant and the institution and may have a negative impact on future care provided to those who filed the complaint.

With the responses to requests for information, GIRE noted that in the last five years, 96 complaints of maternal deaths had been filed against state health services. Federal health institutions, in turn, reported not having any available information on the matter or any complaint of maternal death, or that information was non-existent. As for the IMSS, the Division for the Handling of Complaints of Human Rights Violations reported having received a total of 12 complaints. Nevertheless, it explained that they had been received by the CNDH and, thus, it was impossible to determine if they had also been lodged with the internal comptroller of the institution.

COMPLAINTS OF MATERNAL DEATHS FILED WITH INTERNAL CONTROL BODIES OF HEALTH INSTITUTIONS

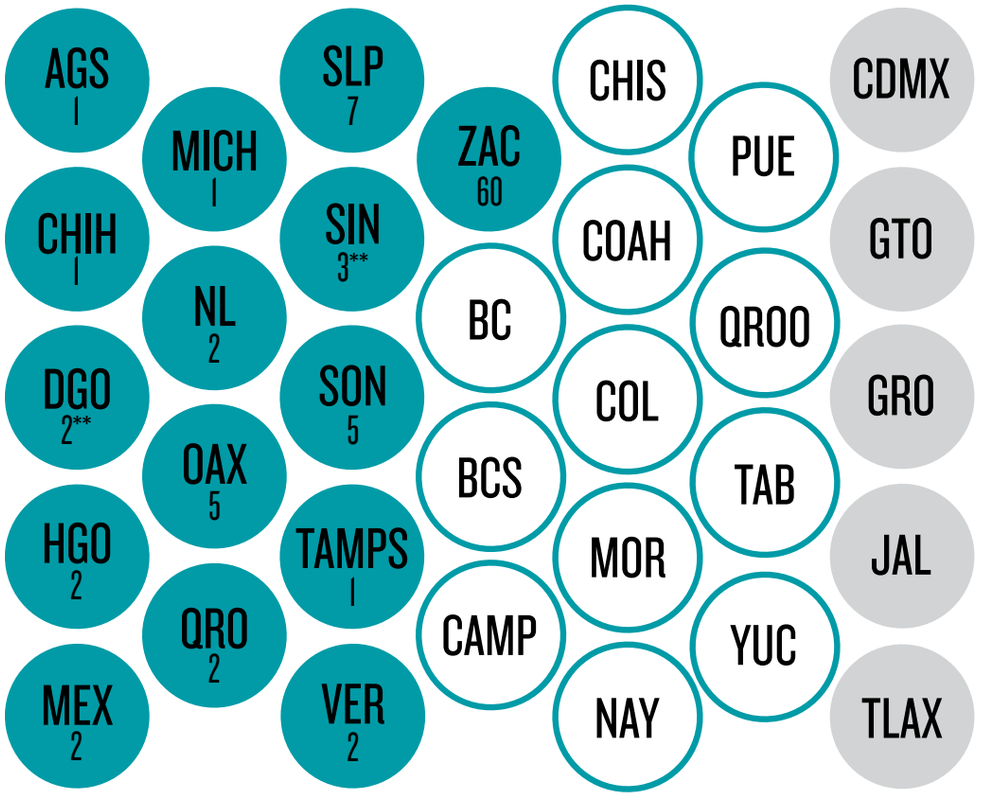
DECEMBER 2012 - OCTOBER 2017

FEDERAL 12 COMPLAINTS

WITH COMPLAINTS | WITH OUT COMPLATINS | DATA NON-EXISTENT OR UNAVAILABLE

IMSS 12* | MOH | ISSSTE | PEMEX

LOCAL 96 COMPLAINTS



* They reported that the complaints had been filed with the CNDH.

** These states did not disaggregate the data by year and did not respond to GIRE's request until January and February 2018. Therefore, it is impossible to accurately determine if the data was for the requested period (2012-2017).

Source: GIRE's graph based on data from requests for public information.

B. APPEALS FILED WITH THE NATIONAL COMMISSION ON MEDICAL ARBITRATION

The National Commission on Medical Arbitration (CONAMED) is a decentralized agency of the federal Ministry of Health. Its main responsibilities include advising users of medical services, dealing with complaints or irregularities in health care, mediating and settling disputes between health providers and users, and providing technical opinions on general issues.

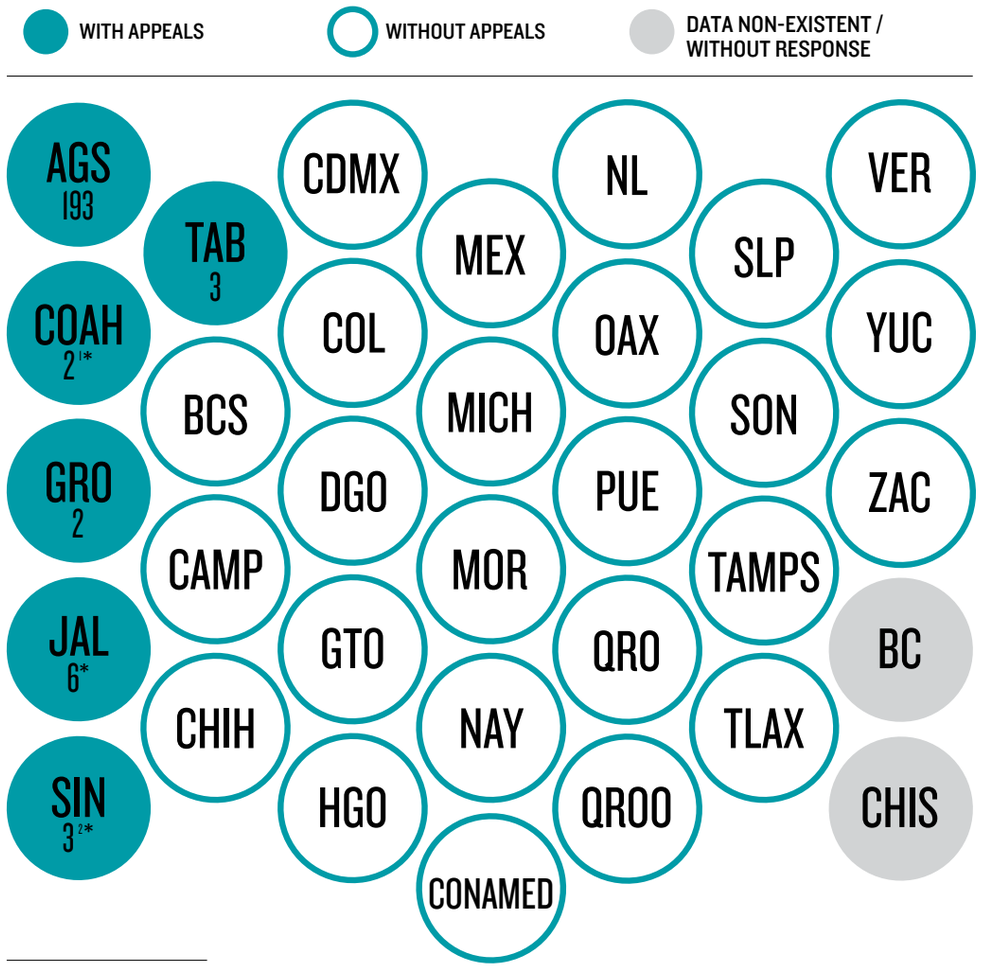
Both CONAMED and its state counterparts represent an option that enables those affected by maternal mortality to receive compensation more easily than if they resorted to jurisdictional bodies. Nonetheless, this option focuses on the individual performance of medical staff and, therefore, it does not consider measures of non-repetition to address the underlying structural problem that produces the high rates of maternal deaths in the country.

GIRE requested public information to CONAMED and its state counterparts to determine the number of cases of maternal deaths submitted in the last five years. The authorities reported having received 209 appeals in the period. Significantly, Aguascalientes reported 193.

APPEALS ON MATERNAL MORTALITY FILED WITH COMMISSIONS ON MEDICAL ARBITRATION

DECEMBER 2012 - OCTOBER 2017

209 APPEALS RECEIVED



[1] One of the appeals was settled.
[2] One appeal was turned to a criminal court, and two other appellants were awarded death compensation.

* These states did not disaggregate the data by year. They did not respond to the request for information until between March and April 2018. Therefore, it is impossible to accurately determine if the data was for the requested period (December 2012 - October 2017).

Source: GIRE's graph based on data from requests for public information.

