

OBSTETRIC VIOLENCE IN THREE DIMENSIONS: DATA, VOICES AND PRACTICES



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Introduction

Obstetric violence (OBV) is a form of gender-based violence that occurs in healthcare settings during pregnancy, childbirth, and postpartum care.¹ It includes practices such as mistreatment, non-consensual procedures, medical negligence — for example, failure to provide pain management — and pressure to adopt unwanted contraceptive methods. This report, prepared by GIRE, the Uehiro Oxford Institute (University of Oxford), and the Institute of Legal Research (National Autonomous University of Mexico), in addition to synthesizing statistical, testimonial, and qualitative evidence on the subject, makes public policy recommendations for addressing OBV through a structural approach, in which State responses do not prioritize punitive measures. The aim is to ensure that the condemnation and punishment of OBV do not take precedence over reparation, prevention, access to comprehensive justice, and the redistribution of resources in health systems to eradicate this phenomenon.

In preparing this report, the following sources of information were consulted: the statistical report *¿Qué dicen los datos públicos? Radiografía de la violencia obstétrica y la muerte materna* (What do the public data show? Radiography of obstetric violence and maternal mortality), prepared by GIRE; the qualitative analysis of 64 cases in which GIRE provided legal support, carried out by Emilia Alton Martelet (University of Oxford) in collaboration with the Uehiro Oxford Institute; and the findings of a dialogue workshop with healthcare personnel organized by GIRE, the Uehiro Oxford Institute and the Institute of Legal Research, which was facilitated and documented by *Colmena Consultoras*. These sources reach the same conclusion: **OBV is a structural phenomenon, so it cannot be attributed exclusively to individual decisions made by healthcare professionals. Thus, focusing on its criminalization is insufficient to eradicate it. What is needed is for the State to transform both the training model for those who provide medical care and the conditions under which the healthcare system operates.**

1 Obstetric violence is, in turn, a manifestation of reproductive violence. The latter includes all actions or omissions that violate or interfere with the autonomy and reproductive rights of individuals because of their reproductive capacity. UN Women, *Documenting reproductive violence: Unveiling opportunities, challenges, and legal pathways for UN investigative mechanisms* (2024), <https://www.unwomen.org/en/digital-library/publications/2024/09/research-paper-documenting-reproductive-violence-unveiling-opportunities-challenges-and-legal-pathways-for-un-investigative-mechanisms>.

Overview of Mexico

How has OBV been addressed in Mexico?

The concept of OBV emerged in Latin America in the early 2000s, driven by civil society organizations and feminist movements.² In 2007, Venezuela was the first country to incorporate OBV as a crime, in its Organic Law on the Rights of Women to a Life Free of Violence, a provision that served as a reference for legislative debates throughout the region.³ This legal change also raised a key question: is it possible to eradicate a structural problem through criminal punishment?

In Mexico, the incorporation of OBV into the legal framework was promoted by local feminists, and it was in the Law on Women's Access to a Life Free of Violence in Veracruz that the term was first recognized. Since then, 29 federal entities have included it in their regulatory frameworks, with different definitions.

At the judicial level, an emblematic precedent was established in 2021, when the Supreme Court of Justice of the Nation decided its first case on OBV. In its ruling in *Amparo en Revisión* 1064/2019, the Court analysed the case of Sandra —in which GIRE provided legal support— who was the victim of non-consensual sterilization, and recognised, based on national and international standards,⁴ that OBV is a form of both institutional and gender-based violence.

One of the reactions to obstetric violence has been its inclusion as a specific offence in criminal codes; however, the current challenge is to prevent criminalization from being regarded as the solution. GIRE has insisted that criminalizing OBV, rather than addressing

2 Verónica Esparza, "Violencia obstétrica en América Latina: una historia feminista de reconocimiento y resistencia", *Animal Político* (November 10, 2025), <https://grupoanimal.mx/opinion/violencia-obstetrica-america-latina-resistencia-feminista>; C. R Williams, C. Jerez, K. Klein, M. Correa, J. M. Belizan and G. Cormick, "Obstetric violence: a Latin American legal response to mistreatment during childbirth." *BJOG: An International Journal of Obstetrics & Gynaecology* 125, no. 10, (2018): 1208-1211, <https://doi.org/10.1111/1471-0528.15270>

3 Paola Sesia, "Violencia obstétrica en México: La consolidación disputada de un nuevo paradigma", in *Violencia obstétrica en América Latina: conceptualización, experiencias, medición y estrategias*, compiled by Patricia Quattrocchi and Natalia Magnone (Universidad Nacional de Lanús, 2020), 4.

