GIRE
GRUPO DE INFORMACIÓN
EN REPRODUCCIÓN ELEGIDA

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Mexico's 9th Periodic Report

Alternative Report on the Reproductive Rights of Mexican Girls, Adolescents and Women
Grupo de Información en Reproducción Elegida, AC (GIRE)

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I. Introduction

The Grupo de Información en Reproducción Elegida (Information Group on Reproductive Choice, GIRE) is a feminist organization that works for reproductive justice via six priority issues: access to safe and legal abortion, maternal mortality, obstetric violence, access to contraception, assisted reproduction techniques, and work-life balance. GIRE has prepared this alternative report with the goal of examining Mexico's 9th periodic report, during the 70th Session of the Committee of the Convention to Eliminate All Forms of Discrimination against Women.

II. Safe and Legal Abortion

Mexico's current legal framework allows for the termination of pregnancy resulting from sexual violence. Several legal instruments regulating access to abortion after rape establish that women and girls, starting at 12 years old, must only request the service in writing and declare under oath that the pregnancy is the result of rape. However, regulatory obstacles at the state level continue to hinder women's access to services. To date, 12 state-level criminal codes establish a time limit for accessing abortion in cases of rape -generally during the first trimester of pregnancy-, while ten criminal codes require some type of authorization to carry out the procedure and 11 codes require that women report the rape to law enforcement agencies to access the service.[1] In addition, GIRE identified 13 administrative regulations that contain requirements that contradict the General Law for Victims (LGV).[2]

Though efforts should be made to harmonize criminal legislation and administrative instruments with the LGV, it is essential that all authorities be informed that the lack of harmonization is not a reason to deny access to abortion in cases of rape. Authorities that have contact with victims should be aware that the LGV is mandatory across Mexico, in accordance with the current constitutional human rights framework.

[1] GIRE, *Violence without Interruption*, Mexico, 2017, pgs. 37 and 38. Available at: http://aborto-por-violacion.gire.org.mx/#/
[2] *Ibid*, pgs. 21-23

GIRE documented that state health ministries reported having carried out a total of 63 abortion procedures under the rape indication from January 1, 2009 to June 30, 2016.[3] The federal Ministry of Health (SSA), the Institute of Social Security and Services for State Workers (ISSSTE), and the Mexican Social Security Institute (IMSS) reported that they did not have this information.

During the aforementioned period, ten Mexican states reported not performing any abortions after rape, and ten additional states affirmed that the requested information did not exist. This contrasts with the 433,983 health institutions' reports to Public Prosecutor's Offices of possible cases of sexual violence during the same time period, of which 49,270 correspond to cases of minors.[4] The above is implausible in a country where nearly 600,000 sexual crimes are reported each year; in which nine out of ten survivors of sexual violence crimes are women; where four out of ten victims of sexual violence are under the age of 15,[5] and in which 41.3% of women over 15 years of age have suffered sexual violence at some point in their lives.[6]

The Mexican State made reference in its periodic report to training workshops for health professionals to improve care in cases of violence against women (paragraph 134). But these workshops correspond to the 2012-2015 time period. In other words, they were carried out prior to modifications to the Official Mexican Norm 046 (NOM 046) that eliminated obstacles to accessing abortion due to rape, published in March 2016. Through requests for access to public information, GIRE asked the SSA about the update and training received by health personnel on NOM 046. The SSA responded that, since the modifications, one four-day workshop was held for training medical personnel.

The answers regarding personnel training, together with the low registry of abortions performed by the health sector, reveal deficient knowledge on the part of health service providers with respect to applicable regulations.