C. COMPLAINTS FILED WITH HUMAN RIGHTS COMMISSIONS

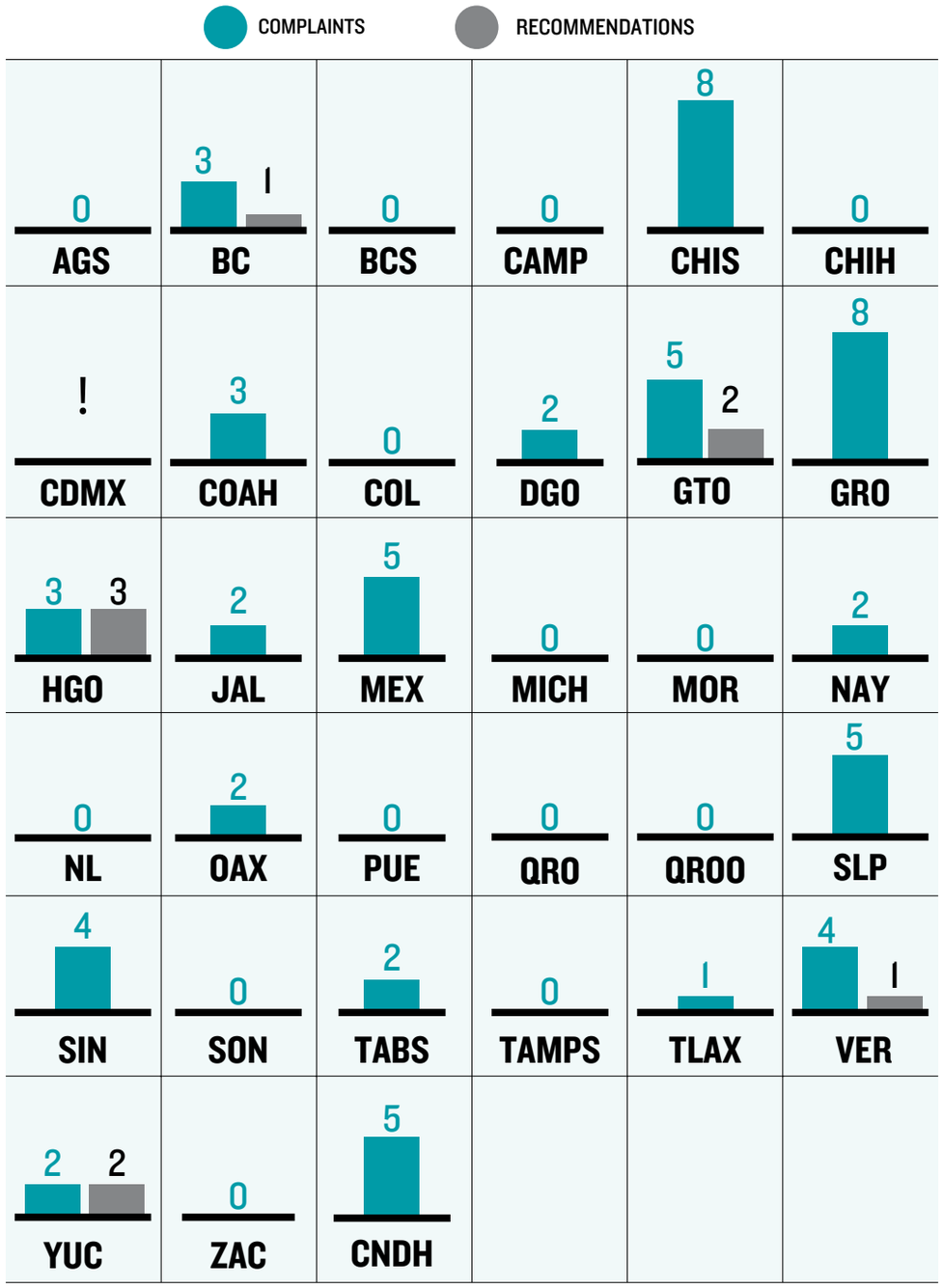
Although Mexico has procedures that can be used in cases of maternal mortality, none stipulates comprehensive reparation for human rights violations even when maternal deaths are usually related to structural issues that go beyond the performance of individual health providers. For that reason, GIRE opts to file complaints with state human rights commissions and the CNDH for the cases that are accompanied. This way, it is more feasible to obtain measures of reparation that help to prevent future cases instead of only imposing penalties on individual health providers. In GIRE's experience, however, complaints often take years to be resolved. Moreover, the specific petitions of the complainants are not taken into consideration and when recommendations are issued, their compliance is limited to the exchange of official documents between authorities.

GIRE submitted requests for public information to the CNDH and state human rights commissions to find out how many complaints of maternal deaths had been submitted in the last five years. In total, 66 complaints were received and nine recommendations were issued during the period.

COMPLAINTS OF MATERNAL MORTALITY FILED WITH HUMAN RIGHTS COMMISSIONS

DECEMBER 2012 – OCTOBER 2017

66 COMPLAINTS **9** RECOMMENDATIONS



! CDMX Commission responded, "Maternal death is not a human right or a violation classified in the Catalogue for the Qualification and Investigation of Human Rights Violations." Request for information. File Number: 3200000007718.

Source: GIRE's graph based on data from requests for public information.

Following are the most frequent behaviors mentioned in the public versions of the recommendations to which GIRE had access:

- Failure to provide the woman and her family with information about her health status.
- The woman was denied care or had to wait to receive it.
- Deficient compilation of clinical files.
- Poor conditions and hygiene at hospitals; lack of water, ambulances and medical personnel.
- The woman was not transferred to a secondary or tertiary care hospital.
- Failure to perform the necessary tests.
- The woman was discharged before the first 24 hours after delivery, in contradiction to the NOM 007.
- Failure to justify the need for episiotomy and to record the procedure in the file.
- Failure to obtain the woman's informed consent.
- Failure to provide the woman and her family with information about care needed and warning signs in the postpartum.
- Failure to provide the necessary care even when the providers knew that the woman had a high-risk pregnancy.

The state human rights commissions included the following measures, among others, in their recommendations:

- Request that the state legislature create a budget item to allocate enough funds to ensure that all health centers suitably equipped.
- Instruct the medical centers in the state to meet the highest standards of hygiene.
- Instruct public health providers to comply with relevant Mexican Official Norms.
- Implement human rights training for health providers.
- Initiate administrative proceedings against personnel involved in a maternal death.
- Take the necessary measures to ensure that staff compile clinical files correctly.

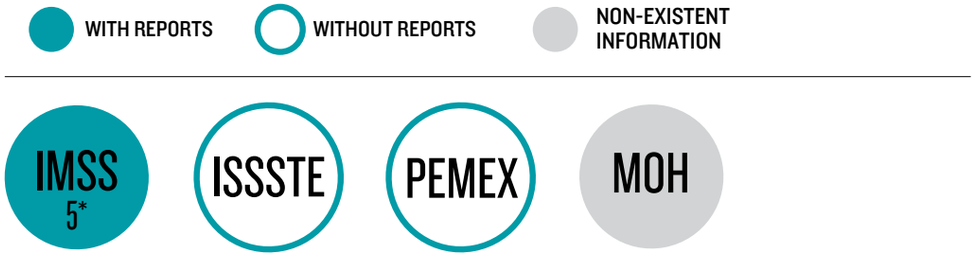
D. COMPENSATION FOR PATRIMONIAL LIABILITY OF THE STATE

The Federal Law on the Patrimonial Liability of the State establishes the conditions to recognize the right to compensation of individuals whose assets or rights had been harmed as the result of the State's administrative activity. For cases of maternal deaths, the victim's relatives can demand that the State pay damages. Nevertheless, compensation as such is not comprehensive reparation for human rights violations, nor does it include measures of non-repetition. GIRE requested public information from federal and state health institutions to determine how the mechanisms were used in cases of maternal mortality. The IMSS reported five cases where compensation was requested between December 2012 and October 2017; only in two cases was compensation awarded to the complainants. At the state level, only Guanajuato and Oaxaca had received requests for compensation.

COMPENSATION FOR PATRIMONIAL LIABILITY OF THE STATE FOR MATERNAL MORTALITY

DECEMBER 2012 - OCTOBER 2017

FEDERAL 5 CASES REPORTED



*In two cases, compensation was awarded to the complainants.

MINISTRY OF HEALTH 3 CASES REPORTED

Source: GIRE's graph based on data from requests for public information.

Between 2013 and September 2018, GIRE registered, documented, and accompanied 24 cases of maternal mortality in the country. Of the cases that GIRE accompanied, seven occurred in Oaxaca, a state with a high MMR. The stories of Anita and Gelleli exemplify the seriousness of the human rights violations that are committed when there is a maternal death, particularly an indigenous woman's, as well as the obstacles to justice faced by the families, who almost always have to wait very long periods for a resolution by the authorities.

CASES REGISTERED, DOCUMENTED, AND ACCOMPANIED BY GIRE / 2013–2018

GIRE believes that resorting to criminal law is not ideal to achieve solutions and provide access to justice in cases of maternal mortality. Imposing penalties on health providers does not address the root causes of these problems; it is not a very effective palliative to change the conditions that promote the prevalence of maternal deaths. Nevertheless, when doctors commit a crime, criminal law becomes a feasible resource. As stated in Article 228 of the Federal Penal Code, "The practitioners […] will be responsible for crimes committed in the exercise of their profession."

GELLELI

OAXACA, 2018

Gelleli was an indigenous Mazatec woman who lived in Jalapa de Diaz, Oaxaca. At 24, she was pregnant for the second time, and her pregnancy was going well, without complications.

In her 40th week of pregnancy, Gelleli began to feel unwell. Thus, together with Martin, her partner, she went to a health center, where she was informed that she needed urgent medical care and should go to the Tuxtepec General Hospital. To travel to the hospital, they needed help because the municipal health center did not have an ambulance.

It was 6:00 pm when Gelleli reached the Tuxtepec hospital but she was not attended to until 8:00 am the following morning. Her partner did not receive any information about her until several hours later, when he was told that Gelleli needed a second surgery because during the C-section they had perforated an artery and she had internal bleeding. At that moment, without further explanation, they made him sign an informed consent form even though he could not read or write in Spanish. He was told that if he refused to sign, Gelleli would die. Nobody gave him any more information about his partner's health that day.

The following morning, the providers informed him that Gelleli needed yet another intervention because they had been unable to stop the hemorrhage. This surgery entailed a high risk to Gelleli's life. Moreover, if she survived, there was no guarantee that her condition would improve. After discussing her status, Martin and Gelleli's family decided to refuse the procedure. The following day, they were notified that Gelleli had died.

GIRE decided to accompany Gelleli's case, which is currently under consideration by the Office for the Defense of the Human Rights of the People of Oaxaca. Her family has been waiting for justice for over a year. Comprehensive reparation is urgently needed.

Should a recommendation be issued, it is expected to offer comprehensive reparation, including relevant penalties; a public apology from the hospital; guarantee of provision of medical, psychological, legal, and social care for Gelleli's family; measures of non-repetition that encompass awareness-raising programs for health personnel, enforcement of current norms, and adequate equipment for the Tuxtepec General Hospital, as well as financial compensation for Gelleli's family for expenses incurred because of her death, among others.

