

Women's Reproductive Rights in Mexico: A Shadow Report

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WOMEN'S REPRODUCTIVE RIGHTS IN MEXICO:
A SHADOW REPORT

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INTRODUCTION

This report is intended to supplement, or “shadow,” the report of the government of Mexico to the Committee on the Elimination of All Forms of Discrimination against Women (CEDAW). It has been compiled and written by the Center for Reproductive Law and Policy (CRLP) and Grupo de Información en Reproducción Elegida (GIRE) (the Information Group on Reproductive Choice). As has been expressed by CEDAW members, NGOs such as CRLP and GIRE can play an essential role in providing credible and reliable independent information to CEDAW regarding the legal status and the real-life situation of women and the efforts made by ratifying governments to comply with the Convention on the Elimination of All Forms of Discrimination against Women (Women’s Convention) provisions. Moreover, if CEDAW’s recommendations can be firmly based in the reality of women’s lives, NGOs can use them to pressure their governments to enact or implement legal and policy changes.

Discrimination against women permeates all societies. Clearly, this discrimination requires urgent action. However, this report is focused particularly on reproductive rights, laws and policies related to such rights, and the realities affecting women’s reproductive rights in Mexico. As such, this report seeks to follow-up on the December 1996 “Roundtable of Human Rights Treaty Bodies on the Human Rights Approaches to Women’s Health with a Focus on Reproductive and Sexual Health Rights” held in Glen Cove, New York by bringing to the attention of treaty monitoring bodies the human rights dimensions of health issues, with a particular focus on women’s reproductive and sexual health. As articulated at the 1994 International Conference on Population and Development in Cairo, as well as the 1995 United Nations Fourth World Conference on Women in Beijing, reproductive rights consist of a number of separate human rights that “are already recognized in national laws, international laws and international human rights documents and other consensus documents,” including the Women’s Convention. We believe that reproductive rights are fundamental to women’s health and equality and that States Parties’ commitment to ensuring them should receive serious attention.

This shadow report links various fundamental reproductive rights issues to the relevant provision(s) of the Women's Convention. Each issue is divided into two distinct sections. The first, shaded section deals with the laws and policies in Mexico relating to the issues and corresponding provisions of the Women's Convention under discussion. The information in the first section is mainly obtained from the Mexico chapter of *Women of the World: Laws and Policies Affecting Their Reproductive Lives – Latin America and the Caribbean*, one of a series of reports in each region of the world being compiled by CRLP in collaboration with national-level NGOs. GIRE collaborated with CRLP and DEMUS, Estudio para la Defensa de los Derechos de la Mujer, on the Mexico chapter. The second section focuses on the implementation and enforcement of those laws and policies -- in other words, the reality of women's lives. GIRE has provided nearly all of the information included in this section.

This report was coordinated and edited by Katherine Hall Martinez for CRLP, with the assistance of Alison-Maria Bartolone, and by Lucía Rayas, Claudia Giacomán and Julieta Herrera for GIRE.

December 1997

Laws and Policies Affecting Women's Reproductive Lives Implementation, Enforcement, and the Reality of Women's Reproductive Lives

A. RIGHT TO HEALTH CARE, INCLUDING REPRODUCTIVE HEALTH CARE AND FAMILY PLANNING (ARTICLES 12, 14 (2) (b), (c) and 10 (h) OF CEDAW)

1. Access to Health Services

Laws & Policies

The Federal Constitution establishes the right to health care and that all persons have access to health services through the National Health System (NHS).¹ The current government program for the health sector is the Reform Program of the Health Sector 1995-2000 (RPHS).² These objectives include:

- to promote quality and efficiency in service provision by decentralizing the services;
- to broaden the coverage provided by the social security system by facilitating the affiliation of the non-state-employed population;
- and to provide basic health services to the marginalized urban and rural population.³

The programs established to implement the health policy include:

- the Program to Promote and Foster Health;
- the Program for Infants and School Children;
- the Reproductive Health and Family Planning Program 1995-2000 (RHFPP);
- the Health Program for Adults and the Elderly;
- Health Programs for the General Public;
- the regional programs;
- and the Program to Promote Hygiene.⁴

The National Health System (NHS) is comprised of private and public health establishments.⁵ Public health providers are divided into the social security system for the salaried population (the insured population), and the public health system for the uninsured population.⁶

Since 1980, investment in the health sector has remained constant at approximately 2% of the gross national product (GNP).⁷ The public services provided by the Ministry of Health are funded via a surcharge paid by the patient which varies according to the individual's income and the type of service provided.⁸ However, in 1992, less than 10% of the Ministry of Health's budget derived from fees charged,⁹ which means that the federal government assumes almost all of the total cost of these services.¹⁰ The budget of the social security system is financed by the employer (70%), the employee (25%), and the federal government (5%).¹¹ 12.5% of employees' salaries is deducted as a contribution to the social security system.¹²

The relationship between the physician and the patient is regulated by the government, and conflicts can be brought before civil and criminal courts, as well as other entities.¹³ Medical negligence is sanctioned by criminal laws established by each state. For the Federal District, the Penal Code establishes serious penalties for the crimes of homicide and assault¹⁴ inflicted by health professionals during the exercise of their functions or with the intention of carrying out their functions.¹⁵

Reality

According to the government, approximately 40% of the population is covered by the social security system.¹⁶ Only 2% of the Mexican population is covered by private health insurance companies.¹⁷ The population that uses this system is primarily urban workers;¹⁸ only 16.7% of the population in rural areas have access to the social security system.¹⁹ The government provision health services comprises approximately 70% of the beds registered in the census;²⁰ the remaining percentage corresponds to the services provided by the private sector.²¹ Public health services do not reach the most vulnerable groups of the population, which include approximately ten million inhabitants.²² In the period between 1991 and 1993, the percentage of women who lacked access to medical services increased from 54% to 59%.²³ In terms of human resources, in 1992 there were approximately 100,000 physicians employed by the state. In 1995, there were 130.4 physicians for every 100,000 inhabitants.²⁴ The public health service employs 66% of the country's physicians and provides approximately 68% of all medical consultations.²⁵

