Obstetric violence criminalised in Mexico: a comparative analysis of hospital complaints filed with the Medical Arbitration Commission

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ABSTRACT

Introduction Disrespect and abuse during childbirth have been reported by numerous countries around the world. One of their principal manifestations is the performance of invasive or surgical procedures without the informed consent of women. Non-dignified treatment is the second most common form of this conduct. Five Mexican states have classified obstetric violence as a crime: Aguascalientes, Chiapas, Guerrero, the State of Mexico and Veracruz. The others have not yet done so although it is provided for in their civil and administrative regulations.

Objective To analyse whether criminalising obstetric violence has been conducive to the recognition and observance of the reproductive rights of women, based on the records of poor health care complaints filed by women with the Medical Arbitration Commissions (CAMs by their Spanish initials) in two Mexican states.

Materials and methods We conducted an observational qualitative study using a phenomenological approach. Analysis included two states with similar partner demographic and maternal health indicators but different legal classifications of obstetric violence: the Chiapas has criminalized this form of violence while Oaxaca has not. We reviewed the records of obstetric care complaints filed with CAMs in both states from 2011 to 2015, all of them concluded and including full information.

Results Differences were observed regarding the contents of complaints, specifically in the categories of abuse, discrimination and neglect during childbirth. The narratives in the other complaint categories were similar between states.

Conclusion After analysing the records of malpractice complaints in Chiapas and Oaxaca, we conclude that the differentiated legal status of obstetric violence has not influenced recognition or observance of the reproductive rights of women. Criminalising obstetric violence has not improved care provided by health personnel.

Key message s

- The reproductive rights of women are far from being recognized and exercised by users who complain about maternal care services
- Doctors who provide maternal care services violate reproductive rights due to lack of knowledge and to insufficient promotion and enforcement of laws.
- Health personnel are in breach of the following obligations: providing adequate information to patients, showing respect for the decisions of women and performing only consented procedures.

INTRODUCTION

Abuse of women by health personnel during childbirth has long been described and studied with no consensual definition on its operationali s ation. [1–4] It has been distinguished from malpractice and negligence, however, in that it involves the deliberate use of different forms of abuse by health personnel during the provision of institutional birth care. Prior to its recognition as such by the WHO in 2014, this behavior had been documented by a number of studies. For instance, in 2002, d ' Oliveira *et al* had defined institutional violence according to four categories of violence: neglect; verbal violence (threats, scolding, screaming and intentional humiliation); physical violence (blows and the refusal to provide pain medication despite

its being technically indicated); and sexual violence. The authors also specified the essential component of this type of violence: the use of professional power by health personnel to reaffirm their hierarchical position relative to the patients and ensure the obedience and submission of the women requiring their services. According to the authors, perpetration of violence in health service facilities can be considered an extension of the high levels of violence against women and their lack of power insociety.[5]

Bowser and Hill classified abuse during institutional birth care according to seven categories adopted by the WHO in 2014.[6]

The WHO has recommended the following criteria for determining the presence of disrespect and abuse during childbirth: '(A) outright physical abuse, (B) profound humiliation and verbal abuse, (C) coercive or unconsented medical procedures (including sterilization), (D) lack of confidentiality, (E) failure to obtain fully informed consent, (F) refusal to give pain medication, (G) gross violations of privacy, (H) refusal of admission to health facilities, (I) neglecting women during childbirth to suffer life-threatening, avoidable complications, and (J) detention of women and their newborns in facilities after childbirth due to an inability to pay'.[7]

Prevalence of disrespect and abuse against women ranges from 15% to 70% globally, and includes behaviours such as physical abuse, verbal abuse, undignified treatment and performance of invasive or surgical procedures without obtaining prior informed consent.[8 9]

These practices, which violate the human rights of women during medical care, have been recognized and recognized and have triggered a series of proposed solutions. Some adj adj countries of the results have been encouraging awareness training and program s aimed at reducing, Regular and elimination of esta behavior.[10 11] In Latin America, intervention strategies involved public policies that impose criminal measures for obstetric violence (disrespect and abuse during childbirth).[12] (In this document, the term 'obstetric violence' It is used as a synonym for what WHO It described 'lack of respect and abuse during childbirth').