Mexico City is the only state where elective abortion is legal during the first trimester of pregnancy, while the 31 other Mexican states continue to restrict abortion in criminal legislation and allow for it only under specific indications. Women continue to be criminalized for terminating pregnancy. From 2015 to 2017, 1,552 preliminary investigations were registered in Public Prosecutor's Offices for the crime of abortion; 512 in 2015; 538 in 2016, and 502 in 2017.[7]

III. Maternal Mortality

Mexico did not comply with its commitments under the Millennium Development Goals (MDG 5.a and 5.b) seeking to reduce the Maternal Mortality Rate (MMR) to 22.3 deaths per 100,000 live births. Three years after

[3] *Ibid*, p. 40
[4] *Ibid*, p. 17
[5] Executive Commission for Attention to Victims, *Primer on the Rights of Child Victims of Sexual Violence*. Available at: http://www.ceav.gob.mx/wp-content/uploads/2016/06/cartilla.pdf
[6] National Institute of Statistics and Geography, *National Survey on the Dynamics of Household Relationships*, Mexico, August 2016. Available at: http://internet.contenidos.inegi.org.mx/contenidos/productos/prod_serv/contenidos/espanol/bvinegi/productos/nueva_estruc/promo/endireh2016_presentacion_ejecutiva.pdf
[7] Executive Secretariat of the National Public Security System, *Criminal incidence of state jurisdictions*. Available at: https://www.gob.mx/sesnsp/acciones-y-programas/incidencia-delictiva-del-fuero-comun-nueva-metodologia?state=published

the deadline to meet the MDG goal, the situation regarding maternal mortality in Mexico is still far from that which was committed. Despite Mexican policies, health sector practices still place women's lives at risk during pregnancy, childbirth and puerperium. These practices include the absence of quality prenatal care; a decline in the quality of primary-level care for deliveries without complications -attended in hospitals generating significant overload-; an increase of unjustified cesareans; and a lack of quality treatment and compliance with evidence-based norms, guidelines and protocols.

In 2013, there were 861 maternal deaths in Mexico, which corresponded to an MMR of 38.2 deaths per 100,000 live births.[8] In 2014, the MMR increased to 38.9, which in absolute numbers translates to 872 maternal deaths in the country.[9] The MMR in 2015 was 36.4, which translates to 778 deaths.[10] In 2016, there were 774 maternal deaths with the MMR at 34.4,[11] and in 2017, the SSA reported - as of January 1, 2018 - 722 maternal deaths, with an MMR of 32 deaths per 100,000 live births.[12] These maternal deaths could have been prevented through the correct monitoring and application of current legislation and public policy. Although there has been a decrease in MMR, it has not been homogenous, presenting important variations according to the region and woman's profile.

Of the total number of maternal deaths in recent years in Mexico, the percentage of those women who speak indigenous languages has remained practically static. In 2013, the death of indigenous-speaking women represented 11.3% of all maternal deaths; for 2014, they were 9.9% and in 2015, 11.2%. The figure contrasts with the last census in Mexico, which reports that the indigenous population represents 6% of the overall population.

There are states where the maternal death of indigenous women is especially high, such as Chiapas. With indigenous people making up 27% of the state's population, 41.9% of the total maternal deaths in 2013 were women who spoke an indigenous language. Although the number decreased slightly in 2014, in 2015 it increased again to 40.3% of the total number of maternal deaths. These figures represent the structural inequality that indigenous women face in accessing reproductive health care.

IV. Obstetric Violence

From October 2011 to October 2016, a total of 8.7 million women in Mexico gave birth at least once. During the same period of time, 33.4% of these women suffered some type of mistreatment by medical professionals. Of the women who suffered some type of abuse during childbirth, 26% spoke an indigenous language or identified as indigenous.[13]

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[8] Maternal Mortality Observatory in Mexico, *Maternal Mortality in Mexico. Numeralia 2013*. Available at: http://www.omm.org.mx/images/stories/Documentos%20grandes/Numeralia%202013,%20OPS%20FINAL%20marzo%2030,%202015.pdf

[9] Maternal Mortality Observatory in Mexico, *Maternal Mortality in Mexico. Numeralia 2014*. Available at: http://www.omm.org.mx/images/stories/Documentos%20grandes/Numeralia_2014_Web.pdf

[10] Maternal Mortality Observatory in Mexico, *Maternal Mortality in Mexico. Numeralia 2015*. Available at: http://www.omm.org.mx/images/stories/Documentos%20grandes/Numeralia_2015_11dic17.pdf

[11] Ministry of Health, *Weekly Reports for the Epidemiological Surveillance of Maternal Deaths 2016. Epidemiological Week 52*. Available at: https://www.gob.mx/cms/uploads/attachment/file/178118/MMAT_2016_SE52.pdf

[12] *Idem*.