Researchers Asa Cristina Laurell and Liliana Ruíz²⁶ agree with the many studies conducted on the Mexican health system which identify as a major problem the system's division into various sub-systems - the salaried sector (social security), the state (open to everyone) and the private - which are, in turn, subdivided and fragmented. "This structural problem results in significant social stratification and inequality with regard to the degree of access and the type of services available to each group."²⁷ Lack of resources has become a chronic problem in Mexican public health institutions in the last decade, resulting in uneven and deteriorating services. At the same time, what some researchers call the "medico-industrial complex," consisting of medical insurance and private medical companies, has grown to such an extent that a new market mentality and the accumulation of capital take precedence over medical practice. The result is a harsh landscape, characterized by inequity, inadequate coverage with little expansion to cover new technologies, deteriorating services with less capacity, financial restrictions and dissatisfied patients.²⁸

In accordance with the binding agreements it ratified at the World Summit for Children held in 1990, Mexico has strengthened its maternal health programs. Some of the steps taken towards achieving this goal include the creation of a National Committee for the Study of Maternal and Perinatal Mortality, the use of "Pregnancy Identification Cards" which aim to promote and facilitate greater involvement of women, together with the introduction of "birthing houses" and training for midwives in rural areas to increase pre-natal and maternal care in those areas. However, as stated by the National Coordinating Committee for the Fourth World Conference on Women,²⁹ the increase in coverage of services for women during pregnancy has not been accompanied by improvements in other areas of women's health care. This indicates the need to more effectively prevent, detect and treat mammary, cervical and uterine tumors, which account for almost half the deaths caused by malignant tumors in women between the ages of 15 and 64.³⁰

2. Access to Comprehensive, Quality Reproductive Health Care Services

Laws & Policies

The Federal Constitution recognizes the right to choose freely, and in a responsible and informed manner, the number and timing of one's children.³¹ The Federal Constitution also mandates that the social security system must provide special protection to women during pregnancy and breast feeding.³² Mexican law provides that maternal and infant health care and family planning are to be considered basic health services,³³ and the former is considered a priority.³⁴ The family planning laws and policies are outlined in the Mexican Regulation on Family Planning Services³⁵ and in the Reproductive Health and Family Planning Program 1995-2000.³⁶

The National Population Program³⁷ established the following demographic goals of the Mexican government include: to attain a population growth rate of 1.75% by the year 2000, and 1.45% by the year 2005, in comparison to the current rate of 2.05%; to attain a global fertility rate of 2.4 children per woman by 2000 and 2.1 per woman by 2005, compared the current rate of 2.9 per woman.³⁸

The Reproductive Health and Family Planning Program³⁹ was created as part of the Reform Program of the Health Sector 1995-2000 (RPHS).⁴⁰ The objective of the RPHS is to integrate the following services: reproductive health, family planning, infant and maternal health care, sexually transmitted diseases, cervical, uterine and breast cancer, and high-risk pregnancies.⁴¹

In respect to its reproductive health and family planning policies, the objectives of the federal government include: to increase to 70% by the year 2000 the prevalence of contraception among women of childbearing age who live with their partner, compared to the current average of 64%; to increase the prevalence of contraception among women that have had children to 70%, compared to the current rate of 51%; to increase the number of vasectomies; and to reduce maternal mortality, currently 4.8 for every 10,000 live births, by half.⁴²

The family planning services provided by the government include information, orientation, counseling, selection, prescription, and distribution of contraceptive methods.⁴³ These services and the contraceptive methods are free of charge.⁴⁴ In particular, public services provide oral hormonal methods, injectable and subdermic methods, intra-uterine devices, sterilization, vasectomy, barrier methods, and spermicides.⁴⁵

The General Health Law establishes that family planning services are a priority within the general provision of health services.⁴⁶ The objectives of the family planning subprogram are: to strengthen and broaden the coverage and quality of family planning information, education and services, with special emphasis on rural areas; to contribute to a decrease in fertility; to reduce the number of unwanted, unplanned and high-risk pregnancies; and to broaden activities designed to diversify the use of modern contraceptive methods.⁴⁷

Reality

According to the government, the participation of the public sector in the provision of family planning services has increased in the last few years. In 1979, just 51.5% of all users of modern contraceptive methods visited a public-sector institution to obtain this service;⁴⁸ in 1995, this number increased to 72%.⁴⁹ Within the public sector, the IMSS and the Ministry of Health are the principal providers of contraceptives, at 44.1% and 16.5%, respectively.⁵⁰ The private sector (pharmacies, private clinics, etc.) provide 28.9% of contraceptive methods.⁵¹ The impact on women's reproductive health is reflected in the following statistics: approximately 87% of childbirths are attended by physicians, 2% by nurses, 9% by midwives, and just 2% are not attended by trained personnel.⁵²

A recent study of the Pan-American Health Organization (PAHO)⁵³ reports that Mexico has had a solid post-natal family planning program for several years which has served as a model for other Latin American countries. However, it does have shortcomings. According to this study, the government's family planning services, through its three principal public institutions, the Ministry of Health, the Mexican Institute for Social Security (IMSS) and the Institute for Security and Social Services for State Workers (ISSSTE), only offer two contraceptive methods: the intrauterine device (IUD) and surgical sterilization.⁵⁴ The Ministry of Health insists that users prefer these over other methods, reporting that 32% of users choose sterilization, 21% IUDs, followed by 21% who choose oral hormones and 12% who opt for intravenous contraceptives.⁵⁵ Many non-governmental organizations (NGOs) have pointed out that the Mexican government places greater emphasis on demographic goals than on covering the real needs of women who would choose other methods.

A further issue is that of abortion. The abortion laws in Mexico are less harsh than in other Latin American countries, but abortion continues to be illegal in most cases.

Women of means can have safe abortions, while poor women have to resort to clandestine abortions in extremely unsafe conditions. The Ministry of Health's facilities attend 50,000 cases of complications following abortions every year.⁵⁶

Post-natal family planning services are available through the Ministry of Health, the ISSSTE and the IMSS. Many women receive advice regarding contraception as part of their pre-natal health care. Some patients have filed complaints against the public sector, alleging that, immediately after giving birth, they were fitted with an IUD or were sterilized without their consent.⁵⁷

One obstacle to obtaining reproductive health care is the enormity of the demand. Moreover, some medical practitioners do not regard post-natal family planning as part of their responsibility. Some Mexican NGOs provide an alternative, offering family planning services with better follow-up care than those provided by the state.

With regard to post abortion family planning, patients are offered this service through the same channels. Though historically there has been less emphasis on family planning for women who suffer complications following induced abortions, there are now some reports that public health officials are beginning to provide better treatment. The needs in Mexico are diverse, but the PAHO report highlights the need to improve reproductive health advice and to obtain informed consent.