In 2007, Mexico enacted the General Law on Women's Access to a Life Free of Violence. This law provides directives for the institutional coordination of the three powers (executive, legislative and judicial) and the three levels of government (federal, state and municipal) towards the prevention, punishment and eradication of violence against women. Obstetric violence was not specifically addressed under this law but was incorporated under the local laws of five states in the following years: Aguascalientes, Chiapas, Guerrero, Mexico and Veracruz have typified obstetric violence as a crime. Other states are in the process of including this conduct under their criminal codes.[13 14]

There is an important background for this in other Latin American countries. In 2007, Venezuela, the first to recognize obstetric violence as a specific form of gender violence, specifically a law against disrespectful and abusive treatment of women during pregnancy, childbirth and postpartum.[14] In 2013, Panama enacted Law 82, which recognizes the right of women to a life free of violence, including obstetric violence. Also in 2013, Bolivia had Law 348;Although it did not specifically focus on obstetric violence, Articles 7 and 8 of the law of this state that the right of women to a life free of violence includes respect for their reproductive rights in health bodies, finally, in 2015, Argentina enacted Law 25 929 on humanized childbirth and women's rights.[15]

Chiapas, the first Mexican state to criminalise obstetric violence, modified its penal code in 2014, incorporating the following provision under Article 183: This crime shall be ascribed to anyone who 'appropriates the body and reproductive processes of a woman through dehumanizing treatment, abuse in the provision of medication or the act of pathologizing natural processes, resulting in the loss of her autonomy and of her capacity to decide freely on matters related to her body and sexuality.' The following article explicitly defines the actions punishable under this crime: omitting timely and effective care in an obstetric emergency, obstructing early mother–child bonding without a justifiable medical reason, altering the natural process of low-risk childbirth without informed consent and performing a caesarean section unnecessarily. The corresponding penalty includes 1–3 years in prison, a fine of up to 200 days (equivalent to US$900), suspension of perpetrators from the profession for the period of the penalty and payment of comprehensive damage repair. Although published in the official journal of the State of Chiapas, this reform was not disseminated to the extent required—neither among health personnel nor among the women using obstetric services.[16 17]

By introducing regulations that sanction specific inappropriate behaviours, the Mexican Government intends to abate violations perpetrated against the rights of society. It has adopted the therapeutic justice approach proposed by David Wexler, which pursues two main objectives: first, to empower healthcare users (in the case of our study, women), and second, to reduce or abolish behaviours considered detrimental to society (in the case of our study, obstetric violence).[18 19]

The Ministry of Health (MOH) has developed interventions against obstetric violence through some of its facilities. Salient among these initiatives is the *Model of care for women during pregnancy, childbirth and puerperium: a humanised, intercultural and safe approach*. Women must always be the protagonists during the maternal care process; this implies emphasising their human rights and, hence, their dignity. In addition to eradicating obstetric violence, this model was aimed

at removing cultural barriers and recovering Mexican evidence-based midwifery practices, considered a source of extensive knowledge and experience under the framework of national diversity. Finally, the *Model of care* initiative was implemented to develop and guarantee safe birth-related conditions as well as the competencies that personnel at the various levels of healthcare must display to ensure the identification of obstetric risks and the satisfactory resolution of all complications.[20] Another noteworthy MOH intervention is the *National Strategy for the Promotion of Good Treatment in Obstetric Care*.[21]

Regarding empowerment, criminalising obstetric violence involves a clear and conclusive recognition of the reproductive rights of women. The inclusion of obstetric violence under the criminal code (a catalogue of harmful and antisocial behaviours) conveys a clear message with regard to this conduct and bolsters the symbolic force of its criminal conviction.[22]

Health service users need to know and assume their rights before they can demand them through complaints and reports to the authorities.

