**Mistreatment and violence against women during reproductive health care with a focus on childbirth.**

**Report submitted by: The Information Group on Reproductive Choice (GIRE)**

1. Please indicate whether in your country there are cases of mistreatment and violence against women during reproductive health care, particularly facility-based childbirth. If so, please specify what kind of cases and describe your country’s response and any good practices, including protection of human rights;

The Information Group on Reproductive Choice (GIRE) is a nonprofit organization that has been working for women's reproductive rights for more than 27 years. It was one of the first organizations in Latin America to use the term obstetric violence and to document the incidence of behaviors and omissions that are grouped under the concept of obstetric violence in Mexico, a specific form of violence against women that happens in the field of pregnancy, delivery and postpartum care in public and private health services, and which constitutes a violation of their human rights.

GIRE’s work has been crucial in making visible the type of situations that constitute obstetric violence: any action or omission on the part of the personnel of the National Health System that causes a physical and / or psychological damage to a woman during pregnancy, childbirth and puerperium, that is expressed in the lack of access to reproductive health services, cruel, inhuman or degrading treatment, or a medicalization abuse, or undermining the ability to decide in a free and informed manner about said reproductive processes. The manifestations of obstetric violence can be physical and psychological. Among the first are invasive practices, for example, cesareans, when they are practiced without justified clinical indications, putting women at risk of suffering health problems, particularly those with little access to comprehensive obstetric care; unjustified supply of medication or a delay in emergency medical care. Among the latter are dehumanized treatment, humiliation and discrimination. These situations continue to be alarmingly frequent in the country.

According to the National Survey on the Dynamics of Relationships in Households 2016 (ENDIREH),[[1]](#footnote-1) the most common manifestations of obstetric violence in Mexico are screaming or scolding (37.42%), delay in attention "by shouting or complaints" of the client (34.44%), ignoring the patient (33.11%), pressuring the patient to accept a contraceptive method or sterilization (30.9%) and forcing them to adopt uncomfortable positions during labor (30.83%). According to survey results, the states with the highest proportion of women who have suffered some type of obstetric violence, in the last five years, are Mexico City (36.5%), the State of Mexico (36%), Queretaro (34.6%), Tlaxcala (34.2%) and Morelos (33.7%). On the other hand, there was a higher incidence of maltreatment during obstetric care in IMSS hospitals and clinics, while the lowest proportion occurred in deliveries attended by midwives.

According to this same survey, in 2016, 42.8% of the women interviewed reported that the birth of their last son or daughter was by caesarean section. Of these, 10.3% reported not having been informed of the reason for the cesarean, and 9.7% stated that they did not ask for or give authorization to perform it, a situation that represents a clear violation of reproductive rights. These figures coincide with those provided by health institutions, which report high rates of cesarean sections in hospital institutions, particularly in entities such as Yucatán and Nayarit.[[2]](#footnote-2) Although the World Health Organization (WHO) emphasizes that it is necessary to focus on the needs of patients and discourage the establishment of maximum goals with regard to the rate of caesarean sections, this figure far exceeds that recommended by international organizations, as well as by NOM-007-SSA2-2016 For the care of women during pregnancy, delivery and puerperium, and of the newborn (NOM 007) (from 10 to 15%), suggesting the prevalence of unjustified cesareans in the country.

Among the responses from the State to address this type of violence, 24 of 32 states have incorporated definitions of obstetric violence in their respective laws on access to a life free of violence. This situation helps to recognize that obstetric violence is a specific form of institutional violence against women and that it constitutes a human rights violation. However, at present, some states have also opted to include obstetric violence as a crime in their penal codes. This is the case of Chiapas, State of Mexico, Guerrero, Quintana Roo and Veracruz.

GIRE considers that resorting disproportionately to criminal law for the treatment of structural social problems such as obstetric violence is not, in itself, compatible with a democratic State of Law. The criminal law individualizes the problem towards medical and nursing staff, who frequently perform their work in conditions that diminish their ability and the quality of care they provide, and will hardly contribute to avoiding obstetric violence practices that have a structural nature. Therefore, public policy measures that reinforce the normative and human rights framework for obstetric care should be sought.