The early detection of cervical cancer continues to present a challenge to the government health-care system. One of the principal problems is that there has been inadequate dissemination of information regarding the need for women to undergo regular "Pap" smears. One study conducted in Mexico City and in the State of Oaxaca⁵⁸ during home interviews with 4,208 women, found that 41.5% of the women interviewed were unaware of the purpose of a Pap smear and, of those, approximately 97% had never undergone such a test. In Mexico City, the factors associated with ignorance of the purpose of the Pap smear were, in order of importance, lack of access to health-

care available through social security, illiteracy and low socioeconomic level. Those living in rural areas showed far less familiarity with the Pap smear than those in urban areas. One of the recommendations of this study was to prioritize the dissemination of information about cervical cancer among those in the lower socioeconomic levels who lack social security and especially among illiterate women in rural areas.

3. Access to Information on Health, Including Reproductive Health and Family Planning

Laws & Policies

The General Health Law provides that service users have the right to “obtain timely health care of an appropriate quality and to receive professionally and ethically responsible treatment, as well as respectful and dignified treatment from technical and auxiliary health professionals.”⁵⁹ The Secretariat of Health is responsible for authorizing advertisements dealing with health issues⁶⁰ and for coordinating the publicity on health matters issued by public sector health establishments.⁶¹ The health authorities and health establishments are required to implement orientation and counseling procedures to service users on the use of health services.⁶² A presidential decree⁶³ established the National Commission of Medical Arbitration (NCMA).⁶⁴ While its decisions are not binding, this entity is charged with resolving conflicts that arise among users of medical services and the providers of those services.⁶⁵ Its functions include: to provide information to medical service users and providers about their rights and duties; to respond to the complaints made by medical service users; to intervene in an “amicable manner” to reconcile conflicts deriving from service provision; and emit their judgments when the parties involved submit to its arbitration.⁶⁶ The Regulation on Family Planning Services also establishes the obligation of health providers to inform patients about the different contraceptive methods and to obtain their consent in the selection of any particular method.⁶⁷

The General Health Law establishes that advertising of medicine must be limited to the public audience at which it is directed; advertising directed to health professionals does not require authorization except when regulated in specific cases.⁶⁸ Mass advertising is only permitted when the medicine is sold without a prescription.⁶⁹ In such cases, the advertisements must be limited to the general characteristics of the product in question, and its properties and methods of usage, and they must point out the benefits of consulting a physician prior to usage.⁷⁰

Reality

According to both official statistics and qualitative studies, information about reproductive health is not always accessible to those within the health system in Mexico. The National Survey on Family Planning (ENPF, 1995) revealed that after giving birth, 22% of women who had not wanted their last pregnancy and who did not want another child at the time of the interview, were still not using any method of contraception. A further 15% had never practiced any fertility control. When these 37% of women were asked why they did not use any form of contraception, they cited lack of information regarding what different birth control options were available and how to use them and, to a lesser extent, how to obtain them.⁷¹

In the city of Cuautla, Morelos, a study⁷² was carried out to determine the perception of women attended for incomplete abortions regarding the quality of care at the “Mario Belanunzarán Tapia,” a secondary level hospital run by the Ministry of Health. Between November 15 and December 30, 1995, 44 women were interviewed at the time of their discharge from the hospital after receiving post-abortion care. The results, presented by the Committee for the Promotion of Maternity Without Risk in Mexico, demonstrated that less than one third of the women (27.3%) were informed of their diagnosis in the hospital. Information about treatment and procedures was very poor and 6.8% of the women were not given any information. Furthermore, the women showed a very poor level of understanding of the information. Information about warning signals was minimal; only 14.5% of the women interviewed received any such information. Regarding family planning, 66.7% of the women were not offered any information on contraceptive methods.

In May 1996, the Network for Women’s Health in Mexico City organized the Tribunal for the Defense of Reproductive Rights, a symbolic event at which women presented testimonies to academics, health authorities, leaders of political parties, legislators and the press. One of the cases presented was that of Patricia López Delgado, 37 years of age, who denounced a public hospital for its negligent diagnosis and explanation of the causes of an illness which resulted in surgery.⁷³ Patricia states that in November 1994, she consulted a private doctor concerning a pain in her kidneys from which she had been suffering for some time. The doctor concluded that she had appendicitis and referred her immediately to the clinic where she was insured. On arrival at the General Iztapalapa Hospital in Mexico, D.F., the attending doctor inserted an intravenous drip (IV) and gave her two injections without providing the patient any explanation. Another doctor examined her and told her that they needed urgently to operate, without stating the reason. Before entering the operating room, they made her sign a document without permitting her to read it. It was only after the surgery that the doctors explained to Patricia’s family that it had been necessary to remove her ovaries. When one of Patricia’s sons complained, the doctor told him not to worry, given that Patricia already had five children. Eight days after she was discharged from the hospital, Patricia started to experience the same pains that she had experienced prior to her initial visit to the doctor. She saw a private doctor who treated her for a urinary tract infection, which was the cause of the problem all along.

4. Contraception

Laws & Policies

The only legal prohibition related to contraceptive methods in Mexican law is the prohibition against abortion as a method of family planning.⁷⁴ The Ministry of Health is responsible for regulating all medicines and health products, including contraceptive methods.⁷⁵ All contraceptive methods must be authorized by the proper health authorities, according to the procedures established by the General Health Law.⁷⁶ This law provides that the processes of production, preparation, preservation, bottling, handling and distribution of all medicine and health products must take place in hygienic conditions, and any form of adulteration, contamination or alteration is prohibited.⁷⁷

Reality

According to the government, in 1995, 66.5% of women of childbearing age who lived with their partner used some method of family planning.⁷⁸ The best known modern contraceptive methods are: the birth control pill, female sterilization, the intrauterine device (IUD), and traditional methods.⁷⁹ Sterilization is most common among women of childbearing age, with an average of 43.3%.⁸⁰ The pill and the IUD are also frequently used, with an average of 15.3% and 17.7%, respectively.⁸¹ The use of contraceptive methods is more common among women with higher educational levels and who reside in urban areas.⁸² There is also greater spacing between pregnancies among women who live in urban areas.⁸³

The unmet demand for contraception covers cases in which fertile women in a relationship: a) do not wish to conceive within a period of 2 years, and b) do not ever wish to have another child. A woman who does not use contraception despite stating that she does not want to be pregnant would find her need unmet. On a national level, the incidence of women whose needs are not met by family planning services is increasingly less. However, there are still sections of the population for whom opposition to the use of contraception, ignorance of the methods available and fear of unwanted side-effects are significant causes of their decision not to use a contraceptive.