Concurrently, health professionals need to understand the full scope of the criminal and administrative laws in force in this matter. Obstetric violence can only be corrected and eradicated if health workers recognise that disrespect and abuse of childbearing women harm women and expose offenders to enforcement measures and sanctions. The relevance of establishing criminal penalties as a pathway to resolving problems directly responsible for maternal morbidity and mortality is currently under debate.[23]

Mexico has developed legal mechanisms for resolving conflicts related to the inadequate provision of health services. For instance, women who wish to press criminal charges for obstetric violence can do so at any Public Ministry office. They can also file a complaint with a State Commission on Human Rights which, in turn, will issue a recommendation to the public hospital concerned.[24]

However, the most immediate and commonly used option for those who have been abused is to file a complaint or a disagreement appeal with a Medical Arbitration Commission (CAM by its Spanish initials); these agencies have been specifically tasked to manage conflicts concerning health service provision. As many as 50%–70% of complaints concerning maternal care are resolved by CAMs at the state level. Because these accusations refer to professional misconduct, they are dealt with via conciliation and mediation mechanisms based on the principle of alternative means for an amicable resolution of conflicts.[25 26]

The objective of this study was to analyse whether criminalising obstetric violence has been conducive to the recognition and observance of the reproductive rights of women, based on the records of poor healthcare complaints filed by women with the CAMs in two Mexican states.

MATERIALS AND METHODOLOGY

Our study followed an observational qualitative design based on a phenomenological conceptual framework.[27] We selected two states with similar maternal health indicators but different legislation on obstetric violence: Chiapas has criminalised this conduct while Oaxaca has not. Both states exhibit similar sociodemographic conditions marked by a high proportion of indigenous population, a wide educational gap, a high marginalisation index and steep maternal mortality rates (68.1 and 46.7 per 100 000 live newborns, respectively).

We examined all state-level CAM records of complaints filed by women from 2011 to 2015. Of the 61 complaints included in the study, 32 pertained to Oaxaca and 29 to Chiapas. Inclusion was determined according to the following criteria: (A) the complaint was concluded; (B) the file was fully integrated and contained a narrative of facts; and (C) the narrative of facts was formulated by either the woman who suffered abuse or her spouse/intimate partner.

Exclusion was determined according to the following criteria: (A) the narrative of facts was unrelated to either birth care or pregnancy; (B) the file was incomplete; or (C) the complaint was not filed by the woman concerned or her spouse/intimate partner.

Patient and public involvement

The patients did not participate in the process of elaboration of the question, since it was based on the WHO criteria, the data were obtained from the CAMs. The information obtained will be sent to the respective commissions and to the CONAMED for feedback.

Analysis plan

We transcribed all the narratives of facts using a Word 2016 word processor. We also designed a coding manual based on the 2014 WHO description of disrespect and abuse of women during childbirth.[7] On completing the readings of all the complaint narratives, we established seven analytic categories: abuse, discrimination, non-consented medical procedures, non-confidential care or lack of privacy, withholding information, admission rejection and neglect during childbirth.

Each narrative was coded using the Atlas.ti V.8.0 program.

RESULTS

We analysed 29 complaint narratives filed with the Chiapas and 32 with the Oaxaca CAMs from 2011 to 2015.