4 GIRE, *Paso a paso: decisiones emblemáticas sobre salud reproductiva* (Mexico, 2024), pp. 54-58, <https://gire.org.mx/wp-content/uploads/2024/06/Paso-a-paso.-Decisiones-emblematicas-sobre-salud-reproductiva.pdf>

what is a structural problem, merely individualizes it. The punitive approach creates resistance among healthcare personnel and encourages the adoption of defensive practices when providing care, for fear of facing complaints or sanctions, which can have negative consequences for healthcare users. Furthermore, this perspective does not take into account that healthcare staff operate in conditions that are often characterised by limited resources, excessive workloads, and insufficient training.

The fact that OBV persists, particularly among populations in situations of vulnerability, reveals the limitations of approaches that rely on individual punishment to eradicate this phenomenon. In addition, prioritizing the criminal justice approach prevents the identification and addressing of structural failures of the healthcare system, which hinder women's and pregnant people's access to health and justice.

What do the public data show?

The National Survey on the Dynamics of Relationships in Households (ENDIREH) is an instrument administered every five years that measures the incidence of types of violence against women in various areas, including obstetric care. According to the 2021 ENDIREH, **31.4 percent of women who had given birth between 2016 and 2021 reported some form of OBV — almost one in three women.** This figure decreased by only two percentage points when compared to the period from 2011 to 2016 (33.4%), demonstrating the persistence and structural nature of OBV.

There is a higher incidence of OBV among women under 30 years of age. On the other hand, when the data are broken down by healthcare institution⁵, IMSS (*Instituto Mexicano del Seguro Social*) users have the highest proportion (39.8%) of OBV, while users of private healthcare services have the lowest (15.1%). In turn, according to marital status, women without a partner have the highest percentage (38.57%) of OBV. In the lowest income deciles, the figure is around 35 percent, compared to 18.4 percent in the highest decile.

When the data are disaggregated by disability or physical limitation, one of the most pronounced intersectional gaps is revealed. **Women with disabilities experience a higher incidence of OBV: 43.9 percent experienced it in their last birth, compared to 30.4 percent of women with neither disabilities nor limitations.** This difference of more than thirteen percentage points shows **that disability acts as a marker of structural discrimination in obstetric care services.**

⁵ Mexico has a mixed (public-private) healthcare system, and the public system is in turn divided into different subsystems.

Disability or limitation status	% of OBV	Difference vs. no disability
Woman with a disability	43.9 %	+13.5 pp
Women with limitations	39.4 %	+9.0 pp
Women without disabilities or limitation	30.4 %	(reference)

GIRE, What do the public data show? *Radiografía de la violencia obstétrica y la muerte materna* (Mexico City: Grupo de Información en Reproducción Elegida, 2023).

When analysing disability by age group, it can be observed that vulnerability to OBV intensifies in younger people. **Adolescent girls between the ages of 15 and 19 with disabilities have the highest incidence of OBV: 55.4 percent, a figure that is almost double that recorded among women between the ages of 40 and 49 without disabilities (22.3%).** In the 20-29 age group, the proportion reaches 45.5 percent, compared to 33.7 percent of their peers without disabilities. **This shows that age and disability operate cumulatively: being young and having a disability increases the risk of experiencing violence in obstetric care.**

Age group	With a disability	With limitation	No disability
15 to 19 years	55.4 %	41.9 %	33.6 %
20 to 29 years	45.5 %	44.2 %	33.7 %
30 to 39 years	42.6 %	37.1 %	27.4 %
40 to 49 years	30.8 %	27.1 %	22.3 %

GIRE, What do the public data show? *Radiografía de la violencia obstétrica y la muerte materna* (Mexico City: Grupo de Información en Reproducción Elegida, 2023).