Based on the statistics of the 1995 National Survey on Family Planning, some researchers have calculated the magnitude of the problem of the unmet need for contraception in Mexico.⁸⁴ It is estimated that 14.2% of cohabiting women have an unmet demand for family planning. The groups of cohabiting women which represent the greatest levels of unmet demand are those with no children (39.2%), those between the ages of 15 and 19 years old (31.3%), those between 20 and 24 years old (19.2%), women with no education (22.8%), and those who live in rural areas (22.0%).

According to an article published by the Academic Support Group for Population Programs,⁸⁵ there is a significant disparity between supply and demand for contraception within the Mexican public health system. This has resulted in a “disturbing decline in coverage of the Family Planning Program.” Comparing statistics, in 1995, the National Health System had 8,051,751 active users of its family planning services. In 1997, the number has fallen to as few as 5,038,000.⁸⁶ The article cites statements of Dr. Rainer Rosenbaum, the Representative in Mexico of the United Nations Population Fund, who told the press the following: “In this country, the economic crisis deepened the disparity between the supply and demand of contraception, as a result of which the demographic goals and, worse still, the achievements of recent decades are at risk (...). The unmet demand for contraception is vast and continues to grow. Its volume is such that the government is unable to meet it, even with the help of international bodies.”⁸⁷

5. Abortion

Laws & Policies

Abortion is illegal in Mexico, and its regulation falls under the jurisdiction of the states.⁸⁸ Such laws punish women who undergo abortion, as well as any individual who performs the abortion with her consent.⁸⁹ Most Mexican states establish exceptional situations in which abortion is not penalized. Comparing the various state laws, the most frequent exceptions include: unintentional abortion or abortion caused by the accidental negligence of the woman (in 29 states and the Federal District);⁹⁰ when pregnancy was the result of rape (in 30 states and the Federal District);⁹¹ when it is necessary to save the life of the woman (in 28 states and the Federal District);⁹² when the pregnancy was the result of nonconsensual artificial insemination (in two states);⁹³ abortion for eugenic

purposes (in nine states);⁹⁴ and when the pregnancy could cause serious damage to the woman's health (in nine states).⁹⁵ Only one state provides that abortion is not punishable for serious and justifiable economic reasons, but only where the woman has at least three children.⁹⁶

In the Federal District and the states, a woman who induces her own abortion, or who allows another person to induce her own abortion, is liable to imprisonment for six months to five years.⁹⁷ Most states outline a series of mitigating factors that could reduce the penalty imposed against the woman who has an abortion, including: the fact that the woman does not have a "bad reputation," that she managed to hide her pregnancy, that the pregnancy is the result of an illegitimate union; and that the abortion takes place in the first five months of the pregnancy.⁹⁸ In such circumstances, the penalty is six months to one year imprisonment.⁹⁹

Reality

The following are statistics on abortion in Mexico, according to various sources:

- The estimated total number of induced abortions in Mexico: 850,000 per year (Maternity Without Risk).¹⁰⁰
- Total number of abortions in Mexico (including miscarriages and induced abortions): 1,700,000 per year (Maternity Without Risk).¹⁰¹
- Abortion is the third or fourth greatest cause of death in Mexico.¹⁰²
- Abortion ranges from the second to the fourth greatest reason for hospitalization in Mexico.¹⁰³
- In IMSS clinics, 63,000 hospitalizations per year are due to abortion.¹⁰⁴
- The official statistic for hospitalizations for abortion is 118,790.¹⁰⁵

The criminalization of abortion in Mexico causes serious problems of social justice and public health; its illegality means that a small sector of the population, namely women who are able to pay, can have safe abortions while the majority of women in Mexico who lack the necessary resources must resort to unsanitary and risky practices. If the criminal laws related to abortion were enforced it would mean that a vast number of people, not only the women who abort, but also their doctors, midwives and others who perform abortions, would have to be charged and prosecuted by legal authorities. As this would be impossible in practice to do, the threat of prosecution for the crime of abortion is a spoken one only. Almost no one reports abortion. The criminalization of abortion, in this sense, is a "preventative" measure.

In 1992, research was conducted in Mexico City to determine how many women had been prosecuted for abortion and were serving a prison sentence in the Federal District and its surroundings.¹⁰⁶ The results show that of a female population of 600 prisoners only one woman, in the Tepepan jail, had been convicted of abortion. The others were serving sentences for crimes against health, theft, fraud and murder. Of these women, 80% of those interviewed had had at least one abortion, although they did not admit to having an induced abortion; they explained that it had been the result of a "fall", a "scare" or other similar reasons. There was much resistance to discussing the matter. These women had no information about sexuality or the use of contraception. 90% had been victims of sexual abuse since childhood and 50% had become pregnant for the first time as the result of forced intercourse.¹⁰⁷ The only woman convicted of abortion was serving a prison term of one year. She was an alternative health worker and midwife, 81 years old and nearly blind. She had performed an abortion on a 16 year old girl. The minor kept the fetus in a jar under her bed. The girl's father found it and reported her to the police. Both the girl and her boyfriend were placed under care of the juvenile authorities for three years.¹⁰⁸ The research also revealed that

although the Office of the Attorney General receives many complaints, almost no women are imprisoned for abortion. If reported, the woman pays approximately Mexican pesos \$1,000 to avoid sentencing and to be released. Therefore, women reported for abortion do not go to jail because of public corruption.¹⁰⁹

In Mexico there are no procedures or regulations which address how an abortion that is not classified as illegal can be requested, such as in cases of pregnancy resulting from rape. The Penal Codes of 30 Mexican states and the Federal District permit abortions in such circumstances. In Mexico City between 1996-1997, only 107 preliminary investigations were pursued for reported rape crimes, reflecting the inadequate commitment on the part of the authorities to prosecute such crimes.¹¹⁰

6. Sterilization

Laws & Policies

Surgical sterilization is authorized in Mexico and is regulated by the Regulation on Family Planning Services. This regulation establishes the following prerequisites prior to sterilization: the patient must be offered counseling services, and the patient must provide her free and voluntary consent to the operation, which must be documented in writing.¹¹¹

Reality

In Mexico, voluntary surgical sterilization is the most common family planning method and has a prevalence rate of 43.3% among women of childbearing age.¹¹²