Abuse

This category of obstetric violence included different manifestations (physical abuse, psychological abuse and neglect) occurring during birth care. Incidents of psychological abuse and neglect were recorded in

both states, whereas physical abuse was only indicated in narratives from Oaxaca. Psychological abuse and neglect were most frequently reported in Chiapas; they invariably involved health professionals and other employees at health facilities such as receptionists and maintenance personnel:

> (…) those covered by public health services, affiliates and workers who have paid dues to this institution for so long expect to receive the care we deserve as Mexican citizens, workers and human beings. When we seek care [from a health facility], we are constantly trampled, hustled and mistreated by the despotic and arrogant directors, even by the people in basic services like reception, nursing and maintenance workers who have the warped idea that they own the hospital and think that they're doing us a favor, when the truth is that they're just doing their duty. (Complainant: husband of patient, Chiapas, 32a)

This fragment of one of the narratives analysed indicates that the complainant, the husband of the woman seeking care, had a clear understanding of the rights he had as a citizen and those he had earned as a worker who had contributed to the institution regularly with his fees. The likelihood of assuming a right is also influenced by gender. In this case, the question arises whether the woman seeking the services at issue had the same clarity concerning her rights as the complainant, her husband, but more specifically, whether she recognised that she had the basic right to a life free of violence.

Likewise, psychological violence was the most prominent form of abuse reported in Oaxaca, and specifically on the part of health professionals (physicians and nurses). However, unlike Chiapas, scolding and an asymmetric attitude towards information emerged as the principal manifestations of psychological violence. Also worthy of mention is the fact that the cases of physical abuse in Oaxaca revolved around rough handling during procedures, particularly during pelvic examinations. These were described by women as being performed excessively and in a flagrantly insensitive manner.

Abuse expressed as neglect was reported in narratives from both states:

> (…) My wife told me she couldn't stand it anymore; everything was blurred and she felt really bad. At that point, I told the intern to give her back to me so that I could take her to a hospital because she looked very sick, and the nurse was saying that she was just having a tantrum and needed a couple of slaps to calm her down. (Complainant: husband of patient, Oaxaca, 28a)

Once more, it was the husband of the patient who filed the complaint and related the seriousness of the situation. The nurse ridiculed the pain the patient was experiencing and did not provide the service required. Moreover, this account reflects the complete naturalisation of violence against the wife of the complainant: 'She… needed a couple of slaps.'

Discrimination

Narrations of discrimination were very specific due to its symbolic content. This form of abuse was generalised in Oaxaca and Chiapas, where complaints in this regard were similar.

In this case, the principal actors were the physicians performing surgery. According to the women, they used discriminatory and derogatory expressions regarding their physical traits.

One complainant from Oaxaca reported the following:

> (…) He [the attending gynecologist-obstetrician] commented to his colleagues that, with a normal patient, he would have already finished the operation, and said, 'I'll have to charge them extra for digging out all this fat.' And there I was, hearing everything they said without being able to defend myself. (Complainant: patient, Oaxaca, 34a)

This comment reveals sarcasm used by a physician in reference to the weight of his patient. References to women's overweight or obesity—whether or not they are true—constitute a form of gender violence rooted in stereotypes of beauty that have been deeply naturalised.

One woman from Chiapas related the following event:

> (…) They said that it would take a long time for me to recover, and with a grotesque remark, they commented that 'if her guts fall out, we'll pick them up and put them back where they were.' (Complainant: husband of patient, Chiapas, 32a)

The preceding fragment describes physicians mocking a woman and minimising her pain. They referred to her internal organs as objects, using disparaging language unacceptable in anyone providing healthcare. They displayed no empathy towards the patient or her condition.

Jokes, hurtful comments and other forms of discriminatory language are an affront to human dignity. Also related to this conduct are a lack of doctor–patient communication and notorious asymmetry in the use of information. Discriminatory events of this nature were reported in both states.

> (…) The doctor arrived five or ten minutes after my mother-in-law informed her [of the birth of my child in the bathroom]. I was on the floor. They took me on a wheelchair, but first they made me get up to get on the wheelchair. No one helped me. (Complainant: patient, Oaxaca, 33a)

The first and most alarming part of this narrative refers to the fact that delivery took place in the bathroom. Although delivery in a bathroom does not always

mean abuse, as occasionally births are precipitous and unexpected, the delay in providing care clearly indicates neglect. Next, the family member accompanying the woman who had barely given birth needed to go out and seek help. Finally, the patient, lying on the floor, was required to stand up without assistance in order to place herself in a wheelchair.