On the other hand, in July 2017, the National Commission for Human Rights (CNDH) issued General Recommendation 31/2017 on Obstetric Violence in the National Health System (SNS), in order to make visible the situation experienced by the women in the context of obstetric care in health institutions and to contribute to the identification and elimination of this practice. In general, the Recommendation agrees with the GIRE’s position, since it states that the solution does not lie in the criminalization of obstetric violence and recognizes the importance of the incorporation of midwifery in the SNS. However, it recommends actions such as the implementation of workshops to sensitize health personnel, which do not include evaluation mechanisms with respect to their effectiveness nor do they propose a change in the professional training of health personnel, from a gender and intercultural perspective. In this sense, it would be essential not only for the CNDH to follow up on compliance with said recommendation before the institutions to which it is directed, but also to include elements that allow evaluating the actions carried out by these institutions in a way that serves as an engine for real change around obstetric care in the country.

2. Please specify if full and informed consent is administered for any type of reproductive health care and if these include childbirth care;

Informed consent is an obligation established in the Regulation of the General Health Law regarding the Provision of Medical Care Services, in NOM 004-SSA3-2012, of the clinical file and in NOM 007-SSA2-2016, for the care of the woman during pregnancy, childbirth and puerperium, and of the newborn. However, of the women surveyed for the preparation of the ENDIREH, 42.8% reported that the birth of their last child was by caesarean section, and of these, 10.3% reported not having been informed of the reason for the cesarean, and 9.7 % stated that they did not ask for your authorization to do it.

Another manifestation of obstetric violence is the imposition of some contraceptive methods, temporary or definitive, without previously obtaining the consent of the woman in a free and informed manner. The ENDIREH 2016 registered that 13.95% of the women who suffered some type of obstetric violence reported that they placed some contraceptive method or operated on it or sterilized it permanently without asking or notifying it. The case of Sandra, a woman accompanied by GIRE, is illustrative of the lack of compliance with the obligation to guarantee informed consent in the context of reproductive health care.

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| Sandra was 31 years old and had her prenatal care in the Family Medical Unit (UMF) 33 of the IMSS, in Tonila, Jalisco. At 38 weeks of gestation, she went to the UMF with labor pains and high blood pressure, so she was referred to the General Hospital of Zona, in Ciudad Guzmán, Jalisco, where she was admitted to the emergency room and remained there all night. The next day she was informed that her pregnancy was going well, but she was not yet full term.  Two days later, the doctor on the morning shift noticed that Sandra no longer had amniotic fluid, but it was until the evening shift that she was admitted to the operating room. At that moment, the doctor informed her that they would perform a caesarean section and questioned her about whether she had already talked with her husband about not having more children. When answering that they still did not talk about it, the doctor referred to her as "irresponsible" and said: "I will go out and talk with your husband, I just hope he is not a male of those who do not understand; What’s more, if not, that's how you're going to stay, to see what time you give birth."  Subsequently, the doctor informed Sandra's relatives that, for health reasons, it was not convenient for her to have another pregnancy and assured them that she already agreed and had signed the consent for a Bilateral Tubal Occlusion (BOT), a contraceptive procedure permanent. Then, her husband signed an authorization document, which Sandra could not check carefully because she was very tired and with contractions for more than four days. She signed it in a context of pressure and intimidation when they entered the operating room to perform an emergency cesarean section.  In October 2017, Sandra, accompanied by GIRE, filed a complaint with the CNDH on the grounds that the way in which the medical staff treated her was inadequate because she did not receive satisfactory counseling and the consent for the OTB was obtained at an inopportune moment. Based on the complaint filed with the CNDH, the Directorate of Attention to the Rightful Holder of the IMSS initiated an investigation into the facts. The complaint is awaiting a resolution.  On the other hand, GIRE accompanied her to file a claim for indirect protection before the District Judge in the state of Jalisco, requesting that she be provided with specialized medical and psychological care and provided with sufficient information on the type of procedure performed and if it is possible to reverse it. In May 2018, GIRE filed an appeal for review against the resolution dismissing the indirect injunction, which has not yet been resolved.  On the other hand, on July 30, the Bipartite Commission of the IMSS resolved that the complaint is irrelevant from the medical point of view and does not result in the payment of compensation, because there is no liability. |