The use of surgical contraception by Mexican women, namely sterilization, has increased in recent decades. The Official Standards for Family Planning Services and the General Law on Health, including the regulations governing the provision of services, such as by the Mexican Institute for Social Security (IMSS), all emphasize the need to inform the client of the characteristics of the surgical method used, especially its irreversible nature, and to obtain express, written consent before proceeding. However, in Mexico, there is reason to be concerned regarding the interaction between those providing family planning services and their clients. The client's decision-making process is often manipulated by providers who impose certain methods in order to succeed in meeting demographic goals. Researcher Juan Guillermo Figueroa has conducted studies to analyze this situation, paying special attention to the moment in which a contraceptive method is selected and the decision-making process leading up to it. In the case of sterilization, concern arises due to the irreversible nature of this method, which presupposes a process of choice based on knowledge and free will. One of his studies, presented to the Fourth National Meeting of Demographic Investigation in Mexico referred to the National Survey on Fertility and Health (1987). Data revealed that one fourth of sterilized women claimed not to have been informed of the irreversible nature of the operation to which they were subjected, or of alternative contraceptive methods available at the time. 39% claimed not to have signed the consent form.¹¹³ This situation depended on the social group, the level of education and the place of residence of the women. Women from more marginal groups received the worst quality service. For example, 18.2% of women who opted for sterilization despite wanting more children, lived in rural areas, while in metropolitan areas, only 5.3% were subjected to this treatment.¹¹⁴

There is an additional significant reported characteristic of public family planning services relating to female sterilization and vasectomy. Juan Guillermo Figueroa, Blanca Margarita Aguilar Ganado and Maria Gabriela Hita analyzed the provision of these services.¹¹⁵ They found that there were a series of inconsistent parameters used in providing these methods to the public. In the case of the female population, only biological factors or obstetric history are considered, while in the case of vasectomy the counter-indications are of a psychological nature; it is counter-indicated in men who appear to have doubts regarding their decision, or who are biologically or psychologically immature, fearful of the health effects of the operation or of possible loss of virility.¹¹⁶ Thus, special attention is given to psychological factors in the case of vasectomy, while this is not true in the case of female sterilization.

One of the cases presented to the Tribunal for the Defense of Reproductive Rights, a symbolic event during which women's testimonies were presented to civil organizations and academics, health authorities, leaders of political parties, legislators and the press, organized in May 1996 by the Network for Women's Health in Mexico City, tells the story of one of many such non-consensual sterilizations carried out in Mexico. Rosa María Palomera Vitorato experienced a normal twin pregnancy. In August 1991, when she was eight months pregnant, she began to spot blood and her water broke, for which she was admitted to IMSS Clinic #7. The doctor who saw her told her she could only pick up one heartbeat and performed an ultrasound in which only one baby could be seen. Later Rosa María was told that there were indeed twins but that both had died and they proceeded to remove the fetuses after anaesthetizing her. When she was about to be discharged from the hospital, Rosa María developed a fever and remained there for about seven more days. During this time, Rosa refers to having been only intermittently conscious and it was not clear what happened. Days later, at home, she noticed a small wound below the navel, which she did not give much thought to, believing it to have been part of the treatment. Three years later, Rosa María decided to have another child and started to worry when she did not become pregnant. After consulting a doctor who performed an hysterosalpingography (X-ray exam of the fallopian tubes and uterus), they realized that her fallopian tubes had been tied without her consent. Rosa María was incredulous since they had never asked for her consent in the IMSS clinic, nor had they told her that she had been sterilized. Rosa and her partner were deeply affected and indignant that such a violation had been committed against them and their reproductive lives, for which they decided to lodge a formal complaint against the IMSS and those responsible.¹¹⁷

7. HIV/AIDS and STDs and Women

Laws & Policies

In 1995, the Mexican government enacted the Regulation for the Prevention and Control of HIV Infection (HIV/AIDS Regulation).¹¹⁸ The objective of this regulation is to standardize the guidelines and criteria governing the network of establishments comprising the National Health System¹¹⁹ that are involved in HIV/AIDS control and prevention.¹²⁰ It notes the necessity of preventive measures that are directed at informing and educating the community and encouraging participation in such campaigns in order to reduce the risk of infection.¹²¹ The HIV/AIDS Regulation establishes that all information regarding patients with HIV/AIDS is confidential,¹²² and indicates that all health institutions are required to provide emergency treatment to HIV/AIDS patients in a respectful manner.¹²³ The HIV/AIDS Regulation also includes recommendations and technical guidelines for health care providers on the treatment of HIV/AIDS patients.¹²⁴ The organizations charged with overseeing implementation of this regulation are the Ministry of Health and the state governments, according to their respective jurisdictions.¹²⁵

The government program directed toward the prevention and treatment of HIV/AIDS and STDs is a subprogram of the Program of Reproductive Health and Family Planning 1995-2000.¹²⁶ The fundamental objective of the subprogram, Prevention and Control of Sexually Transmitted Diseases and HIV/AIDS, is to reduce the morbidity and mortality due to these diseases.¹²⁷ It seeks to broaden the population's access to appropriate information and to quality services to prevent, diagnose and control STDs and HIV/AIDS.¹²⁸ Three strategies have been outlined to promote these objectives: a) the implementation of a permanent program of educational and social communication to promote safe sex; b) the incorporation, at the primary health care level, of information and services on STDs; and c) the development of programs of prevention, early detection, referral and notification of new cases of HIV/AIDS.

The subprogram's goals for the year 2000 include: a 30% reduction of STD cases,¹²⁹ a reduction in the number of children infected with HIV during pregnancy, childbirth or breast feeding by 50%; and that 80% of HIV positive individuals are detected and treated in a timely manner.¹³⁰

Reality

According to the government, the number of reported cases of HIV/AIDS in Mexico has increased from six cases in 1983 to more than 21,000 cases in 1994.¹³¹ Thirteen percent of these cases of HIV/AIDS were women.¹³² Blood transfusions are the most common means of transmission for women, representing 56.5% of the AIDS cases in adult women.¹³³ Sexual transmission is the means of infection in four out of every ten cases of women with AIDS.¹³⁴ In 1995, it was estimated that the prevalence of HIV in pregnant women was one of every 3,000 cases, and that every year, 500 HIV-positive women become pregnant.¹³⁵

The Program for HIV/AIDS and other STDs forms part of the government's priorities for the prevention and control of diseases. In Mexico, HIV/AIDS is believed to have been introduced in the mid-1970s and the first AIDS cases were identified in 1981. The disease began to be monitored as an epidemic in 1983. Since then and through December 31, 1996, the Ministry of Health has received reports of 29,962 cases.¹³⁶ The epidemic maintains a variable pattern in Mexico but is predominantly a sexually transmitted disease of which 90.5% of cases in men and 53.3% of cases in women are attributable to sexual transmission. Among homosexuals, it is primarily transmitted

sexually and is on the rise. There is also a small increase in transmission among heterosexual men. Prostitutes have a low incidence of the disease- between 0.04 and 0.4%.¹³⁷

Certainly, the increase in cases of HIV/AIDS among Mexican women is of concern, although the disease is more common among men. Some research points to women's growing vulnerability to the disease as the epidemic spreads.