[13] National Institute of Statistics and Geography, *Op cit., 2016*

The most frequent types of abuse reported involved yelling at or scolding the woman, delaying treatment because the woman "was complaining or screaming a lot," withholding information about the birth, or pressuring the woman to accept a contraceptive method or sterilization. Of the women who suffered abuse during childbirth, 40.8% were treated by the Mexican Social Security Institute (IMSS).

Among populations who suffer discrimination related to reproductive health services, women and girls with disabilities must be emphasized. At present, the Official Mexican Norm NOM-005-SSA2-1993- Family Planning Services refers to "mental delay" as an indicator to recommend permanent contraception through bilateral tubal occlusion, which implicitly implies that women with a mental disability should not reproduce. This discriminatory provision should be eliminated.

The National Human Rights Commission (CNDH) published a General Recommendation on obstetric violence in July 2017.[14] The Recommendation states that "the lack of standardized, exhaustive and consensual information, identification criteria and definitions regarding the mistreatment of women during childbirth in health facilities complicates the research and development of tools necessary to handle this problem".[15] It should be noted that the Recommendations section does not include a perspective of intersectionality for the prevention and eradication of obstetric violence, which is likely to occur disproportionately to women who are indigenous, living in rural communities, migrants, disabled, or in a situation of poverty. In addition, the incorporation of a gender and human rights perspective is not promoted by the professional training of health personnel, but only through isolated workshops, campaigns or seminars.

GIRE has documented a total of 47 cases of obstetric violence since 2013; 19 of which resulted in neonatal death. The recommendations emitted by the CNDH on GIRE-represented cases include reparation measures such as monetary compensation, rehabilitation and measures of non-repetition. However, monitoring the implementation of such measures has been deficient to ensure women's access to justice as well as for the prevention of future cases.

V. Women's Labor Conditions

In Mexico, conditions that would allow individuals to balance work and personal life do not exist. This situation disproportionately affects women's decisions regarding the exercise of their right to have children or not, and the number and spacing of the same. It also affects their opportunities of entering the labor market, given that girls, adolescents and women perform most unpaid care work. In Mexico, women spend an average of 39 hours a week on unpaid care work, while men spend a little less than 12 hours a week on domestic

[14] National Human Rights Commission, General Recommendation No. 31/2017 *"On Obstetric Violence in the National Health System"*, Mexico City, July 31, 2017. Available at: http://www.cndh.org.mx/sites/all/doc/Recomendaciones/generales/RecGral_031.pdf
[15] *Ibid*, par. 20.

tasks.[16] For the most part, women are the only caregivers, or represent those who spend more time providing care in homes (between 60 and 80%).[17]

At present, the Federal Labor Law (LFT) provides working fathers the right to take paternity leave however, said leave consists of only five days. Unlike maternity leave, paternity leave is paid by the employer and does not have a public subsidy. In this regard, the IMSS reported to GIRE that a registry of workers who have exercised this right does not exist meanwhile, the ISSSTE reported that, in 2015, only 522 male workers took paternity leave, in contrast to 45,545 women workers who took maternity leave in the same period.[18]

At the same time, the LFT contemplates payment during a 12-week maternity leave, compared to the recommended 14 weeks indicated by the International Labour Organization (ILO) Convention 183. Therefore, in Mexico, the maternity leave is lower than the international standard. In addition, for the IMSS to cover payment of the 12-week leave, the woman must have been working for at least 30 weeks before the leave; to the contrary, the employer is responsible for full payment. The distinction between those who have working for 30 weeks and those who have not may be the reason why employers resort to the discriminatory practice of requesting a medical certificate certifying that the woman is not pregnant at the time of hiring. Between 2011 to 2016, 11.8% of employed women between 15 and 49 reported this practice.[19] In addition, the difference in the periods covered between maternity and paternity leave under current law perpetuates the stereotype that childcare is the sole responsibility of women.