Among women who experienced some form of OBV, the second most frequent form identified by ENDIREH was pressure to adopt a contraceptive method or undergo sterilisation. Additionally, these practices showed an upward trend: they went from 27.7 percent in 2016 to 31.5 percent in 2021. Among them, forced sterilization recorded the highest increase during the analysed period, constituting a direct violation of women's reproductive rights.

The ENDIREH also shows an increase in the number of caesarean sections, which is particularly concerning. This increase can be seen when comparing aggregate periods: the proportion rose from 42.8 percent for births occurring between 2011 and 2016 to 47.4 percent for those occurring between 2016 and 2021, an increase of 4.6 percentage points, giving a total of 3,718,900 caesarean births. In 2021, the figure reached 49.1 percent, more than three times the upper limit of the 10 to 15 percent range recommended by the World Health Organization (WHO).

The gaps in the incidence of OBV in different vulnerable populations show how inequalities in access to healthcare services reflect and reproduce social inequalities. The results of the ENDIREH are clear: women and people with childbearing potential who face greater conditions of vulnerability are also those who most frequently experience OBV. In order to tackle this gap, it is necessary to improve the conditions of the institutions of the national health system. Approaching the problem from an intersectional perspective implies considering alternatives that address these conditions in all their complexity.

Experiences: voices from the system

The ENDIREH data show the magnitude of OBV in Mexico, but do not explain the mechanisms that generate and sustain it. To do this, it is necessary to analyse the experiences of both the women who have gone through these situations and the healthcare personnel who contribute to reproducing them within the structural dynamics of the health system.

Patterns of obstetric violence in supported cases

The qualitative analysis of 64 cases of obstetric violence and 12 cases of maternal death in which GIRE provided legal support documents one of the most serious dimensions of OBV: the consequences arising from chains of institutional omissions and shortcomings. From these cases, Emilia Alton Martelet (University of Oxford) identified systematic patterns using thematic coding organized into seven analytical categories. The grouping of cases according to different vulnerability factors made it possible to observe that their

accumulation affects the quality of care received. These findings coincide with the public data from ENDIREH regarding the unequal distribution of OBV.

The 64 women who experienced OBV were grouped into seven profiles according to the intersection of vulnerability factors: basic education (26 cases), belonging to Indigenous peoples (10), pre-existing health condition (15), basic education and belonging to Indigenous peoples (6), basic education and health condition (2), belonging to Indigenous peoples and a health condition (2), and the combination of the three factors (3). **The intersection of these conditions was associated with an increase in care failures.**

Among Indigenous women (N=10), 100 percent of the cases had a delayed clinical response; 88 percent required transfer due to a lack of infrastructure in the primary care unit; 63 percent obtained recognition of institutional responsibility at some stage; and 88 percent faced a shift in institutional blame, as the system attempted to justify the damages by appealing to external factors or individual errors. This pattern shows that Indigenous women face great difficulties both in receiving timely and adequate care and in having institutional responsibility recognized when their rights are violated.

OBV also manifested itself on an affective and relational level: 50 percent of the women experienced physical or emotional abuse or serious omissions in communication between healthcare personnel and their families, were denied timely access to critical information, or were prevented from participating in an informed manner. Half of the cases included inadequate transmission of clinical information, which affected the continuity and quality of care, as well as timely decision-making.

The twelve cases of maternal mortality reveal a recurring pattern: in 75 percent, insufficient infrastructure was identified; in 67 percent, an inadequate risk assessment; in 58 percent, a delayed clinical response; and in 42 percent, there was an institutional shift of blame. In the six cases with combined mortality — both mother and child — these factors were present simultaneously, in an accumulation of care failures.

Overall, the cases analysed show that women in contexts of greater vulnerability — with less education, belonging to Indigenous peoples, or with pre-existing health conditions — face more obstacles in care. They also make it possible to identify institutional practices that limit access to justice, such as the shifting of blame, the loss of records, the refusal to provide information, or pressure on families to accept the institutions' accounts of what happened.