Coercive or non-consented medical procedures

This analytic category referred to actions carried out by health professionals who did not comply with the obligation of obtaining informed consent from their patients prior to performing a medical procedure. Salient among these actions were requesting consent without providing full and adequate information; requesting consent in conditions of coercion or harassment; requesting a signature without explaining the content or purpose of the document being signed; and failing to request consent for a procedure from the patient or caregiver (in case of disability).

It is worth noting that differences emerged between states in this category of abuse: Oaxaca, where obstetric violence was not classified as a crime, reported more cases of requests for informed consent either under pressure or without providing adequate information.

Requests for signatures without explaining the medical procedures that were to be performed were reported in both states.

> (…) I vaguely remember that he gave me a piece of paper to sign and took my thumb to take my fingerprint which he then affixed on the paper. (Complainant: patient, Chiapas, 28a)
>
> (…) the bad news was that my wife was seriously ill and required surgery… they gave me a piece of paper to sign authorizing the procedure. When I saw my wife's signature on the paper, I signed too. (Complainant: husband of patient, Oaxaca, 27a)

In both situations above, the signatories were unaware of the procedures they were authorising.

Non-confidential care or lack of privacy during childbirth

This category involved actions such as divulging personal information about pregnant women, performing medical examinations without taking the necessary measures to ensure privacy and hospitalising women in common areas (eg, corridors) without robes. Although not all of these actions were specified in women's complaints, lack of privacy was highly recurrent in Oaxaca.

> (…) I came out of the delivery area in a gurney and they left me in the corridor waiting for a bed. (Complainant: patient, Oaxaca, 26a)

Lack of privacy is also a form of violence against women because it implies objectification. Personnel who leave women in the corridors, examine them without closing the door and expose their breasts or genitals ignore, among other things, the confidentiality to which all patients are entitled during their care.

Failure to provide information to pregnant women and family members

Both states fielded complaints from women who had received no information whatsoever about their health status during pregnancy and/or childbirth. Information about the conditions of patients is a key component of informed consent. Non-compliance with this obligation constitutes a violation of autonomy.

As expressed by a woman from Oaxaca:

> (…) I asked for an explanation of why my baby died… I had carried out all the control measures during my pregnancy and kept every one of my appointments, but they didn't want to explain anything to me. (Complainant: patient, Oaxaca, 23a) [The underlining is the authors'.]

Access to information is a basic right of all health service users in Mexico, including the mothers who lose their babies during birth care. Furthermore, the information provided must be true and submitted in a timely manner. (Artículo 51 Bis 1—DE LA LEY GENERAL DE SALUD, señala: 'Los usuarios tendrán derecho a recibir información suficiente, clara, oportuna, y veraz, así como la orientación que sea necesaria respecto de su salud y sobre los riesgos y alternativas de los procedimientos, diagnósticos terapéuticos y quirúrgicos que se le indiquen o apliquen.' https://www.wipo.int/edocs/lexdocs/laws/es/mx/mx218es.pdf, consultada 24 July 2019) (Under Artícle 51 Bis 1 of the General Health Law in Mexico, 'Users have the right to sufficient, clear, opportune and true information, as well as to full guidance, as required, in relation to their health and to the risks involved in the surgical and therapeutic procedures and diagnoses indicated or applied to them, and their alternatives.' (https://www.wipo.int/edocs/lexdocs/laws/es/mx/mx218es.pdf, consulted for the last time on 24 July 2019))

Admission refusal at a health centre

This category related to situations where pregnant women were not admitted to a health facility for lack of response capacity, insufficient personnel, unavailable inputs or the need for referral to another level of care.

