Committee for the Elimination of Racial Discrimination (CERD)

Alternative Report on the Situation of Sexual and Reproductive Rights of Indigenous Women in Mexico

Grupo de Información en Reproducción Elegida, A.C.[1]

I. Introduction

Mexico is a very racially diverse country, with an indigenous population of twelve million twenty-five thousand nine hundred and forty-seven people, constituting 10.1% of the total population, according to the 2015 Intercensal Survey. Of the total indigenous population, six million one hundred forty-six thousand four hundred and seventy-nine are women (51.1%). Although there is an indigenous population in every state, more than 75% is concentrated in eight states: Oaxaca (14.4%), Chiapas (14.2%), Veracruz (9.2%), State of Mexico (9.1%), Puebla (9.1%), Yucatan (8.8%), Guerrero (5.7%) and Hidalgo (5%).[2]

In Mexico, conditions that allow women to make decisions regarding their reproductive life do not exist at present. This situation particularly affects women who experience multiple layers of discrimination, such as indigenous girls and women.

II. Indigenous Peoples' Reproductive Health Status

Access to information and contraceptive services without discrimination for people of indigenous descent represents a fundamental human rights challenge for the Mexican State. Indigenous women in Mexico have historically faced serious and systematic violations of their reproductive rights ranging from forced sterilization and mistreatment in health services to lack of access to information and health services in their maternal language and with an intercultural perspective.

According to the 2014 National Survey on Demographic Dynamics (ENADID), 54% of indigenous women of reproductive age became mothers during their adolescence, a higher percentage than among those who do not speak an indigenous language (45.9%). Regarding the use of contraceptives by sexually active adolescents, it was found that six out of ten speakers of an indigenous language do not use contraceptives. Likewise, the 2016 National Survey on the Dynamics of Household Relationships (ENDIREH) reported that 20.08% of adolescents who identify as indigenous claim to have had at least one pregnancy, as opposed to the 16.15% of their peers who do not identify themselves as such.

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[1] The Grupo de Información en Reproducción Elegida, A.C. (GIRE) is a feminist organization that works for reproductive justice based on six priority issues: access to legal and safe abortion, maternal mortality, obstetric violence, contraception, assisted reproduction techniques and the conciliation of work and personal life.

[2] Indigenous Women, Current Statistical Data for Mexico; National Institute of Indigenous Communities, available at *https://www.gob.mx/inpi/es/articulos/mujeres-indigenas-datos-estadisticos-en-el-mexico-actual?idiom=es*

The Committee for the Elimination of Racial Discrimination (CERD) highlighted the need for interpreters to guarantee indigenous peoples' full access to health services in its 2012 report to Mexico.[3] However, the information obtained by GIRE through requests for access to government information demonstrates that, at the federal level, no health institution reported having trained personnel to provide consultation on reproductive health and contraceptive methods in any language other than Spanish.

One response provided by the Women's Hospital was notable, reporting 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 Mexican Social Security Institute (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.[4]

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.

At the state level, 16 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. 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.[5]