The cases of Anita and Gelleli are not isolated outliers, and the violations of their human rights left direct and indirect victims. The preventable death of a woman during or after delivery, especially one who suffered abuse and discrimination, is a problem that is yet to be resolved by the health system. This pending issue, as shown by hard data, must urgently be addressed by the Mexican State.

Photo: Chiaroscuro

4.3
CONCLUSIONS

Preventable maternal deaths stem from multiple violations of women's human rights. They are largely due to structural flaws of the health sector: understaffed health facilities—which foster overuse of health providers at the expense of their labor rights and the quality and timeliness of care—, a lack of medical supplies and infrastructure, as well as inadequately located facilities that make women, especially indigenous women, travel long hours to seek care, hours that may be the difference between life and death. In some other cases, structural flaws add to ill treatment and discrimination by health providers against the women and their families (obstetric violence).

It is essential that the State guarantees women's universal access to quality obstetric services regardless of their affiliation to health regimens or lack thereof, especially during labor or any obstetric emergency. Given that full compliance with this obligation can be difficult to enforce in the immediate future, the new administration should urgently start to take steps toward that end, define priority actions focused on providing women with access to health services when they are at their most vulnerable, ensure that medical staff adheres to the current normative framework in matters of pregnancy, labor/delivery, and postpartum care, and strengthen mechanisms for the enforceability and justiciability of the rights that are compromised in cases of maternal mortality.

5

LIMITED ACCESS TO SOCIAL SECURITY

LIMITED ACCESS TO SOCIAL SECURITY

WOMEN AFFILIATED TO

UNIVERSAL HEALTH INSURANCE PROGRAM	IMSS	ISSSTE
54.8%	**42.36%**	**9.56%**

The Universal Health Insurance Program offers basic health services but does not provide such social security benefits as daycare centers, maternity and paternity leaves, sick leave or pensions.

Source: CONEVAL, 2018.

MEN WITH NO ACCESS TO DAYCARE FOR THEIR CHILDREN

A LARGER PROPORTION OF WOMEN WORK IN THE INFORMAL SECTOR

Source: INEGI, 2018

BALANCE BETWEEN WORK AND PERSONAL LIFE IN MEXICO

NUMBER OF HOURS A WEEK DEDICATED TO UNPAID CARE WORK	6.61	16.7
NUMBER OF HOURS A WEEK DEDICATED TO HOUSEWORK	9.49	18.57

Source: ENOE, 2018.

MATERNITY AND PATERNITY LEAVES

MEXICO	5 days	12 weeks
INTERNATIONAL STANDARDS	4.3 weeks OECD AVERAGE	14 weeks ILO STANDARD

Photos: Instituto Mexicano del Seguro Social

Social security is a human right expressed in the International Covenant on Economic, Social, and Cultural Rights, ratified by Mexico. Nevertheless, the exercise of this right is contingent on having formal employment. In other words, people employed in the informal sector—59.1% of the population, including 29 in 100 women—do not have access to social security,[1] specifically health-care services. Those affiliated to, for example, the Universal Health Insurance Program cannot enjoy benefits such as maternity and paternity leaves or daycare for children. Hence, people who work in the informal sector lack labor protection and social security and, moreover, they suffer discrimination, violations of their human rights, and the negative effects of the lack of policies based on the approach of shared responsibility in the formal sector.

1 INEGI, México: *Nuevas estadísticas de informalidad laboral*, Mexico, slide 9, 2018. Available at: http://www.inegi.org.mx/est/contenidos/Proyectos/encuestas/hogares/regulares/enoe/.

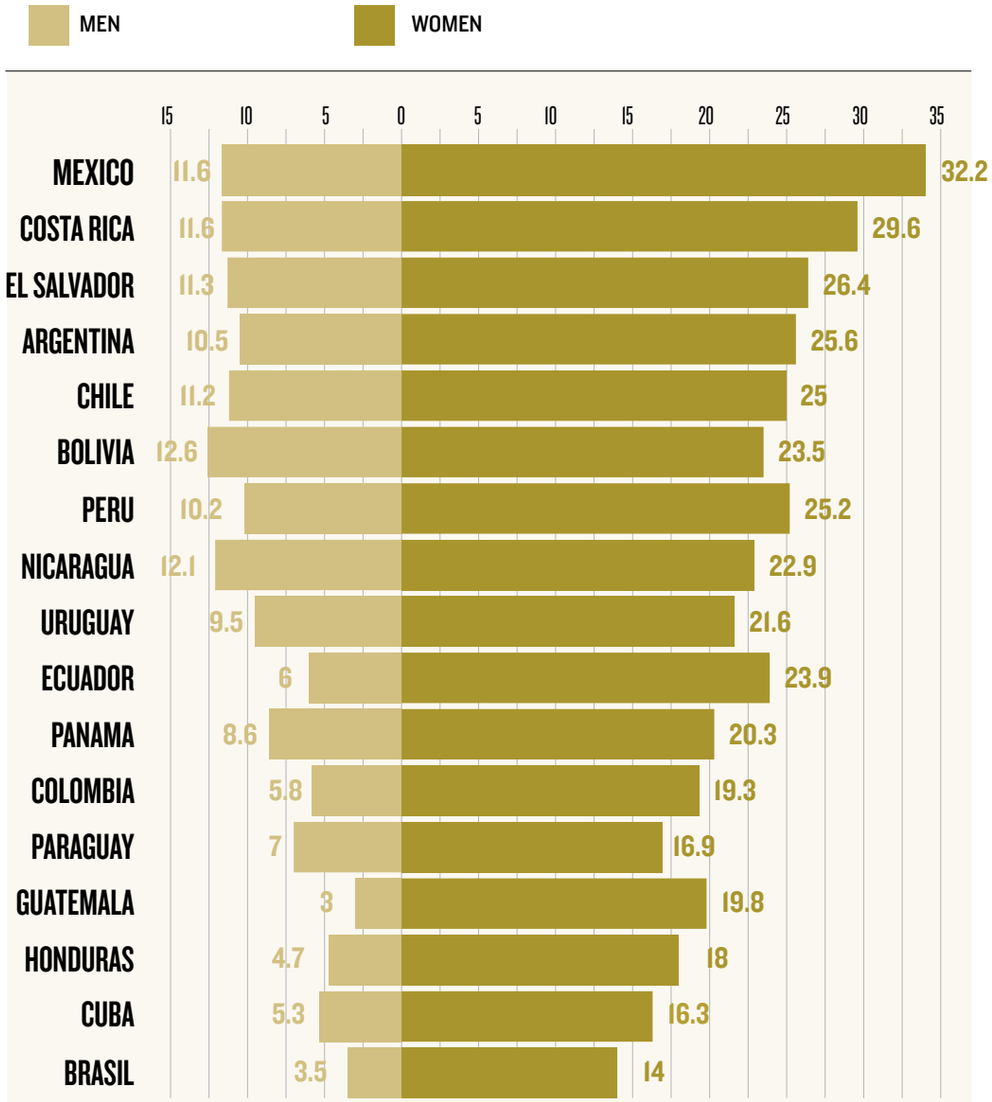
5.1
SITUATION IN MEXICO

According to the Economic Commission for Latin America and the Caribbean (ECLAC),[2] women in Mexico dedicate more time to housework and care responsibilities than men, compared to other Latin American countries. The fact that mostly women carry out such tasks means that they often work double or triple shifts with no remuneration or recognition. In addition, it is important to remember that both in Mexico and in the rest of the region, social protection schemes that are directly linked to employment are the norm.[3] This situation creates a cycle that prevents women—who are thought of as responsible for these chores—from obtaining formal employment. Consequently, they are forced to find jobs—usually in the informal sector, without labor benefits and often in precarious conditions—that allow them to carry out their care responsibilities.

2 ECLAC. *Economic Survey of Latin America and the Caribbean. The dynamics of the current economic cycle and the policy challenges to boost investment and growth*. 2017. Available at: https://www.ilo.org/wcmsp5/groups/public/---americas/---ro-lima/documents/publication/wcms_633654.pdf.
3 *Ibid*.

PERCENTAGE OF THE DAY DEDICATED TO HOUSEHOLD AND CARE WORK

2017



Source: ECLAC, 2017.

In view of this situation, it is essential to implement a series of measures, including universal access to daycare centers, health services, pensions, sick leaves, and maternity, paternity and parental leaves, in accordance with human rights standards. In addition, it is imperative that the State takes steps to promote equal sharing of household and care responsibilities between women and men.

A. LEAVES OF ABSENCE

Convention 183, Article 4, of the International Labor Organization (ILO) states that women are entitled to a period of maternity leave of 14 weeks. Further, Recommendation 191 (a document supplementing the Convention) stipulates, "Members should endeavor to extend the period of maternity leave referred to in Article 4 of the Convention to at least 18 weeks."[4] At the global level, there has been a trend to establish periods of maternity leave that match or exceed the ILO standard. In fact, the average time granted by OECD member countries is 32.2 weeks.

The Mexican State, however, has not ratified ILO's Convention 183, emitted in 2000. This shows Mexico's lack of interest in guaranteeing working women's reproductive rights. The period of maternity leave in Mexico—12 weeks—is far below international standards.

Currently, in Mexico, Article 170 of the Federal Labor Law grants women (except those who work in the public sector) 12 weeks of paid maternity leave (six weeks before and after childbirth). Women can choose to take four of the predelivery weeks after they have given birth, provided they are in good health. The Law also grants a six-week maternity leave in cases of adoption.

Furthermore, the Law stipulates that women are entitled to a subsidy equal to 100% of their wages during their leave (Article 101). For the IMSS to pay the subsidy, the woman must have paid social security fees for at least 30 weeks before her leave. Otherwise, the employer will pay her wages in full. This distinction between women who have paid their fees for 30 weeks and those who have not might contribute towards discriminatory practices among employers, who often require women to produce proof they are not pregnant to hire them. In like manner, women are entitled to the above provided they are social security beneficiaries; in other words, if they have formal employment and, hence, all the benefits afforded by law. In contrast, women working in the informal sector do not have any form of protection in this regard.