Healthcare personnel perspective

In June 2025, GIRE, the Uehiro Oxford Institute (University of Oxford), and the Institute of Legal Research (National Autonomous University of Mexico) organised a workshop in which 39 healthcare professionals participated. They had the following professional

profiles: obstetrician-gynaecologists; obstetric nurses and professional midwives; specialised perinatal nurses; and decision-makers from the healthcare sector. **The objective was to open a space for interdisciplinary and intersectoral dialogue to explore the perspectives of activists, academia, and healthcare personnel in relation to OBV.** The discussions made it possible to identify consensus and tensions regarding how the healthcare system understands, perceives, and reproduces this type of violence.

The participants agreed to define OBV as violence which sits at the intersection of gender-based violence and institutional violence. They described it as violence **that is exercised through acts or omissions during the process of caring for the pregnant person and that can have physical, psychological, or social repercussions on that person and even on the new-born.** In particular, the group of nurses and midwives emphasized that OBV is a lived experience, deeply rooted in sociocultural determinants, and linked to concepts such as blame, hierarchy, loss of bodily autonomy, violation, punishment, and dispossession.

When reflecting on OBV, the participants identified both positive aspects of using the concept 'OBV' and risks of presenting it as the exclusive result of individual decisions. Among the former, they highlighted that it is a term that makes the problem visible, empowers healthcare users, promotes improvements in the quality of care, and advances the guarantee of the human rights of women and people with the capacity to gestate. Regarding the risks, they pointed out the criminalization of healthcare personnel; the stigma associated with the term—which can categorise personnel as violent or negligent, without recognising the structural factors that condition their work—; the adoption of defensive practices by personnel, more oriented towards avoiding sanctions than towards providing adequate care; and the invisibilisation of the lack of hospital resources which in turn conditions clinical practice. On this point, the midwives were very clear in pointing out that the healthcare system limits the possibility of naming these practices:

“When we name the violence, when we confront it, violence is directed back at us [by the healthcare system]. It puts us in a vulnerable position between women and institutions, and it causes us frustration and fatigue. OBV can be so broad that it makes midwives complicit when we work within institutions. **Making OBV evident and naming it is synonymous with causing discomfort and being alarmist, and it has repercussions.** When women are cared for by midwives, they are punished because of this; the violence escalates to the point where care is made conditional, misdiagnoses are made and inadequate approaches are taken, and users are even frightened to the point that healthcare personnel lie to them about their diagnoses in order to **blame them for seeking care from midwives.***[sic]*

Among the structural causes of OBV identified by the healthcare personnel themselves, the following stand out: poor training in rights and a gender perspective; lack of knowledge about what OBV is; lack of training to identify and prevent OBV; lack of clarity about the roles of those who make up the care teams; administrative logics focused on productivity, which subordinate the needs of users; work overload and staff burnout; as well as the absence of evaluation mechanisms aimed at improving the quality of care. In this context, **the workshop participants showed significant resistance to treating OBV as a matter of individual responsibility. The participants described it more as a relational and systemic phenomenon involving actors, institutions and structures than as the exclusive responsibility of individual healthcare personnel.**

Based on their experience, the participating healthcare personnel made specific proposals: reform curricula to include humanized care; promote ongoing training in interpersonal skills and informed consent; integrate multidisciplinary teams; standardize national protocols for obstetric care; and design evaluation mechanisms that measure quality in addition to productivity. These proposals are relevant because they reflect the transformations that are considered viable within the health institutions themselves. Another finding of the workshop was the difference in perspectives based on the profiles of the participants. The obstetrician-gynecologists emphasized the limits imposed by infrastructure and resources; the nurses and midwives pointed to hierarchies within the health team as a source of violence; and the decision-makers stressed the need to establish quality indicators that go beyond productivity metrics. Rather than weakening the diagnosis, this diversity of views shows that **OBV is a multidimensional problem and that addressing it requires responses at several levels.**

Key findings

Based on different sources of information and methodological approaches, the findings converge on three key conclusions:

1. **OBV is a structural and institutional phenomenon, not just the result of individual behaviours.** Data from the ENDIREH show that the incidence of OBV remained virtually unchanged between 2016 and 2021, despite the fact that 29 federal entities have already incorporated it into their laws on access to a life free of violence. This suggests that its mere incorporation into the regulatory framework has not translated into sustained improvements.