In May 1996, the Network for Women's Health in Mexico City organized the Tribunal for the Defense of Reproductive Rights, a symbolic event in which women presented their testimonies to civil organizations and academics, health authorities, leaders of political parties, legislators and the press. The testimony of one of the women who told her story anonymously demonstrates how the treatment of women with HIV/AIDS are treated in the health-care system is so inadequate as to resemble a series of "dead ends." Ironically, this particular woman became infected while working as a nurse in a state-run hospital.

In 1992, the nurse was working in the intensive care unit in a public hospital, where she remembers having attended patients diagnosed as having AIDS and that, on occasion, she had given them injections. However, she never imagined she herself would become infected with HIV. She began to show acute symptoms, with continual diarrhea and high temperatures and was treated without the cause being detected. Soon after, her symptoms disappeared. Later she married and had two children. The youngest child began to have health problems but in the state clinic where she went with her child, she was told that "it was not an important case." After attending a private consultation with her husband, the doctor suggested carrying out an HIV test. They went to a private hospital where the results were given with little guarantee of confidentiality[...] The doctor, having received the positive HIV test results for the child, refused to continue seeing her. With the painful knowledge of what their daughter, and probably themselves, was suffering from, they began the search for medical attention and guidance from other governmental institutions and from the National Council for the Prevention of AIDS (CONASIDA), where they experienced discrimination and poor attention. In CONASIDA, it was suggested they both have an HIV test: hers was positive while her husband's was negative. Both said they felt persecuted and harassed. One of the people who saw them suggested that the wife admit that she had contracted the virus through an extra-marital affair. Their daughter died at six months of age. A year later, they found out that she was pregnant. They had no idea how to deal with the pregnancy, given the lack of guidance and support they had received. They went to a state clinic, asking for the pregnancy to be terminated and were turned away. They returned to CONASIDA where they received better treatment and were told what options were available. The couple decided to have an abortion, despite the fact that this was illegal. Finally, they went to a private doctor who carried out the abortion and gave them emotional support.¹³⁸

8. Adolescent Reproductive Health

Laws & Policies

The Federal Constitution establishes that "it is the duty of the parents to support the right of minors to have their basic needs met and to care for their physical and mental health."¹³⁹

One of the fundamental objectives of the Program of Reproductive Health and Family Planning (PRHFP) is to provide for the sexual and reproductive health of adolescents.¹⁴⁰ Its goals include: broadening the coverage of information on sexual and reproductive health; increasing the age of adolescent woman at first birth; preventing unwanted pregnancies, abortions and sexually transmitted diseases; and providing high-quality contraceptive information and services, as well as counseling.¹⁴¹ In order to reach these objectives, the Ministry of Health has established 102 service modules, located in health centers and hospitals in all 32 states.¹⁴²

[See also Section D.2, covering Information and Education on Sexuality and Family Planning.]

Reality

According to the government, the fertility rate of Mexican women between the ages of 15 to 19 dropped from 132 births per 1,000 women in 1978, to 78 in 1994.¹⁴³ The prevalence of contraceptive use among women between the ages of 15 and 19 increased from 14.2% in 1976 to 36.4% in 1992.¹⁴⁴ In 1995, 36.1% of adolescents who cohabit with their partner use some form of contraception.¹⁴⁵ The most commonly used methods are: hormonal methods (40.3%), the intra-uterine device (IUD) (33.5%), and barrier methods (8.7%).¹⁴⁶ The average age of women at first birth is 21.¹⁴⁷ The maternal mortality rate for women under the age of 20 is six percent higher than that of women between the ages of 20 and 24.¹⁴⁸ Between 1990 and 1993, the number of cases of sexually transmitted diseases among young adults between the ages of 15 and 24 increased 14 percent.¹⁴⁹

The majority of young people in Mexico confront the risks of sexual relations with little information and a great deal of mystification. They receive little or no advice as to how to deal with their sexuality in a responsible way; they have poor knowledge about reproductive health; and they have only limited access to contraceptive services and methods. However, despite the obvious need for urgent action, programs to improve young people's sexual and reproductive health are the subject of controversy long before they are introduced. A small number of conservative groups that have significant influence in Mexico are always present in the debate, censoring everything from the content of chapters on sexual education in government textbooks to messages about safe sex in the press. These groups advocate sexual abstinence, no sex outside of marriage and the withholding of information about contraception from young people so as to "alienate" them from sex. Meanwhile, the statistics speak for themselves.

According to the National Family Planning Survey,¹⁵⁰ the percentage of young women between the ages of 15 and 19 who have already had sexual relations and do not use any form of contraception is as high as 99.8% for single women and 63.9% for women in a steady relationship. The same source shows that one of the groups of women in stable relationships that presents the greatest levels of unmet demand for family planning is comprised of women between 15 and 19 years of age (31.3%).

One of the problems that exists due to the lack of information about sexuality and contraception is that of unwanted pregnancies. According to the Survey on Fertility in Mexico carried out by the National Institute of Geography (INEGI),¹⁵¹ the total number of women under 19 who had had children in 1993 was 524,362. Adolescents who decide to terminate their unplanned pregnancies are not normally deterred by the fact that abortion is illegal in Mexico. Thus, such abortions are usually performed under the worst of conditions. 70% of teenage pregnancies in Mexico are unwanted.¹⁵²

Despite the fact that young people are vulnerable to becoming infected with HIV/AIDS, research by the National Council for the Prevention and Control of AIDS shows that, although 90% of people interviewed know what the disease is and how it is transmitted, less than 35% have made any changes in their sexual practices to curb the risks.¹⁵³ According to a survey by CONASIDA, 30% of people living in the capital, between the ages of 15 and 60 and sexually active, expressed "having difficulties with condoms" during sexual relations.