Of the total number of children between zero and six years of age who are not cared for by their parents, 51.2% are cared for by their grandmothers, 11.3% attend child care facilities or public daycares, 4.3% attend private daycare centers and 33.3% are categorized as "other".[20] Access to public daycares or those that are affiliated with IMSS is recognized in the Social Security Law exclusively for working women and only exceptionally for working fathers if they are widowed, divorced, if by court order they have full custody of their children and have not remarried, or if they have full custody of a minor and cannot provide care. These legal regulations reproduce the notion that women are fundamentally responsible for childcare and therefore, only women should be granted the possibility that their children attend public daycare.

The Second Chamber of the Mexican Supreme Court has established, through three sentences on GIRE-defended cases, that the aforementioned norms are unconstitutional because they are discriminatory.[21] However, this has not yet resulted in legislative or policy change that guarantees access to childcare facilities under equal conditions for working mothers and fathers.

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[16] National Institute of Statistics and Geography and the National Institute of Women, "National Survey on the Use of Time", Mexico, 2009.
[17] National Institute of Statistics and Geography and the National Institute of Women, "Labor Survey and Social Co-responsibility", Mexico, 2012.
[18] GIRE, *Working Hours: Co-responsibility in Work and Personal Life*, Mexico, 2017, p. 148. Available at: http://corresponsabilidad.gire.org.mx/assets/pdfs/VIDA_LABORAL_Y_REPRODUCTIVA.pdf
[19] National Institute of Statistics and Geography Op. cit. 2016
[20] GIRE, *Working hours: Co-responsibility in work and personal life*, p. 215
[21] Legal Stay in Review 59/2016, June 29, 2016, speaker: Justice Margarita Luna Ramos; Legal Stay in Review 700/2017, December 06, 2017, speaker: Justice Margarita Luna Ramos; Legal Stay in Review 1369/2017, May 16, 2018, speaker: Justice Javier Laynez Potisek

VI. Recommendations

A) Harmonize criminal legislation and administrative regulations on abortion after rape with the General Law of Victims and NOM 046, eliminating time limits, formal reporting of the crime and previous authorization.
B) Guarantee emergency medical attention in cases of sexual violence by state and federal health authorities, consisting of emergency contraception, prophylaxis to prevent sexually transmitted infections and abortion, as well as their registration, disaggregated by legal indication, age, ethnicity and disability, if applicable.
C) Eliminate legal provisions that criminalize women who terminate their pregnancies and modify health legislation to guarantee access to reproductive health services for all women.
D) Strengthen universal access to healthcare for women with obstetric emergencies within all institutions of the National Health System, through the availability of supplies and sufficient budget to cover the medical care needs of pregnant women, especially in the primary level of care.
E) Create mechanisms for the identification and eradication of obstetric violence as a specific form of human rights violation and violence against women, among the personnel that attend birth, delivery and puerperium, both in the public and private sectors.
F) Eliminate "Mental Delay" as an indicator to recommend candidates for bilateral tubal occlusion from Appendix "A" of the Official Mexican Norm NOM-005-SSA2-1993 on Family Planning Services.
G) Guarantee comprehensive reparations for human rights violations in cases of obstetric violence and maternal mortality.
H) Increase maternity leave to 14 weeks and paternity leave to an obligatory 15 days, establishing incentives for workers and employers to make use of these leaves through public subsidies.
I) Make the necessary regulatory changes so that both male and female workers have the same right to access government childcare facilities for their children.
J) Ensure that men and women have the same opportunity to balance work and family responsibilities, through measures such as flexible work schedules, shortened work weeks and the option of remote working, both in the public and private sectors; and facilitate working women's exercise of breastfeeding.