3. Please specify whether there are accountability mechanisms in place within the health facilities to ensure redress for victims of mistreatment and violence, including filing complaints, financial compensation, acknowledgement of wrongdoing and guarantees of non-repetition. Please indicate whether the ombudsperson is mandated to address such human rights violations;

Among the procedures that can be initiated in situations of obstetric violence, are the presentation of written complaints to the health institutions in which the care was received, the trials of administrative responsibility and the medical arbitration that comes in cases of public services and private. None of these provides for the establishment of comprehensive reparation measures for human rights violations.

It is also possible to present complaints to public human rights organizations when public sector health personnel are involved. This last mechanism, although it contains limitations, makes it possible to visualize the structural nature of the problem, to offer solutions that do not fall purely on the individual and to contemplate integral reparation measures for the victims.

*Administrative path*: The most immediate recourse to an obstetric violence situation is the presentation of a written complaint to the internal control unit of the health institution. With this, an investigation will begin on the deficiencies in medical care that have been reported. The procedure to be followed for the complaint is determined by each health institution. The lack of homogeneity creates uncertainty regarding the procedure to be followed by a woman who has suffered obstetric violence, in addition to the fact that the complaint is filed with the same institution about which the obstetric violence is reported, and is the same institution the one that decides the procedure and result of the same one, can create a conflict of interest to establish the responsibility of the personnel of health.

Through requests for access to government information made by GIRE, it was found that from December 2012 to September 2017 there were 684 complaints filed with federal health institutions for obstetric violence, while from December 2012 to October 2017 867 complaints were filed, for the same reason, with local health institutions. However, it is impossible to know the resolution of these complaints as an effective mechanism for the victims of said violations.

*Comisiones de arbitraje médico:* La Comisión Nacional de Arbitraje Médico (CONAMED) fue creada en 1996 con el fin de ofrecer mecanismos alternos de solución de controversias entre usuarios y prestadores de servicios médicos. Es un órgano desconcentrado de la Secretaría de Salud federal, con autonomía técnica para emitir acuerdos y laudos. Sus principales atribuciones consisten en brindar asesoría a los usuarios de servicios médicos, atender quejas por irregularidades en el servicio médico y negación de acceso al mismo, intervenir en conciliaciones entre prestadores de servicios y usuarios, fungir en el arbitraje entre ambos, y emitir opiniones técnicas sobre asuntos de carácter general que consideren de importancia, aunque no estén relacionados con una queja particular.

Medical Arbitration Commissions: The National Commission of Medical Arbitration (CONAMED) was created in 1996 with the purpose of offering alternative dispute resolution mechanisms between users and providers of medical services. It is a decentralized body of the federal Ministry of Health, with technical autonomy to issue agreements and awards. Its main functions are to provide advice to users of medical services, address complaints of irregularities in the medical service and denial of access to it, intervene in conciliations between providers of services and users, serve in the arbitration between them, and issue technical opinions. about matters of a general nature that they consider important, even if they are not related to a particular complaint.

Through requests for access to information made by GIRE, it was known that, from December 2012 to October 2017, CONAMED issued 11 condemnatory awards related to gynecological care. Although CONAMED and the local arbitration commissions are a possible way for victims of obstetric violence to obtain compensation more quickly and easily than in a court, by focusing this mechanism exclusively on the individual performance of health personnel, not analyzing the obstacles or structural failures that caused the situation of obstetric violence, does not allow guarantees of non-repetition, and the conciliation or award in which it concludes limits its effects to the parties involved.

*Human Rights Commissions*: The National Commission for Human Rights and local human rights commissions are autonomous bodies for reporting human rights violations committed by public officials. These autonomous bodies are empowered to hear reports regarding acts or omissions that violate human rights from public officials, as well as to issue public, autonomous and non-binding recommendations, given that they are not judicial bodies. Due to the latter, compliance with them ultimately depends on the political will of the corresponding public institution.