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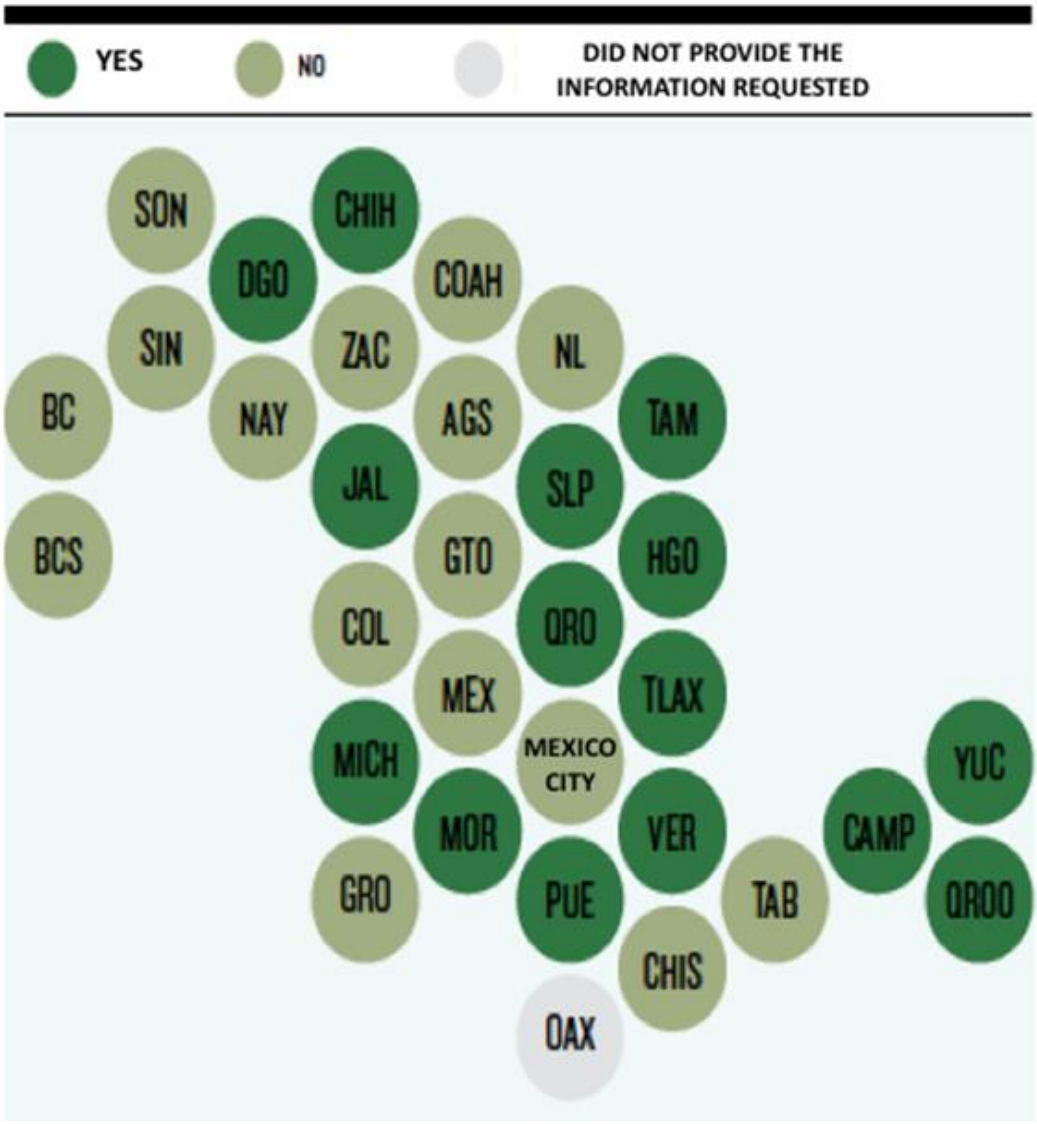
[3] UN, Final observations of the Committee for the Elimination of Racial Discrimination* CERD/C/MEX/CO/16-17 (March 9, 2012), paragraph 19, available at: https://www2.ohchr.org/english/bodies/cerd/docs/CERD.C.MEX.CO.16-17_sp.pdf

[4] GIRE, *The Missing Piece: Reproductive Justice*, 2018, p. 31, available at: https://justiciareproductiva.gire.org.mx/assets/pdf/JusticiaReproductiva.pdf

[5] GIRE, *The Missing Piece, Reproductive Justice*, *op. cit.*, p. 31.

INTERPRETERS FOR CONTRACEPTIVE COUNSELING IN INDIGENOUS LANGUAGES
STATE-LEVEL MINISTRIES OF HEALTH



Source: Developed by GIRE based on requests to public information.[6]

[6] GIRE, *The Missing Piece: Reproductive Justice*, *op. cit.*, p. 32.

III. Obstetric Violence

According to the 2016 ENDIREH, in Mexico, of the 8.7 million women who gave birth at least once between 2011 and 2016, 33.4% reported having suffered mistreatment by those who attended them; 26% of those women speak an indigenous language or identify as indigenous.

Obstetric violence is a human rights and justice problem requiring actions that systematically transform the way in which women's health care is conceived. Despite the fact that there are certain advances in legislation on the issue in Mexico, such as the recognition of the concept in most state regulatory frameworks, strategies and mechanisms are still required to disseminate this problem in an ample and consistent manner from a human rights perspective, as a permanent policy and not as an action related solely to a current situation.

Irma's case is important in raising awareness on the obstetric violence suffered by indigenous women in Mexico, which is rooted in the health system's crisis; unable to guarantee and offer effective, clear, opportune and efficient sexual and reproductive health services without discrimination against women.