One positive development is that the government is beginning to lift the veil of ignorance that used to be drawn over the sexual and reproductive health of young people. The National Program for Reproductive Health and Family Planning 1995-2000, whose programming included input from NGOs for the first time, recognizes the basic needs of young people and contemplates setting up permanent mechanisms for information, education and communication regarding their sexual and reproductive health. In the same document, marking a milestone in Mexico's history, the government has committed itself to promoting the use of condoms which it describes as an indispensable means of protecting young people's health.

B. FAMILY RELATIONS (ARTICLE 16)

1. Marriage and Customary Marriage

Laws & Policies

The Mexican Constitution states that the principal function of the law is to protect the organization and development of the family.¹⁵⁴ The states regulate marriage. For both those living in the Federal District of Mexico City, and for the entire country in federal matters, the Federal District's Civil Code (FD Civil Code) provides that marriage is a contract to be formalized before the competent authorities according to the requirements outlined by law.¹⁵⁵ The minimum age to enter into marriage is 18 years.¹⁵⁶

Husband and wife are obligated to contribute to the maintenance of the home and to mutually support each other.¹⁵⁷ As long as both spouses are adults, they have the legal capacity to administer and dispose of their property.¹⁵⁸ They have the right to decide, based on mutual agreement, on the number and timing of any children.¹⁵⁹ The rights and duties that arise as a result of marriage are the same for both spouses regardless of their contribution to the maintenance of the home.¹⁶⁰ The father and mother are required to jointly administer the household and to provide for the education and formation of their children.¹⁶¹ In the Federal District, the penal code defines adultery as a crime punishable by a maximum of two years imprisonment and suspension of one's civil rights for up to six years.¹⁶²

Although the Constitution establishes the complete legal equality of men and women,¹⁶³ . Some codes still require that women obtain the authorization of their husbands to work or to sign contracts,¹⁶⁴ and in some states, the penalty for rape is less than the penalty for stealing an animal.¹⁶⁵ Many Mexican women bear all the responsibility for childrearing and domestic work, yet their work is not recognized as a contribution to the family's maintenance.¹⁶⁶

The regulation of common law marriages is also under the jurisdiction of each state. The FD Civil Code regulates numerous aspects of common law marriages under the term "concubinage," though it does not explicitly regulate such unions. It establishes that the man and woman involved in such a relationship have the right to inheritance according to the rules of succession applicable to spouses¹⁶⁷ when the concubinage has lasted five years or if they have a child together, and as long

as neither of them has been married during the period of concubinage.¹⁶⁸ If one of the partners in a concubinage is survived by more than one partner, none of them has inheritance rights.¹⁶⁹ Similarly, the FD Civil Code establishes that couples who cohabit in a concubinage are required, as is the case for spouses, to mutually provide for each other.¹⁷⁰ In addition, the civil code provides that paternity is presumed to the benefit of the children of the partners in a concubinage.¹⁷¹

Reality

A Mexican NGO called Group for Popular Education for Women (GEM) conducted a study in 1994 on family organization, consisting of a survey of 822 homes in the cities of Guadalajara (in the state of Jalisco), Matamoros (in Tamaulipas) and Orizaba (in Veracruz) (this was part of the evidence used for the National Survey on Employment by INEGI).¹⁷² The results show that subjective cultural concepts and perceptions of the roles that should be played by men and women persist. Women continue to be responsible for their children's education and domestic tasks, even when they have a job outside the home, while men contribute less and less to family income. Women in most households in the country have a double workload.

A study done in 1991¹⁷³ set out to find out what resources low-income women in Mexico City have for obtaining support when the man is not contributing to the maintenance of the household. Of a total of 95 women who had sought the advice of an NGO specializing in the legal defense of women, only seven managed to obtain maintenance. A further 13 won legal claims for maintenance, but never received it; almost 20 more got an allowance but in an atmosphere of domestic violence, exchanging money for blows. 60% of the women abandoned formal proceedings before obtaining a result. 80% were married, 14 were cohabiting and one was single. It should be noted that the Federal Civil Code dates back to 1928 and upholds the legal notion that as long as a father is living in the matrimonial home, he is presumed to be making a financial contribution. There is no legal means of claiming maintenance so long as the father is living at home. If the husband is not contributing to the maintenance of the home, the wife must petition for divorce if she wants to secure alimony and child support. A further obstacle to obtaining maintenance is that if the father leaves the family home for less than 6 months, the law presumes that he has not failed to make his financial contribution.

2. Divorce and Child Custody

Laws & Policies

Civil marriage may be terminated by a legally sanctioned divorce in Mexico.¹⁷⁴ Grounds for divorce include: adultery; if the wife gives birth during the marriage to a child conceived prior to the marriage that is not the child of the woman's spouse; failure to fulfill one's duty as a spouse or as a mother or father; cruel treatment of the spouse; conduct on the part of a spouse that corrupts their children; grave injuries caused by one spouse to the other; alcoholism or the habitual use of drugs; and by mutual consent of both spouses.¹⁷⁵ The judgement decreeing the divorce establishes which spouse is granted custody of their children and the amount of maintenance to be paid.¹⁷⁶ Property is divided evenly between the spouses when marriage was contracted under a joint ownership or community property regime,¹⁷⁷ though measures may be imposed to assure that the spouses fulfill their obligations to each other and to their children.¹⁷⁸ The cost of maintaining the household, feeding and educating the children, and feeding the spouse when the law so requires, must be

fulfilled by the spouses as provides by law in case of separation and divorce.¹⁷⁹ The “guilty” spouse loses everything that the “innocent” spouse may have given or promised to him or her, while the innocent spouse may keep anything received from the other spouse and may demand any previously agreed upon item.¹⁸⁰

Reality

The 16 grounds for holding a person “guilty” for divorce involves a wearing process for the parties involved. Moreover, as Magistrate Judge Alicia Elena Pérez Duarte¹⁸¹ concludes, divorce cases involving adultery demonstrate how the law generally favors the man. Thus, regardless of which spouse brings the action against the other for adultery, an idiosyncrasy of Mexican law blames the woman – only her extramarital relations could introduce an “illegitimate” child to the marriage. This doctrine, to some extent, justifies male adultery: adultery is not considered to be the cause of divorce if the person who commits it feels pushed into doing it by repeated refusal of “conjugal rights”, namely sexual relations, or when these are given with such “difficulty”, “protest” and “finality” that the “poor” adulterer has no choice but to seek satisfaction of his “natural instincts” by having illicit relationships. The woman is condemned for being the adulterer or for provoking her husband to commit adultery, making her the guilty party responsible for the divorce.