The Federal Law of Workers in the Service of the State (LFTSE) defines the framework for individuals affiliated to social security schemes of the state, including those with PEMEX, ISSSTE, and the Social Security Institute for the Mexican Armed Forces. It grants one-month maternity leave before the delivery date and two months after childbirth. It does not, however, allow women to take the predelivery weeks in the postnatal period (Article 28). It is essential that women who work for the State are afforded greater flexibility to use their weeks after delivery to better care for themselves and their newborn. The decision should be made according to the needs of each woman or family.

4 ILO, *Recommendation 191 — Maternity Protection Recommendation*, 2000, Article 1 (1). Available at: https://www.ilo.org/dyn/normlex/es/f?p=NORMLEXPUB:12100:0::NO::P12100_INSTRUMENT_ID:312529.

Regarding paternity leaves, the Federal Labor Law (LTF) requires employers to "Grant five working days of paid paternity leave to workers after childbirth or adopting a child" (Article 132, paragraph XXVII bis). In contrast, the LFTSE does not include provisions for paternity leaves but the LTF has suppletory application to the case. The ISSSTE Law was reformed in 2013 to include five days of paternity leave for beneficiaries. The Social Security Law, which has not been reformed, states that the five days of leave granted by the LTF will be paid by the employer. Therefore, working fathers suffer double discrimination: a paternity leave that is significantly shorter and a lack of public subsidies for it.

The short period of paternity leave reinforces the stereotype that household and child care are the sole or main responsibility of women. Some federal and state public institutions grant a longer period of leave than that stated in the legislation. Nevertheless, the period is not enough when compared to the average number of weeks granted by OECD countries—4.3 weeks.[5]

FEDERAL PUBLIC INSTITUTIONS	
Electoral Court of the Judiciary of the Federation	10 working days
National Women's Institute	
National Institute for Social Development	

STATE PUBLIC INSTITUTIONS	
Administrative Courts of the State of Mexico	10 days
Administrative Courts of the State of Oaxaca	
Guadalajara Municipality	
Government of Quintana Roo	
CDMX Human Rights Commission	Three weeks but can be extended to five if the infant or the mother requires hospital care, if the mother dies in childbirth, in case of a multiple birth, or if the infant is born with a disability
CDMX Council for the Prevention and Elimination of Discrimination (COPRED)	30 days

Source: GIRE, *Working Hours*, 2017.

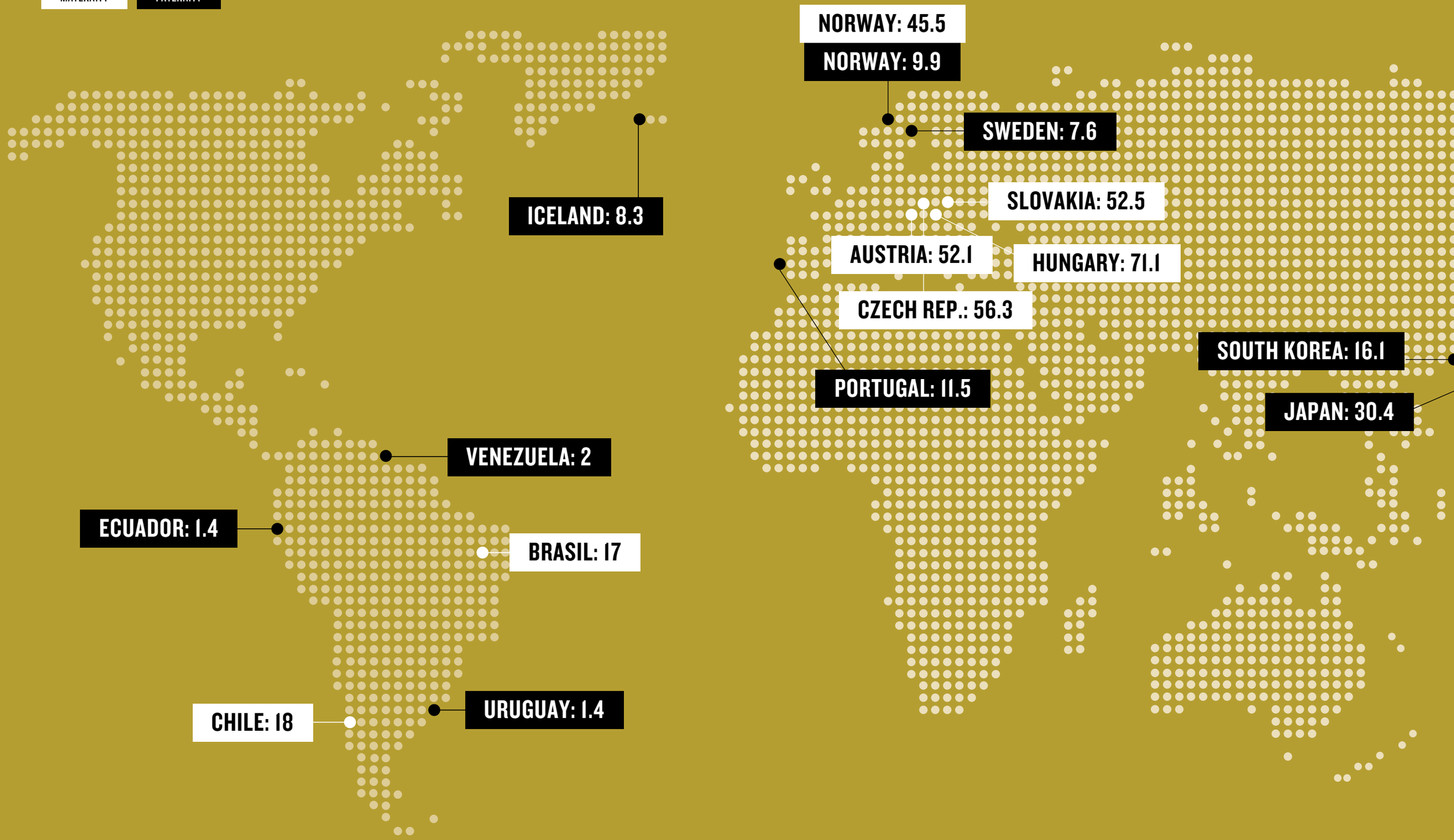
If Mexico is looking to match the standards set by OECD countries, it should seek to apply, at least, at the OECD average. Alternatively, it could design a parental leave scheme that resembles that used in some countries whereby the couple decides how to handle the period granted—a modality that is still not provided for in the Mexican legislation.

5 The Economist, "Daily chart. The best -and worst-places to be a working woman", March 3, 2016. Available in: www.economist.com/blogs/graphicdetail/2016/03/daily-chart-0?fsrc=scn/fb/te/bl/ed/thebestandworstplacestobeaworkingwoman

MATERNITY AND PATERNITY LEAVES WORLDWIDE

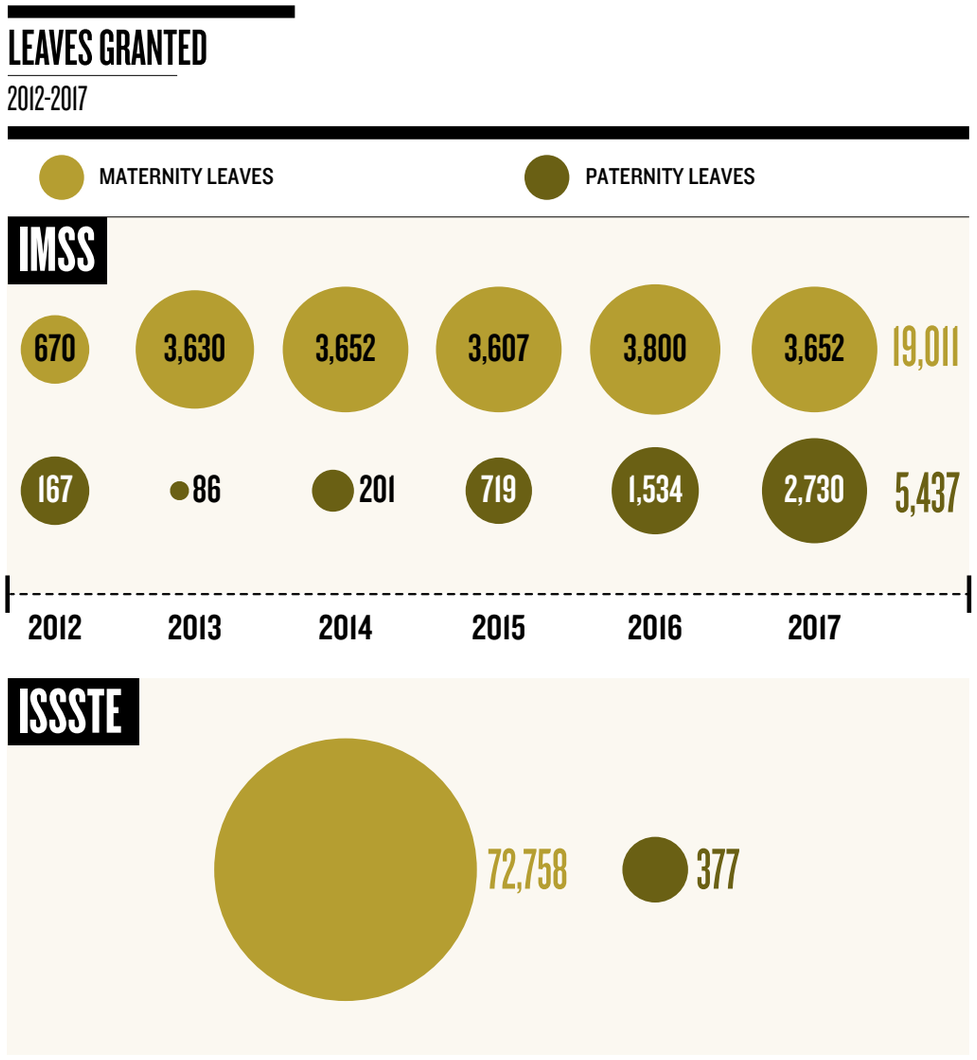
WEEKS OF LEAVE

MATERNITY | PATERNITY



Source: GIRE's graph based on information from *The Economist*, March 2016 / GIRE, *Working Hours*, 2017 / ILO–UNDP, 2009.