Irma
Oaxaca, 2013
Irma is a Mazatec woman and lives in precarious economic conditions. Upon arriving to the San Felipe Jalapa de Díaz Health Center in Oaxaca, nursing staff told her to go for a walk, confident that her baby was not yet going to be born. While Irma was walking in the hospital's courtyard, her waters broke and moments later her son was born, in absence of any medical assistance whatsoever.

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

To date, the physical conditions of the health center remain inadequate. GIRE continues to take steps to ensure full compliance with the agreement from the Oaxacan Government and thereby, ensure access to justice for Irma and her son.

It is necessary to design and implement public policies that seek to eradicate and prevent actions or omissions that constitute obstetric violence, with a focus on gender and interculturality. Among the urgent actions in this regard is the need to prioritize low-risk delivery at the primary

level of care and improve hospital equipment and infrastructure, with a priority in remote and socially marginalized areas. It is also necessary to institutionalize the training of health personnel who directly intervene in the care of women during pregnancy, birth and postpartum.

IV. Maternal Mortality in Mexico

Between 1990 and 2013 in Mexico, 2,186 women died due to preventable obstetric causes. In 2015, the total was 778, which corresponds to a Maternal Mortality Ratio (MMR) of 36.4, well above the Millennium Development Goal established more than 15 years ago. For 2016, this figure was reduced to 774 and, in 2017, to 722.[7]

Although the number of maternal deaths seems to decrease each year, this reduction has been insufficient and reflects the inequalities that are persistent in the country. Structural failures in the health system have a particular impact on women in indigenous communities, who have to travel long distances to health centers that are in poor condition, without basic medical personnel or interpreters of languages other than Spanish, and who encounter discriminatory attitudes from the staff.[8]

In 2015, 6% of the Mexican population were indigenous women. However, 11.2% of the total maternal deaths that year correspond to this population. This reveals that maternal mortality disproportionately affects this population.[9] The CERD noted its concern about the high maternal mortality figures related to the indigenous population in its 2012 report to Mexico and recommended that the State generate clear data on maternal mortality in indigenous communities.[10]

The stories of Anita and Gelleli exemplify the seriousness of human rights violations in cases of maternal mortality -especially for indigenous women-, as well as the obstacles in accessing justice that their families face. In most cases, they must endure long processes before achieving some resolution from an authority.

ANITA
PUEBLA, 2018

Anita was a young indigenous woman who lived 20 minutes from the center of Huehuetla, Puebla. She was in high school and worked in a stationery store that belongs to her godparents. Her father died five months before the events and, at present, her brothers economically maintain the household.

When she was 16 years old, Anita became pregnant. At about 37 weeks of gestation, she began to feel contractions and decided to go, accompanied by her mother Rosa, to the Huehuetla Community Hospital. Upon arrival at the hospital, the doctor who attended her told her that it was still a long time before the baby would be born and that she should return in the afternoon for a second check-up.

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[7] GIRE, *51%: An Agenda for Equality*, p. 22, available at: https://gire.org.mx/wp-content/uploads/2018/05/51-Una-agenda-para-la-igualdad.pdf.
[8] GIRE, *The Missing Piece: Reproductive Justice*, *op. cit*., p. 117.
[9] Maternal Mortality Observatory, *Numeralia 2015*.
[10] UN, *Final Observations from the Committee for the Elimination of Racial Descrimination** CERD/C/MEX/CO/16-17 (March 9, 2012), paragraph 19.

Anita and her mother went home and waited until the afternoon to return to the hospital, where the doctor told her again that there was still time and she should go for a walk.

Anita entered the hospital around 10:00 pm. The doctor examined her and told her that everything was fine. However, an hour later, Anita sent for her mother and told her that she felt very bad and that she preferred to be transferred to the Ixtepec Hospital so they could perform a cesarean, as they had indicated during her prenatal check-up, due to her young age. Her mother spoke with the doctor to request the transfer, who responded, annoyed, that Anita was not a doctor and could not decide and that the delivery would be vaginal. At around 4:00 am, she was admitted to the delivery room, and an hour later, the doctor called Rosa to come and see her. Anita was unconscious and there was blood all over the floor and doctor and nurses' clothing. Rosa cleaned Anita and asked the doctor not to hurt her anymore. The doctor and the nurse made signs and told her to leave.