Both states presented such cases. In Chiapas, the causes cited referred mainly to insufficient personnel or inputs, while in Oaxaca, they involved lack of response capacity and the need for referral to the next level of care. Both states demonstrated major health system shortfalls as regards coverage and the designation of medical students (interns) to deliver services of great responsibility, which they were as yet unprepared to perform. This normally causes complications in birth care:

> (…) I arrived during the indicated schedule, but they told me that the gynecologist-obstetrician

> wasn't there at that time so I would be attended to at the other hospital because I needed to be treated promptly in view of the discomfort I was experiencing. (Complainant: patient, Chiapas, 31a)
> (…) the intern who was on duty at the hospital sent me to Hospital XX, where they said they couldn't help me because I didn't have my referral form updated. So we returned to the health center. (Complainant: patient, Oaxaca, 21a)

The preceding narratives illustrate a lack of capacity to respond to urgent situations—in both cases, complications during childbirth. Failure to provide services in an emergency can entail fatal consequences.

Neglect during childbirth

Neglect was also generalised in the complaint narratives of both states. However, differences emerged regarding one of its manifestations, delay in care, which in Chiapas was associated predominantly with insufficient initial assessment due to lack of human resources.

> (…) the doctor who came on duty informed me that my baby was given to her in very serious condition, and that she was told he was bleeding profusely and had been given a blood transfusion. She also commented that he had air in one lung and it had been necessary to insert a watermark. At 03:30 a.m., on October 6th, my baby passed away, without my receiving an adequate explanation of everything that had happened. (Complainant: patient, Chiapas, 27a)

This was decidedly a case of neglect. The patient reported not having received an adequate explanation of her baby's condition and made it clear that care provided was not sufficient to save his life.

In Oaxaca, neglect included delay in birth care, abandonment during labour and adverse obstetric and perinatal outcomes. A number of complaints referred to procedures proscribed in obstetric practice for being harmful and causing injury (eg, Kristeller manoeuvre). Others concerned omissions during surgery or labour. These complaints were filed by either the patients themselves or their husbands.

> (…) so a doctor came in saying 'how much longer until this lady's taken care of?' and 'they're going to end up seeing her really late.' The doctor took her to the delivery room, but she didn't feel the baby anymore. Attempting to save the baby, they put her in delivery position and made her start pushing while two individuals climbed up on her abdomen and pressured. They inserted forceps to take out the baby, and that's when she felt the blood draining. I don't know what intention they had: after taking out the baby, already dead, my wife tells me they laid it on her chest instead of helping it live. (Complainant: husband of patient, Oaxaca, 28a)

Two phases of medical malpractice can be identified in this narrative: first, the patient was not treated urgently, as required; second, proscribed procedures (Kristeller manoeuvre and forceps) were used. The consequences were fatal.

DISCUSSION

In 2014, several Mexican states classified obstetric violence as a crime in an effort to move towards therapeutic justice. They included this form of violence in their catalogue of crimes as a pathway to eradicating actions perpetrated against the dignity and physical integrity of women and their offspring. In Latin America, the term 'obstetric violence' designates the violation of reproductive rights. It is important to note that, in many countries in the region, Mexico included, the struggle against violence has been a constant focus of the feminist movement. It is for this reason that violence is referred to under different forms and modalities, salient among which is the denigrating and discriminatory treatment often experienced in healthcare facilities. Comprising several acts of violence documented in the commentaries presented here, 'obstetric violence' thus proves a more appropriate term than 'disrespect and abuse during childbirth'.[25]

In public policy, implementation must always be preceded by extensive dissemination. Assessing the criminalisation of obstetric violence must rest on three fundamental components: first, recognition of the reproductive rights of women and internalisation of these rights by the women themselves; second, knowledge of these rights on the part of health professionals in order that they may provide adequate care, that is, services that comply with the principles of citizenship and of full respect for human rights; and third, respect, promotion and defence of these rights by the institutions.[26]

As health service users, women must recognise and assume their rights in order to claim them using appropriate legal channels. The criminalisation of obstetric violence must be matched by specific action programmes if its impact is to be perceived and acknowledged by all involved: women, health personnel and institutions. According to our findings, criminalising obstetric violence has not produced a substantial change in healthcare in Mexico.