The Mexican legislation does not grant extended leaves, nor does it guarantee their accessibility. Moreover, work schemes may pose formal and informal obstacles to request them. According to the 2013 National Survey on Employment and Social Security (ENESS), 50.1% of women aged 15-49 who required pregnancy or delivery care that year did not receive maternity leave,[6] which constitutes a violation of their human rights. To find out how many maternity and paternity leaves had been granted by the main social security institutions in the country, GIRE requested access to public information.



Source: GIRE's graph based on data from requests for public information.

6 INEGI, 2013 *National Survey on Employment and Social Security*, p. 54. Notably, Mexican legislation considers maternity leave and disability plans for complications related to pregnancy and childbirth, but does not stipulate leaves or sick leaves that are expressly abortion-related.

The information available does not allow for the determination if the number of leaves reported is the percentage between men and women—insured under each scheme—that had children in a given year. Nevertheless, the responses from both institutions show a large difference between the number of paternity and maternity leaves. Although the data provided by the IMSS allowed accounting for a yearly increase in paternity leaves, they are still significantly fewer than maternity leaves. The information from the ISSSTE had not been disaggregated by year and, thus, it was not possible to determine whether there had been an increase in leaves over time. The contrast between the number of paternity and maternity leaves is alarming and suggests that the low participation of men in newborn care continues to be the norm and that there are informal obstacles to enjoy the benefit.

Lastly, it is important to note that the types of leaves in the current legislation are based on a heteronormative view of family and reproductive life, which assumes that families are composed by a man and a woman and the presence of biological children. According to present legislation, there is a lack of clarity regarding the way in which same-sex couples can access social security benefits. For example, in a lesbian relationship, the pregnant woman would request a maternity leave but her partner would not be able to receive a matching benefit that would allow her to take care of the newborn. Of note, the LFTSE does not provide leaves for adoptive parents. Although some public agencies grant such leaves (including the CDMX Human Rights Commission), the absence of regulations places government workers at a disadvantage because they cannot access this important benefit; nor can same-sex couples or single individuals living in informal unions. Therefore, the normative and public policy framework in Mexico should recognize and protect the different types of families in the country and ensure that they can enjoy these social security benefits without suffering discrimination.

B. DAYCARE CENTERS

In Mexico, the responsibility for the care of children very frequently lies with people outside the immediate family. Of all minors 0 to 6 years of age looked after by individuals other than their parents, 51.2% are cared for by their grandmothers, whereas 11.3% are taken to public daycare centers, 4.3% to private daycare centers, and 33% are cared for by others.[7]

Parents in Mexico should be able to ensure care for their children. It is the State's obligation to address obstacles related to child care, particularly those that impose a disproportionate burden on women. One way of dealing with this obligation is by formulating public policies and regulations to either subsidize or provide public child care services, which can be directly rendered by the State (including local governments) or the private sector.[8]

7 INEGI, 2013 National Survey on Employment and Social Security, *op. cit.*, p. 56.
8 World Bank, Annual Report 2012, pp. 26-27.

Access to daycare centers is established in Article 123 of the Mexican Constitution.

> **Section A:**
> XXIX. The Social Security Law is of public utility and will include insurance schemes for daycare and any other service designed for the protection and welfare of workers, farmers, non-salaried workers, and individuals from other social sectors and their families;
> **Section B:**
> XI. Social security will be organized in accordance with the following, as a minimum:
> c) Women will enjoy daycare services.

The LFT, the Social Security Law, the LFTSE, and the above constitutional article stipulate that affiliates are entitled to the child care benefits provided by their social security institutions—IMSS and ISSSTE. These laws and their regulations establish the criteria to access the services and the different modalities in which they are offered (direct or subsidized services). Other public institutions—SEDESOL, PEMEX, the National System for the Comprehensive Development of the Family, the Ministry of Public Education, and ISSFAM—offer these services in different modalities.

The Social Security Law establishes access to daycare services for working women and, exceptionally, working fathers who are widowers or divorced, have sole custody of their children and have not married again, or who by judicial resolution have custody of a minor for whom they cannot provide care. These regulations reproduce the idea that women are responsible for care work, particularly child care. Therefore, GIRE has accompanied individuals and families who have been denied access to daycare centers in accordance with the above criteria, seeking to change the legislation to promote shared responsibility in matters of child care.

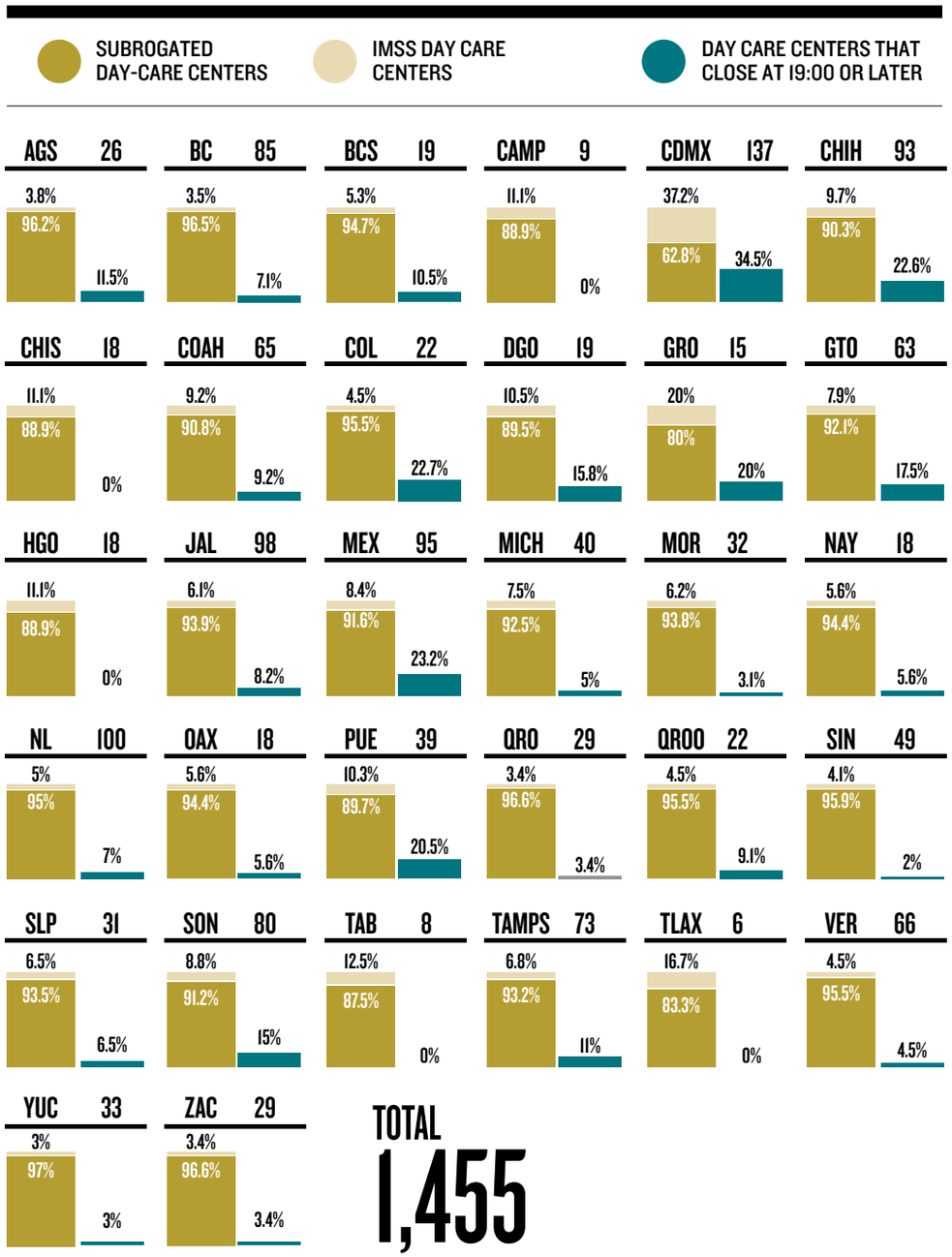
The public provision of child care services in Mexico has increased significantly since the 1990's. Between 2006 and 2011, the number of IMSS, ISSSTE, and SEDESOL daycare centers increased 599% and the number of children looked after increased 200%. Three factors can account for such fast growth: a) a change by the IMSS in the rules for funding daycare centers; b) the adoption of new daycare service provision models by the ISSSTE and the IMSS; and c) the appearance of a new service "provider" (or many new providers) through SEDESOL. The General Law on the Provision of Child Care and Comprehensive Development Services defines "Care Centers" as "spaces—public, private, or mixed—that provide child care and comprehensive development services within a framework that allows children aged 43 days and older to fully exercise their rights" (Article 8.1). In Mexico, child care services are public, private, and mixed, and some companies and organizations include them in their benefit packages.

Through requests for public information, GIRE learned that between December 2012 and November 2017 the IMSS had 1,455 daycare centers in the country. Of these, 142 were operated directly by the IMSS and 1,313 were subsidized. This means that there are 5.4 daycare centers per 100,000 IMSS affiliates in the country,[9] which suggests that the current infrastructure is not enough.