In turn, the analysis of the 64 cases shows that manifestations of OBV stem from chains of institutional omissions — such as late responses or transfers due to lack of infrastructure — and not only from isolated decisions by healthcare professionals. The workshop held with healthcare personnel confirms the weight that institutional

design has in the reproduction of this violence. Taken together, these elements indicate that OBV's recognition in the regulatory framework is not sufficient to address the structural factors that contribute to its reproduction.

2. **Women and pregnant people who belong to groups in situations of vulnerability are more exposed to experiencing OBV.** The various sources of information show that the obstetric care provided to population groups in situations of greater vulnerability is usually of lower quality and in less safe conditions.

ENDIREH data show patterns of inequality in obstetric care that affect various populations, associated with factors such as age, disability, income, marital status, and the care institution. In addition, the cases supported by GIRE confirm this with qualitative evidence, identifying Indigenous women as the most vulnerable to experiencing failures in clinical care during their pregnancies.

For their part, healthcare personnel pointed out that Indigenous women, young women, women with disabilities, women experiencing homelessness, and migrant women are the most exposed to OBV, due to the convergence of prejudices, language barriers, active discrimination, and a shortage of specialized resources to care for them. In other words, the intersection of conditions of vulnerability leads to specific obstacles in care, so proposals to address OBV must incorporate a perspective that responds directly to this structural reality.

3. **The systemic conditions that make OBV possible make access to justice difficult.** The cases accompanied by GIRE made it possible to identify institutional mechanisms that prevent accountability: loss of records, refusal to provide clinical information, pressure on families to accept the institutions' accounts of what happened, and evasion of responsibility by attributing blame to external factors. Within the health system, the midwives and obstetric nurses who participated in the workshop pointed out that they face reprisals when speaking about OBV, and that this is one of the many factors that limit the visibility of failures in care. Both sources of information show that barriers to accessing justice are a fundamental part of this phenomenon, encourage its reproduction, and have more serious consequences for the most vulnerable populations.

Public policy recommendations

The following recommendations derive from the joint analysis of statistical evidence, cases supported by GIRE, and the perspectives of healthcare personnel.

1. Training and practice in obstetric care

The training of healthcare personnel is one of the most urgent areas for intervention. The workshop with healthcare personnel revealed the absence of theoretical and practical tools to ensure respectful childbirth and humanized care. The participants indicated the need to modify curricula to include these topics — both in basic and specialized training — as well as to promote ongoing training in interpersonal skills in health care and informed consent. Regarding practical experience, they pointed out that students and residents who are familiar with the current recommendations on respectful childbirth and humanized care have never seen them implemented, which makes their application difficult. This gap between theoretical knowledge and clinical practice contributes to the reproduction of patterns that the evidence documents as causes of OBV.

In this regard, it is recommended that content on humanized and respectful childbirth care, gender-based violence as a health problem, reproductive rights, bioethics, and human rights regulatory frameworks be incorporated into the curricula of medicine, nursing, and midwifery on a mandatory basis.⁶ Likewise, it is necessary to eradicate the forms of violence that occur during the training of students and residents, since they reproduce hierarchies that later affect the quality of care for users. In the case of staff who are already practicing, it is also recommended that continuing education programs be developed that focus on informed consent and social-emotional skills.

2. Conditions of the health system

Statistical evidence, cases supported by GIRE, and the perspective of healthcare personnel are in agreement that the material and institutional conditions in which the health system operates are direct causes of OBV. Staff exhaustion, shortages of supplies, hospital overcrowding, and a lack of infrastructure contribute to its occurrence.