The data collected during our study demonstrate that penalisation alone is insufficient to ensure the recognition of reproductive rights. The accounts presented herein indicate that health personnel often lack respect for women using obstetric services and that these women themselves are unaware of their rights.

It is therefore necessary to find a solution to this structural problem through other options involving greater participation on the part of government—the guarantor of and actor responsible for these rights. It is also necessary to implement institutional programmes aimed at promoting knowledge on reproductive rights, and an extensive awareness-raising campaign among women, such that they exercise their prerogatives and are able to report the transgressions they endure; more

specifically, in order that women empower themselves and become leaders in their own reproductive process.

In and of themselves, laws do not solve the problem of violence against women during perinatal care; they do constitute, however, a first step forward: they provide a solid foundation on which to build the defence of human rights and improve the quality of maternal care with special emphasis on the dignity of the users.[14]

Those complaints filed by men (the husbands of the patients subjected to abuse) demonstrated that they had assumed these rights: they categorically affirmed that it was their financial contributions that maintained the healthcare system, that health personnel had the obligation to provide adequate service and that those who failed to do so must be held responsible. This gender-related component opens a new avenue for future research.

Another relevant point to consider is that all complaints filed in both states were directed against individuals—health personnel in specific settings—whom complainants deemed responsible for care. Not once did they contemplate the possibility of holding the government, that is, the state health authorities, accountable for the deficiencies in care, although they determine the human and material resources for service delivery to the population.

Furthermore, all the complaints described structural limitations. The narratives did describe inadequate diagnostic and operative assessment on the part of health personnel; and they pointed to deficient structural conditions such as insufficient hospital beds, unavailable basic inputs and inefficient coordination among the primary, secondary and tertiary levels of care, all of them essential to birth care. However, the criminalisation of obstetric violence covers only the individual behaviour of health personnel; it does not consider the participation of state authorities in service omissions.[27–29]

We also noted that certain social, ethnic and other minority groups bore the burden of inequity. The WHO has recognised that the following characteristics render individuals more prone to experiences of disrespect and abuse during pregnancy and childbirth: being adolescent, single, economically disadvantaged, a member of an ethnic minority group and an immigrant, as well as having an HIV diagnosis. Chiapas and Oaxaca, where marginalisation and limited access to health have reached the level of risk factors, are among the Mexican states with the highest percentage of indigenous residents.[5] Ethnicity, a characteristic shared by a large proportion of the Chiapanecan and Oaxacan populations, increases the vulnerability of women to different forms of gender violence.[30 31]

Finally, withholding information and performing coercive procedures violate the autonomy of women. Although these practices were among the principal forms of disrespect and abuse observed, they were not considered priorities in relation to dignified treatment and were mentioned only as secondary problems in the narratives of unsatisfactory treatment.[32]

The term ‘obstetric violence’ was not used in any of the narratives analysed; neither was failure to recognise or ensure the reproductive rights of women mentioned as the basis of complaint. Reference was made, however, to the rights, or employment benefits, earned as contributors to the health institution, which the husband of one patient believed legally entitled him to submit a complaint.[33]

CONCLUSIONS

Incorporating obstetric violence under the criminal code has not led to a substantive difference in how the citizenship rights of pregnant and birthing women are recognised or observed. The therapeutic justice objective of criminalisation—to produce a change in those targeted by the legal reform on obstetric violence—has not been achieved.

This is largely attributable to the fact that health personnel are not acquainted with the current regulations in this matter nor with the legal consequences of malpractice. Neither are they sensitised to the principles of citizenship rights that govern their work with childbearing women or to the experience of childbirth from the perspective of their patients. It is essential for Mexican health authorities to assume their responsibility and take all necessary measures to ensure that health institutions provide women with dignified, competent and responsible care during pregnancy, childbirth and the postnatal period.fv

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