9 This rate is based on the total number of IMSS affiliates as of January 2018. It, however, does not consider the real capacity of each center or the geographical distribution of affiliates with children. Available at: http://www.inegi.org.mx/Sistemas/BIE/Default.aspx?idserPadre=10100290.

IMSS DAYCARE CENTERS BY STATE

2012 - 2017



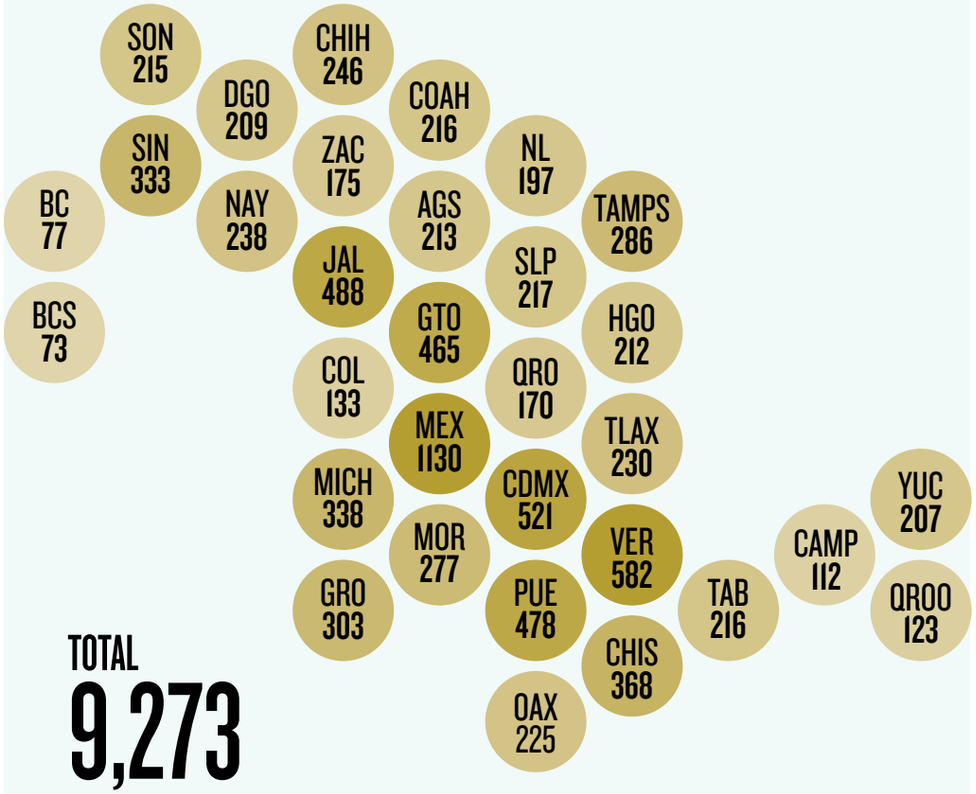
Source: GIRE's graph based on data from requests for public information.

The data provided by the IMSS showed that the states that have the largest number of daycare centers are Mexico City (CDMX), Nuevo Leon, Jalisco, State of Mexico and Chihuahua. The states with fewest centers are Tlaxcala, Tabasco, Campeche, Guerrero, Chiapas, Hidalgo and Nayarit. Nevertheless, the lack of information about each center's capacity does not allow for the estimation of the gap between available services and potential demand or identifying the barriers in accessing the services.

Further, there are considerable differences in opening hours, particularly closing times, between the centers. This has a significant impact on individuals, particularly women, whose working hours do not allow them to use the services and, thus, may perpetuate the existing inequalities between men and women. Although extended opening hours at daycare centers can help to increase access of people who, for example, work long shifts or in the evening, the centers should not exempt the State from guaranteeing that working days are not excessively long, as is common practice in Mexico. Indeed, compared to other OECD countries, people in Mexico dedicate more time to paid work and the country ranks second to last in paid rest. In addition, there is an unequal distribution of unpaid work in the household, which mainly affects women.[10] Therefore, the lack of shared responsibility for work and personal life should be addressed by means of comprehensive measures and not only by increasing the number of daycare centers with extended hours.

Based on the responses from ISSSTE to GIRE's requests for public information for December 2012 to November 2017, the institution had 242 daycare centers. Of these, ISSSTE operated 123 directly and 119 were subsidized. The information, however, was not disaggregated by state and differed considerably from the data obtained directly from its directories: 9,273 daycare centers throughout the country,[11] whose distribution is shown in the graph below. The directories did not specify each center's capacity and, hence, it is not possible to determine if the infrastructure is enough to meet the needs of the user population.

ISSSTE DAYCARE CENTERS BY STATE



Source: GIRE's graph based on data from ISSSTE directories.

10 OECD, *Building an Inclusive Mexico. Public Policy and Governance for Gender Equality*, 2017, p.31. Available at: www.oecd.org/centrodemexico/medios/Estudio%20G%C3%A9nero%20M%C3%A9xico_CUADERNILLO%20RESUMEN.pdf.

11 Available at: www.gob.mx/cms/uploads/attachment/file/396423/directorio_responsables_ei_sept2018.pdf [Accessed on: September 23, 2018].

Photo: Claroscuro

The State's obligations in matters of social security services are not only to make sure that they satisfy the demand from the insured but also their availability and quality. As the graph on IMSS daycare centers shows, there are significantly more subsidized centers than IMSS-operated centers. In that regard, importantly, the State is under the obligation to appropriately oversee the condition of subsidized service facilities, ensure that they have enough trained personnel and, in general, guarantee the safety of the minors looked after at centers operated by a public institution or by third parties. The case of the ABC Daycare Center is a painful and outrageous example of the State's failure to comply with the above obligations.

DAYCARE CENTERS FROM A HUMAN RIGHTS PERSPECTIVE

The Mexican Supreme Court's ruling on the case of the 49 children who died at the ABC Daycare Center developed scope and content of the right to social security. The Court emphasized that "daycare" or child care services are part of this right to which both adults and children are entitled:

> Underlying social rights is the idea that the State must contribute to providing the citizens with a common floor for material wellbeing that allows them to realize their life plan. In like manner, the right to social security emerges from society's concern with seeking the minimum level of wellbeing that ensures a decent life for all.
>
> Indeed, several international legal instruments expressly recognize the right to daycare services. They stipulate that not only adults but also children are entitled to this social security right.

Thus, the State must guarantee access to daycare services and make sure that they are provided in accordance with the highest quality and safety standards. Competent authorities should make certain that daycare centers comply with the following obligations:

- Adhere to the relevant normative framework to ensure appropriate operation of daycare centers.
- Guarantee that daycare centers are safe, that children are not exposed to risks that compromise the full exercise of their rights.
- Make sure that daycare centers have competent and duly trained personnel.
- Supervise the operation of daycare centers and compliance with quality standards.

It is crucial that the Mexican State carries out a nationwide assessment of this situation with a view to formulating a comprehensive and effective public policy. Such policy should contribute to providing all mothers and fathers with equal access to public or private child care institutions that are affordable and offer appropriate and quality stimulation and learning programs, guarantee safety, and adapt to the needs of working people and their children.

RECOMMENDATIONS TO MEXICO BY THE CESCR AND THE CEDAW COMMITTEE

In March and July 2018, the CESCR and the CEDAW Committee, respectively, examined compliance by Mexico of its obligations under the International Covenant on Economic, Social and Cultural Rights and the Convention on the Elimination of All Forms of Discrimination against Women.

The CESCR expressed the following concerns:

The Committee is concerned that the State party's social protection system is sectorally fragmented and closely linked to formal employment, which means that a significant number of persons, such as informal workers, self-employed workers and persons, especially women, who do unpaid domestic and care work, are not covered by the social protection system (art. 9).

The Committee is concerned that approximately 57% of workers are employed in the informal economy and are thus not properly covered by labor laws or the social protection system (arts. 6, 7 and 9).

The Committee is concerned at the difficulties faced by women seeking to enter the labour market and the fact that they have significantly lower labor force participation rates than men. It is also concerned by reports of discriminatory practices against women in the workplace, such as the requirement that they undergo pregnancy tests before being hired, and the persistent pay gap between men and women (arts. 6 and 7).

The CESCR recommended that Mexico:

Continue making efforts to develop a social security system that guarantees universal social protection coverage and provides appropriate benefits for all persons, especially those belonging to the most disadvantaged and marginalized groups, with a view to ensuring that they have a decent standard of living. In addition, it urges the State party to strengthen its efforts to develop a social protection floor that includes basic universal social guarantees. The Committee draws the State party's attention to its general comment No. 19 (2008) on the right to social security and its statement of 2015 on "Social protection floors: an essential element of the right to social security and of the sustainable development goals."

The Committee recommends that the State party redouble its efforts to progressively lower the number of workers in the informal sector of the economy, to bring those workers into the formal sector and to ensure that they are covered by labor laws and have access to social protection. In addition, it recommends that the State party systematically include the informal sector of the economy in the activities of the labor inspection and occupational health and safety services. The Committee draws the State party's attention to its general comments No. 18 (2005) on the right to work, No. 19 (2009) on the right to social security and No. 23 (2016) on the right to just and favorable conditions of work, as well as its statement of 2015 on "Social protection floors: an essential element of the right to social security and of the sustainable development goals" (E/C.12/2015/1).

The Committee recommended that the State party take effective measures to:

(a) Increase women's participation in the labor market, possibly by adopting a policy on care to achieve a more equitable distribution of caregiving tasks between men and women;

The Committee encourages the State party to continue its efforts to achieve substantive equality between men and women in all spheres. In particular, the Committee recommends that the State party:

(a) Take effective steps to dispel gender stereotypes in the family and in society, including through information campaigns designed to promote the equal sharing of family responsibilities by men and women, and to make people aware of equal job opportunities to which they can gain access by completing their studies and by seeking training in areas other than those traditionally associated with one sex or the other.