GIRE’s experience in this mechanism in the cases that we accompany shows that this way has not always been a true alternative of integral reparation for women. Among the factors that influence this situation are the limited participation that is given to aggrieved persons during the processing of the complaint; the lack of consideration of the victims' requests when issuing recommendations to guarantee an integral reparation in accordance with human rights, and the limits and obstacles in accessing the complaint files for the victims and their legal representatives. It is also common for recommendations issued to be accepted by the authorities, but they are not given prompt follow-up nor is evidence collected about their compliance. On occasion, the CNDH considers the recommendation to be satisfactory, despite the fact that there is no complete compliance by the responsible authority and limited to the exchange of offices between authorities.

In response to requests for access to information presented by GIRE, human rights commissions, national and local, reported different levels of information: in some cases, they do not even recognize the term obstetric violence or claim not to classify information in that way. In others, partial or incomplete information was obtained. In total, local human rights commissions reported having registered 1,010 complaints related to obstetric violence, 147 recommendations issued and 84 accepted, in the period from December 2012 to October 2017. The CNDH, meanwhile, reports 567 related complaints with obstetric violence, in the period from December 2012 to September 2017.

1. Does your health systems have policies that guide health responses to VAW and are these in line with WHO guidelines and standards on this issue?

The General Law on Women's Access to a Life Free of Violence (LGAMVLV), published in 2007, does not expressly specify obstetric violence as a form of violence against women. However, other contemplated figures, such as psychological, physical and institutional violence, provide an adequate framework for framing the behaviors that constitute obstetric violence. To date, 24 federal entities have incorporated definitions of obstetric violence in their respective laws of access to a life free of violence. This situation helps to recognize that obstetric violence is a specific form of institutional violence against women and constitutes a violation of human rights.

The General Health Law (LGS) and the Regulation on the Provision of Medical Care Services regulate the provision of health services, including those empowered to provide obstetric care and contraception services. Chapter V of the Law, dedicated to maternal and child care, establishes as a priority action in article 61, the comprehensive care of women during pregnancy, childbirth and puerperium, including psychological care as necessary. Article 64, section IV establishes the obligation of the health authorities to provide training to traditional birth attendants with the aim of strengthening their technical competence in obstetric care.

For its part, NOM 007 establishes the criteria for women’s care during pregnancy, childbirth and postpartum, as well as the newborn and is of mandatory application and observance in the health units that make up the National Health System. This norm also obliges all health institutions to train obstetric nurses, technical and traditional midwives to identify complications of pregnancy, childbirth and puerperium, and provide facilities for referral and accompaniment of pregnant women to facilities for medical care. Thus, low-risk deliveries can be attended by trained obstetric nurses, technical midwives and traditional birth attendants. Although this represents an important beginning, there are still major challenges related to obstetric care and midwifery in Mexico, such as the lack of clarity in the legal framework regarding the accreditation and training of midwives, the lack of recognition of the value of traditional midwifery and the reticence on the part of the medical union for the inclusion of mid-level personnel trained for obstetric care.

In general, it can be affirmed that the existing legal framework in Mexico is adequate in terms of human rights standards. In this sense, the challenges consist, in the effective implementation of the legal framework by health personnel and, on the other hand, in structural obstacles that hinder the solidification of the contents of the regulations, for example: the complex institutional design of the National Health System, insufficient budgets, hospital infrastructure, medical and nursing staff. This facilitates the saturation of the health system in Mexico, particularly in the second and third level hospitals, which significantly affects the quality of medical care, makes it difficult to respond to obstetric emergencies and, therefore, affects the incidence of cases of obstetric violence and maternal death.

1. According to Roberto Castro and Sonia M. Frías, “This study presents the first measurement conducted anywhere in the world (to our knowledge) of the problem of obstetric violence through a probabilistic nationally representative household survey.” For more information, see “Obstetric Violence in Mexico: Results From a 2016 National Household Survey” in *Violence Against Women*, April 8, 2019, online. [↑](#footnote-ref-1)
2. For more information, see GIRE 2018, *La pieza faltante. Justicia reproductiva*. Available in Spanish at justiciareproductiva.gire.org.mx p. 87. [↑](#footnote-ref-2)