No one gave the family any information about Anita's health until 8:00 am, when the doctor came out to inform them that she had died, and that they had not extracted the fetus because they realized that Anita "did not want it" and that she "had not put in the effort" for the delivery to evolve satisfactorily.

Rosa did not sign the hospital documents for the delivery of the body because she wanted to find out what had happened. As a result, personnel from the Health Jurisdiction of Zacatlan arrived to assure her that the medical staff had carried out their work correctly. Later, authorities from the Puebla Prosecutor's Office also appeared, requesting that the family authorize the transfer of the body to Zacatlan.

The family buried Anita and her baby on August 6, 2018. GIRE learned about the case through Anita's godfather and has accompanied the family in their search for justice.

GELLELI
OAXACA, 2018

Gelleli was a Mazatec woman who lived in Jalapa de Diaz, Oaxaca. At age 24, she was in her second pregnancy without complications.

After feeling unwell during the 40th week of her pregnancy, Gelleli, accompanied by her partner Martin, sought medical attention at the municipal health center. There, they were told she required urgent medical attention, for which they had to go to the Tuxtepec General Hospital. To do this, they had to seek travel assistance because the municipal health center did not have an ambulance.

Gelleli arrived at the Tuxtepec Hospital at 6:00 pm, but she did not receive attention until 8:00 am the following day. They did not provide any information to her partner until several hours later, when they informed him that they would perform a second operation because during the cesarean, they had perforated an artery resulting in an internal hemorrhage. At that time, and without explaining further, they made Martin sign an informed consent form, even though he does not know how to read or write in Spanish. They told him that if he did not sign, Gelleli would die. They did not provide further information about his partner's health throughout the rest of the day.

The next morning, Martin was informed that Gelleli needed another operation because the bleeding did not subside. The operation implied a high possibility risk of death and, if she survived, there was no guarantee of improvement. After discussing it, Martin and Gelleli's family decided to refuse the procedure. The next day, hospital staff informed them of her death.

GIRE is accompanying the case, which is currently being processed before the Oaxaca Human Rights Ombudsman. Gelleli's family has been waiting for justice for more than a year and desperately needs comprehensive reparations.

If a recommendation is issued, we hope that the comprehensive reparations consider the corresponding sanctions; a public apology from the hospital; the guarantee of medical, psychological, legal and social care for Gelleli's family; guarantees of non-repetition that contemplate personnel awareness programs; the application of current regulations and adequate equipment for the Tuxtepec General Hospital; as well as economic compensation for Gelleli's family for the expenses they incurred before their loss, among other things.

The actions that the Mexican State has taken to improve the quality of obstetric care and inform the CERD[11] are insufficient in guaranteeing the human rights to which the State is obliged, particularly in relation to populations that live in conditions of vulnerability and face multiple discriminations, such as indigenous girls and women, Afro-descendant populations, migrants and asylum seekers, among others.

V. Recommendations for the State

STATE AND FEDERAL EXECUTIVE BRANCH (HEALTH INSTITUTIONS)

- Ensure the inclusion of friendly consultation services in primary care units, within a framework of human rights, and with a gender and intercultural perspective.
- Guarantee the availability of an interpreter in health services, at all levels of care.
- Guarantee universal access to obstetric health services, particularly during labor, ensuring compliance with the General Agreement of Inter-institutional Collaboration for Emergency Obstetric Care and "zero rejection" of women with obstetric emergencies.
- Consolidate the attention provided at the primary level by strengthening low-risk delivery care to reduce the saturation of secondary and tertiary level services and ensure timely referral to these services for the resolution of obstetric emergencies.
- Institutionalize the training of health personnel involved in obstetric care and evaluate the impact of these actions.

[11] Exam of the reports presented by the States in virtue of Article 9 of the Convention, CERD/C/ME/ 18-21, (August 25, 2017) paragraphs 150-155, https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CERD%2FC%2FMEX%2F18-21&Lang=es

- Regularly certify the technical capacities of health personnel.
- Strengthen the training and accreditation actions of obstetric midwives and nurses to incorporate them progressively into health services.
- Monitor the implementation of NOM 007 regarding pregnancy, delivery and puerperium care.

PUBLIC INSTITUTIONS FOR HIGHER EDUCATION TRAINING OF MEDICAL SURGEONS, SPECIALISTS IN OBSTETRICS, GYNECOLOGY AND NURSING

- Modify the professional training of medical and nursing staff in the care of women during pregnancy, childbirth and postpartum to include a gender and intercultural perspective.