The CEDAW Committee expressed the following concerns:

The unequal distribution of domestic and care work between women and men and the short periods of paternity leave, which force many women into low-income, part-time jobs in the informal sector;

The fact that the social security system does not adequately protect women because of their involvement in unpaid care work and because many are employed in the informal sector.

And recommended that the Mexican State

Monitor and enforce the legislation promoting and protecting maternity leave, strengthen incentives for men to avail themselves of their right to parental leave and expedite the adoption of the national care policy to provide sufficient and adequate childcare facilities. Increase access for women to the national social security system and develop coordinated social protection and compensation programs for women.

Photo: GIRE archive

5.2
ACCESS TO JUSTICE

Access to social security services and benefits, including daycare, entails the exercise of the rights to social security, equality, and non-discrimination, among other human rights. Guarantee of these rights requires regulations and public policies to offer benefits to paid and unpaid workers.

Current criteria to access daycare services in Mexico are discriminatory. They are based on gender stereotypes that do not promote shared responsibility for child care and often force women to become the only caregivers. Therefore, they must work double or triple shifts or in precarious or low-income jobs. In view of this situation, GIRE has opted to resort to legal stays to achieve structural changes and help families to access the justice that they are due.

GERMAN AND NADIA

CDMX

German and Nadia are married and have a five-year-old son. German is formally employed and is an IMSS beneficiary. Nadia is a housewife and, therefore, not entitled to social security.

In 2016, German visited several daycare centers near their home and asked what was required to enroll their son. It was then that he found out that according to the legislation, he would not be able to do so. The Social Security Law, in Article 201, only includes provisions for widowers and divorced men with legal custody of their children. He was, therefore, not entitled to the service.

Accompanied by GIRE, German and Nadia went to the Department of Daycare Centers of the Central Office for Services related to Financial and Social Benefits of the IMSS Northern District. There they were told that, according to current norms, German was not entitled to the service but that they would receive his application for daycare as he was an insured working father. Days later, the IMSS issued an official notification denying his request.

In view of this, German, in his own right and representing his son, decided to file, together with Nadia, a legal stay. The authorities had denied his son access to daycare based on unconstitutional criteria and because there are no norms that ensure the effective and human rights-based access of IMSS beneficiaries to these social security services. The Second District Labor Court of Mexico City ruled in favor of granting the legal stay against the above discriminatory provision in the Social Security Law and ordered the Department of Daycare Centers to provide German with the same services that insured working women receive.

The case of Nadia and German is not the only one. Many women who work in the home or in the informal sector need someone to look after their children while they are working. The fact that only insured mothers or fathers—under exceptional circumstances—are entitled to this right suggests the assumption that a woman lacking formal employment has the sole obligation to look after her children. This, besides constituting a violation of women's rights to equality and non-discrimination, gives rise to a series of difficulties, the first of which is the impossibility of finding a job or having to work in precarious conditions.

For women, the flaws in accessing social security benefits in Mexico are not only related to the short periods of leave or the legal requirements that fall short of international standards and human rights obligations with which the State is to comply. They are also the result of implementation issues; that is, the State has failed to guarantee even the minimum benefits stipulated in the law. Such is the case of maternity leaves; in addition to the very short periods established in the legislation, women must often overcome formal and informal obstacles to exercise this right, as illustrated by Vanessa's case.

VANESSA

COAHUILA, 2015

In November 2015, Vanessa, then 27 years of age, learned that she was pregnant. When she was 29 weeks pregnant, she was diagnosed with preeclampsia by her private doctor, who referred her to the IMSS Family Medicine Unit (UMF) No. 73 in Saltillo to request sick leave. At the facility, she waited more than 12 hours for a gynecologist to sign the document. All the while she remained seated on a bench without access to water or food. Although her doctor had prescribed complete bed rest because she had a high-risk pregnancy, they denied her the sick leave arguing that the IMSS does not regard preeclampsia as an impediment to work, and that the condition resolves itself over time.

Eventually, Vanessa was granted a six-day leave. Her condition, however, worsened, threatening her pregnancy and her life, and she returned to the UMF to request an extension of her leave. There they told her that she must have "healed" after the six-day rest. The following day, she was admitted to the Concepción Hospital in Saltillo for an emergency C-section. Vanessa had a baby girl, who was born weighing two kilograms and had to remain in the neonatal intensive care unit for 37 days.

Since her daughter was born at 31 weeks' gestation and the IMSS grants a maternity leave as of week 34, Vanessa was denied leave for the period before the delivery and was only granted the weeks after childbirth. Concerned about the special care that her baby would require, Vanessa talked to the UMF deputy director, who informed her that she should return to the facility before the end of her leave with a letter from her private doctor to request the weeks of leave needed to take care of her daughter. Vanessa returned as instructed but she was denied the leave. They told her that only if her baby was admitted to the UMF would they be able to grant her more days. The baby girl was seriously ill and Vanessa did not want to run any risks. At work, she managed to negotiate a six-month—unpaid—leave to stay home with her baby.

Considering all this, Vanessa, accompanied by GIRE, filed a complaint with the CNDH. In October 2017, the Commission reached a conciliatory settlement with the IMSS regarding 28 cases of total or partial denial of maternity leaves, including Vanessa's. In the settlement, the IMSS acknowledges that it violated the human rights of the women and that it failed to consider the best interests of the newborns "by refusing to grant the full period of at least 12 weeks of maternity leave."

Nonetheless, the language in the document is confusing. It defines the victims in accordance with the General Law for Victims but orders a form of reparation that only covers payment for the days of leave that were not granted. Furthermore, the settlement suggests that the IMSS consider paying for 14 additional days because of the medical care that the newborns required. The CNDH thus deemed the complaint closed.

Even though the IMSS issued a check to Vanessa covering the 42 days that she had not been paid, it contended that it was not under the obligation to pay for the 14 additional days of special care for her daughter. Vanessa chose not to accept the payment because she knew that otherwise her complaint would be closed. GIRE is accompanying Vanessa in her pursuit of comprehensive reparation for her and her daughter.

From 2015 to September 2018, GIRE registered, documented, and accompanied cases of denial of access to daycare centers and maternity leaves. The objective was to identify the patterns that hinder the exercise of reproductive rights in the sphere of social security and accompany those who seek justice and comprehensive reparation for human rights violations.

CASES REGISTERED, DOCUMENTED, AND ACCOMPANIED BY GIRE / 2015–2018

	Day care Centers	Maternity Leaves	Total
Registered	26	5	31
Documented	3	1	4
Accompanied	21	1	22
			59

Regarding denial of access to daycare, the Supreme Court granted a legal stay in three of the cases that GIRE accompanied. The Court ruled that the differentiated treatment—stemming from the denial of access to daycare centers—for the children of affiliated fathers is unjustified and based on gender stereotypes.

> […] this different treatment denies equality of rights, which is guaranteed for every person regardless of their sex. Moreover, such treatment is an obstacle that hinders access of working fathers to a service to which men and women are equally entitled. Thus, this difference places men at a disadvantage.
>
> The above worsens when the differentiated treatment stems from assigning women the role of caregivers of their children merely because they are women. This is based on a gender stereotype; that is, on the preconception that the responsibility for rearing and taking care of children lies with the woman, and it does not consider that the responsibility should be equally shared by the parents.[12]

12 Legal Stay under Review 59/2016.

5.3 CONCLUSIONS

Considering the international commitments assumed by Mexico, the current legislation does not sufficiently recognize the social security benefits that are related to reproductive and family life. Furthermore, it creates specific discriminatory situations that largely affect women.

In general, the norms on maternity and paternity leaves and access to daycare centers in Mexico are based on the stereotype that the responsibility for household and care work lies mainly with women. This becomes particularly obvious in the requirements to access daycare centers; in practice, they deny the service to families that do not have a woman who is directly affiliated to a social security regimen and assume that if she is not formally employed, she should take care of the children. Similarly, the limited period of paternity leaves conveys the message that men's participation in child care is unnecessary. The lack of child care services and the impossibility of having a period of paid leave that is long enough to adapt to the birth or adoption of a child means that currently many working people must deal with this situation without a minimum floor that ensures basic social security protections.

Despite the inadequacy of these benefits, there is a significant number of people in Mexico who need but cannot access the services because they are contingent on having formal employment. This is discriminatory, particularly against women, who work mainly in the informal sector, in precarious conditions, and without minimum protections or benefits. To guarantee a true protection of human rights within a framework of reproductive justice, a universal social security system is needed, one that covers all working people in both the formal and the informal sector. In addition, this requires eliminating the discriminatory provisions in the legislation that affect specific groups, including the one that establishes a different—and more restrictive—affiliation scheme for domestic workers, which falls short of relevant international standards.

URGENT ISSUES

ADOLESCENT PREGNANCY

EXECUTIVE BRANCH

— Evaluate the results, objectives, and action lines of the National Strategy for the Prevention of Adolescent Pregnancy (ENAPEA) to guarantee that the public policy promoted by the State in this regard is effective, sufficiently funded, with evaluation mechanisms, and prioritizes prevention and care for victims of sexual violence from a gender and a human rights perspective and considers the principles of the best interests of the child and progressive autonomy.

FEDERAL AND STATE HEALTH INSTITUTIONS

— Guarantee access to emergency contraceptive methods and abortion for rape without imposing unjustified requirements or barriers, in accordance with NOM 046 and the General Law for Victims.

— Ensure the inclusion of adolescent friendly counseling services at the primary health care level to prevent and provide care for pregnancy among girls and adolescents within a human rights framework, from a gender and an intercultural perspective.

— Implement the necessary measures to enable health personnel to provide girls and adolescents with special pregnancy, labor/delivery, and postpartum care and consider both the different types of risks that they face due to their young age and the principle of the best interests of the child.

LEGISLATIVE BRANCH

FEDERAL CONGRESS

— Reform NOM 005 to eliminate the recommendation of a permanent contraceptive method for people with intellectual or cognitive disabilities.