In this regard, it is recommended to ensure the availability of sufficient personnel, as well as adequate supplies and medical equipment in all obstetric care units, especially primary-level care units and those that serve populations in situations of greater vulnerability. Reducing staff workloads is a necessary condition for staff to be able to provide quality care. Burnout, identified by the staff themselves as one of the structural causes of OBV, cannot be resolved through isolated training if working conditions remain the same. In turn, it is necessary to reorient hospital care models so that they are no longer organized primarily around productivity and instead focus on health outcomes and the experience of users.

6 César Palacios-González conducted a preliminary analysis of the curricula of the Medicine degree program at the public universities with the largest number of students. No specific references to the subject of obstetric violence were found in the syllabi of the Bioethics and Medical Ethics courses.

Finally, referral and counter-referral mechanisms between the different levels of care must be strengthened to ensure that women are not transferred without follow-up, information, or continuity of their case. The fragmentation of services creates gaps in which violence can take root.

3. Institutional organization of care

Beyond the material conditions, the way in which care is organized within institutions largely determines the presence or prevention of OBV. The lack of clarity in roles, the absence of planning for obstetric emergencies, and the lack of quality-oriented oversight mechanisms are some of the institutional factors that contribute to its perpetuation.

We recommend that national obstetric care protocols be standardized according to the updated recommendations of the WHO, PAHO, and the Health Secretariat, and that their effective application in hospital services be ensured. During the workshop with healthcare personnel, it was identified that, in Mexico, progress in the development of clinical practice guidelines and other guidance has not resulted in their implementation. Clear pathways for obstetric emergency care must also be established, with explicit prioritization criteria. Finally, tools such as the birth plan — prepared jointly by the woman and the pregnancy clubs — with content aimed at empowering users, contribute to transforming the one-way relationship of care into informed participation, which in turn can modify institutional care models.

4. Evaluation, accountability and access to information

It is recommended that effective mechanisms be implemented to evaluate the quality of obstetric care that go beyond productivity metrics, such as exit surveys and indicators of satisfaction and outcomes, as well as the role of the proactive witness for internal monitoring. These instruments must produce information that is analysed periodically by hospital committees and that results in concrete and documented actions.

In terms of access to information, access to complete clinical records must be guaranteed and clear, accessible, and non-punitive procedures must be established to address administrative complaints. These mechanisms must be understandable to women and pregnant people and their families, and be aimed at identifying institutional responsibilities and preventing the recurrence of events. It is also recommended that administrative and jurisdictional — not criminal — channels for accountability be strengthened, so that investigations into violations of rights during childbirth can identify system failures and not be limited to the prosecution of healthcare professionals.

5. Intersectional approach to care

Evidence shows that structural inequalities in the health system reflect and reproduce broader social inequalities. Given that those in situations of greater vulnerability face the most serious and frequent forms of violence, it is recommended that tailored strategies be implemented. In the case of Indigenous women, this implies guaranteeing the availability of interpreters and personnel with intercultural competence, facilitating the use of their languages at all times during care, and incorporating intercultural midwives in units that serve this population. For women with disabilities, it is necessary to adapt the informed consent and communication protocols to their specific needs. The intersectional approach must be incorporated as a mandatory cross-cutting axis in care models, staff training plans, and evaluation mechanisms.

6. Public policy approach: beyond criminalization

The analysis of the three sources of evidence shows that resorting to the criminalization of OBV as the main strategy to combat it is insufficient and has counterproductive effects. The workshop with healthcare personnel showed a resistance to understanding OBV as an individual responsibility. Criminalization stigmatizes staff who try to name the problem and contributes to making the structural failures of the system invisible. In this sense, public policy must be committed to transforming the structural conditions that make this type of violence possible.

It is recommended that progress be made towards regulatory frameworks oriented towards humanized childbirth that establish clear obligations for institutions in relation to the rights of pregnant people. These frameworks must be accompanied by the harmonization of the internal policies of health institutions with current national and international regulations. Finally, priority should be given to continuous monitoring mechanisms that make it possible to evaluate the impact of the public policies implemented and to keep the diagnosis that supports them updated.

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