CRIMINALIZATION OF ABORTION

EXECUTIVE BRANCH

HEALTH INSTITUTIONS

— Guarantee access to abortion in cases of rape, in accordance with NOM 046 and the LGV.
— Guarantee access to abortion for legal indications, without imposing unjustified obstacles.
— Ensure that facilities always have enough doctors who are not conscientious objectors to guarantee provision of abortion services.

LEGISLATIVE BRANCH

FEDERAL AND STATE CONGRESSES

— Decriminalize elective abortion within the first trimester of pregnancy, at least.

Possible ways to decriminalize abortion in Mexico include:

1. Total or partial decriminalization
   At the state level, by
   — Reforming state penal codes to decriminalize abortion within the first trimester of pregnancy at least.
   — Reforming state health laws to establish legal abortion programs.

   In addition, decriminalization can be promoted at federal health institutions by
   — Reforming the Federal Penal Code to decriminalize abortion within the first trimester of pregnancy at least.
   — Reforming the General Health Law to establish federal legal abortion programs.

2. A National Penal Code
   — Reform Article 2 of the Constitution to authorize the Federal Congress to legislate on criminal law.
   — Publish a National Penal Code that decriminalizes elective abortion within the first trimester of pregnancy at least.
   — Reform the General Health Law to establish abortion programs nationwide.

3. A Federal Penal Code
   — Reform Article 73 of the Constitution to authorize the Federal Congress to legislate on abortion.
   — Reform the Federal Penal Code to decriminalize abortion within the first trimester of pregnancy at least.
   — Reform the General Health Law to establish abortion programs nationwide.

STATE LEGISLATURES

— Eliminate the requirements to access abortion for rape from penal codes that have not been harmonized in accordance with NOM 046 and the LGV.

OBSTETRIC VIOLENCE AND MATERNAL DEATH

EXECUTIVE BRANCH

FEDERAL AND STATE HEALTH INSTITUTIONS

— Guarantee universal access to obstetric care services, especially during labor, while ensuring compliance with the General Convention of Interagency Collaboration for Obstetric Emergency Care and "zero service denial" in cases of obstetric emergencies.
— Improve services at the primary health care level by strengthening low-risk pregnancy care to decrease service saturation at the secondary and tertiary levels and ensuring timely referrals to the latter in cases of obstetric emergencies.
— Institutionalize training for health providers of obstetric care and assess its impact.
— Periodically certify the technical skills of health providers.
— Strengthen training and credentialing of midwives and obstetric nurses to gradually incorporate them into health services.
— Monitor implementation of NOM 007, on pregnancy, labor and delivery, and postpartum care.
— Comply with General Recommendation 31/2017, issued by the CNDH, on obstetric violence in the National Health System.

PUBLIC HIGHER EDUCATION INSTITUTIONS FOR SURGEONS, OB/GYN DOCTORS, AND NURSES

— Redesign medical and nursing curricula to include women's care during pregnancy, labor/delivery, and the postpartum from a gender and an intercultural perspective.

LIMITED ACCESS TO SOCIAL SECURITY

EXECUTIVE BRANCH

TO INSTITUTIONS THAT PROVIDE DAYCARE SERVICES

— Ensure the quality, accessibility, and availability of services provided by daycare centers, including subsidized centers.

TO THE MINISTRY OF LABOR AND SOCIAL WELFARE

— Establish mechanisms for work inspection to ascertain that the length of working days adheres to Article 61 of the Federal Labor Law.
— Guarantee that the periods of maternity and paternity leaves adhere to current legislation.

LEGISLATIVE BRANCH

FEDERAL CONGRESS

— Create a universal social security system for all working people in both the formal and the informal sector.
  —Reform the Social Security Law to allow men and women to enroll their children in IMSS daycare centers regardless of their marital and custody status.
— Reform the Federal Labor Law to harmonize it in accordance with relevant international standards, as follows:
  • Extend the period of maternity leave to, at least, 16 weeks, as established by the International Labor Organization.
  • Extend the period of paternity leave to, at least, 4.3 weeks—the average in OECD countries.
— Reform the Federal Law of Workers in the Service of the State to harmonize it in accordance with relevant international standards, as follows:
  • Extend the period of maternity leave to, at least, 16 weeks, and guarantee that women can use the weeks before or after child birth, as needed.

FEDERAL SENATE

— Ratify the following ILO Conventions:
  • Convention 156, on workers with family responsibilities.
  • Convention 183, on maternity protection.
  • Convention 189, on domestic workers.

EQUALITY AND NON-DISCRIMINATION

— Guarantee that the legislation, public policy and performance of public servants are governed by a gender, human rights, and intercultural perspective and adhere to the principles of the best interests of the child and progressive autonomy of adolescents.
— Ensure availability of interpreters for indigenous users of health services, particularly contraception and obstetric care, at facilities throughout the country.
— Make sure that people with disabilities have specialized support and the necessary inputs to make decisions and exercise their reproductive rights in a free, full, and informed manner.

ACCESS TO JUSTICE AND COMPREHENSIVE REPARATIONS FOR HUMAN RIGHTS VIOLATIONS

TO THE CNDH AND STATE HUMAN RIGHTS COMMISSIONS

— Issue recommendations in accordance with the highest human rights standards.
  • Closely monitor compliance with General Recommendations with special emphasis on guaranteeing effective measures of non-repetition to bring about structural changes.
  • Effectively monitor compliance with recommendations for individual cases that honor the victims' requests, in communication with the people affected by the violations.
— Ensure access to justice and comprehensive reparations for victims of reproductive rights violations, in accordance with relevant international standards.

ANNEX: COMPREHENSIVE REPARATIONS FOR HUMAN RIGHTS VIOLATIONS

Human rights violations create a new legal obligation for the State: the obligation of providing comprehensive reparations for the victims.[1] A reparation seeks to fully restore a victim to the condition before the violation occurred *(restitutio in integrum*). This notwithstanding, in most cases (for example, a maternal death) is impossible to achieve. Therefore, the reparation will focus on eliminating the consequences of the violation and awarding damages.[2] A fundamental aspect of a comprehensive reparation is that it goes beyond the individual victim. It seeks to eliminate the social and symbolic effects of the human rights violations and, ultimately, transform the circumstances that gave rise to them.[3]

1 I/A Court H.R., *Case of Ximenes-Lopes v Brazil, Preliminary Objection, Judgment of September 30, 2005*. Series C. No. 139, paragraph 232..
2 Serrano, Sandra, and Vázquez, Daniel, Los derechos en acción: *obligaciones y principios de derechos humanos,* Flacso, Mexico, 2013, pp. 93-94.
3 *Ibid*, p. 93.

FORMS OF REPARATION

I. COMPENSATION

Money awarded as compensation for material and immaterial damages.

I.I MATERIAL DAMAGES

Consequential damages or loss of profits.
Consequential damages are direct and immediate expenses incurred by the victims as the result of the violations of their human rights.[4]

EXAMPLES

Denial of abortion for legal indications.	Expenses incurred by the victim to receive medical care as the result of being denied an abortion.
Obstetric violence.	Expenses incurred by the victim to receive medical care and access justice.
Maternal death.	Expenses incurred by the woman's family to receive medical care, access justice and pay for funeral services.
Denial of daycare services.	Expenses incurred to hire child care or private daycare services.

Loss of profits refers to compensation for impairment of the victim's earning capacity caused by a violation to their human rights. This is very evident in cases of maternal deaths: the death of the victim results in her family's loss of income. Another example is a victim of obstetric violence, who may be temporarily or permanently incapacitated to work.

I.2 IMMATERIAL DAMAGES

The Inter-American Court of Human Rights stresses that "non-economic damages include suffering and hardship caused to the actual victim and those close to them, as well as the damage to people's important valuables, and the non-economic disruption in the life of the victim or their family."[5]

4 Nash Rojas, Claudio, *Las reparaciones ante la Corte Inetramericana de Derechos Humanos* (1988-2007), University of Chile, 2009, p. 43.
5 Nash Rojas, Claudio, *op. cit.*, p. 155.

Immaterial damages include moral damages, which refer to all direct psychological and emotional harm. The Mexican Supreme Court has awarded moral damages to people affected by human rights violations;[6] in the case of a maternal death, the immediate family of the deceased woman, such as her partner and children. Women who are denied an abortion for legal indications may experience deep anguish. This is a moral damage and the victims are therefore entitled to reparations.

2. REHABILITATION

The State is obliged to provide adequate care to victims suffering physical and psychological ailments derived from human rights violations. Care includes medical, psychological, thanatological, legal and social services.

For cases of obstetric violence, the State may guarantee medical consultations and tests, surgeries, and the necessary medications to restore the health of the victim. As for maternal deaths, it may include care for the emotional and psychological effects of the death of the woman on her family.

3. MEASURES OF SATISFACTION

This form of reparation for immaterial damages seeks to restore the honor, do justice, and pay tribute to the memory of a victim. It involves an apology by the State and recognition of the victim's position on the violations.[7]

Measures of satisfaction should be determined based on the needs and wishes expressed by the victims. The measures may include disseminating recommendations issued by public human rights bodies and a public apology—that includes a description of the seriousness of the events—by the health institution found responsible for the violations.

4. MEASURES OF NON-REPETITION

Measures designed to identify and modify the root causes of human rights violations and avoid repetition. The measures may consist of legislative and institutional reforms, actions to improve the operation of health services, including the strengthening of the primary health care level, more and better technical and human resources, and mechanisms that guarantee accountability.

6 SCJN, First Chamber, Amparo Directo 31/2013, Session as of February 26, 2014, Speaker: Justice Arturo Zaldivar Lelo de Larrea, public version of the judgment, p. 90. Available at: http://www2.scjn.gob.mx/juridica/engroses/cerrados/Publico/13000310.001-2183.doc.
7 Serrano, Sandra, and Vázquez, Daniel, *op. cit.*, pp. 96-97.

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