The person who has been declared innocent is entitled to alimony from the person who is held to blame. The “guilty” spouse never has such entitlement. As far as the marital property is concerned, the person who caused the divorce loses everything given or promised to his/her spouse; the innocent party keeps everything already received and has a claim over that which have been given or promised. A judicial decision of divorce also determines the situation of the children and the judge has wide powers to determine the rights and obligations inherent to paternal authority. The latter can be lost for specified reasons, such as being convicted of a serious crime twice or more, for abandonment of more than six months, or where the health, safety or morality of the children is at risk because of the “depraved behavior”, maltreatment or abandonment of either parent. The expression “depraved behavior” stands out as it has been the basis of judicial decisions to terminate the parent’s rights, almost always the mother’s, when she has been living with someone other than the father or has committed adultery. Without further inquiry, the mother that begins a new relationship with someone other than the father is treated as a concubine or adulteress.¹⁸²

Mexico’s demographic statistics include a category entitled “head of household.” The head of household is presumed to be the person who makes the main financial contribution or who exerts authority and makes important family decisions. Of the 17 million family homes that existed in 1990, 1.7 million had only one parent, usually the mother.¹⁸³ Mothers as “head of household” are increasingly common, due largely to the growing disintegration of the family, domestic violence and male irresponsibility relating to everyday family needs.¹⁸⁴ The 1995 National Survey of Family Planning introduced some questions designed to get a better understanding of the concept of “head of household.” It was found that in 94% of cases where a male heads the household, he is also the one who makes the important family decisions, whereas in only 4.3% of such cases does the woman make the decisions. When a woman heads the household, she makes the decisions in 93% of cases.

3. Early Marriage

Laws & Policies

The minimum age required to marry in the Federal District is 18.¹⁸⁵ However, men over the age of 16 and women over the age of 14 may marry with the express consent of either father or mother.¹⁸⁶ In cases in which no parents exist, the marriage may be authorized by the paternal grandparents or, if there are no paternal grandparents, by the maternal grandparents.¹⁸⁷ The authorities established by law may make an exemption from the age requirement if serious and justified causes are involved, thereby authorizing the marriage of minors without the consent of the above-mentioned persons.¹⁸⁸

Reality

According to the government, the average age at which Mexican women first marry was 19 in 1992.¹⁸⁹ In rural areas, women tend to establish their first union (marriage or cohabitation) at an earlier age — 17 — while women in urban areas do so at the age of 18.7.¹⁹⁰ Women establish such unions an average of two years later than men.¹⁹¹

Statistics from 1990¹⁹² show that in that year 6.4% of 15-19 year olds were married. In the 20-24 age group, the percentage went up to 34.5% and for 25-29 year olds it reached 60.5%. In absolute numbers for the entire population of young people in 1990, there were just over 7 million married (between the ages of 15 and 29). The research shows that in the states of Chiapas, Veracruz, Nayarit and Hidalgo the number of young people in relationships of cohabitation was higher (15.3%, 14.5%, 14.0%, 13.3%, respectively).

A study carried out a few years ago by United Nations Children Education Fund (UNICEF)¹⁹³ provides some clues to understand, albeit indirectly, the context in which the phenomenon of early marriage has grown in Mexico. This qualitative study was carried out in one of the most marginal areas of Mexico City known as La Independencia, in the Valle de Chalco. La Independencia lacks a sewer system, and clean water and electricity were recently brought to some, but not all, of the area; the houses are very humble, streets are not paved and are strewn with garbage. It has a population of 282,940 (INEGI, 1990), with one primary school, one secondary school and a kindergarten. The objective was to find out how children between the ages of 7 and 14 years spend their time to determine if this reflected any sexual discrimination. The researchers worked with four families with children between the ages of 7 and 14 and one family with young women and men between the ages of 14 and 21. The mothers and children were the main sources of information, given that the fathers left early for work and returned home late.

Among the important discoveries relevant to understanding the reasons for early marriage in Mexico was that children between the ages of 12 and 14 (which the researchers classify as pre-adolescents) have clearly defined “male” and “female” roles and that their activities are very different. Unlike the girls, the boys spend their time before meals playing with other children in the yard or in the street: they are quite separate from the domestic world. The girls of this age who no longer go to school (2, that is, half) assume many of the domestic duties in the home: they wash clothes for the whole family and look after their younger siblings and help them with their homework. The younger siblings see them as substitute mothers when their own mothers are not present. Girls are taught household duties from a very early age.

In the same study, questionnaires were given to 62 children (37 girls and 25 boys), asking, among other things, what they would like to do when they grow up, to which the girls replied, in the following order: 1) to have a husband; 2) to have a man who respected them and did take up with other women; 3) to have children; 4) to help their parents; 5) to work, and 6) to own a car.¹⁹⁴

4. Right to Access Family Planning without Spousal Consent

Laws & Policies

Spousal consent is not required to obtain contraceptives. The Official Standards for Family Planning Services in Mexico, together with the General Law on Health and the regulations governing provision of services by governmental institutions like the IMSS, state that family planning services shall be free of charge, informed and open to anyone of reproductive age. The general guidelines contained in the Official Standards for Family Planning Services applicable to female as well as male sterilization require “written authorization indicating informed consent of the client or his/her legal representative.”¹⁹⁵ It is nowhere stated that the spouse’s consent or authorization is required. As was mentioned in the section on sterilization, where irreversible methods (female sterilization or vasectomy) are used the client must be counseled before agreeing to proceed and he or she or a legal representative must give written authorization.

Reality

Although nothing is specified regarding spousal authorization, the reference to “a legal representative”¹⁹⁶ has, in practice, given rise to violations of the patient’s rights, particularly at the time a woman gives birth or during post-abortion care. These are stressful moments in a woman’s life and although offering sterilization at such times has certain advantages - the woman avoids another surgery and the hospital saves time and resources - these are not times when the woman is relaxed and in any condition to make such a choice. This has commonly been the moment when spouses or other family members have been asked by medical personnel to make the decision instead of the woman. GIRE has not, however, found hard evidence of this happening, except in the opinions of persons who have worked and/or are researching in the field of family planning or in public hospitals.

C. SEXUAL VIOLENCE AGAINST WOMEN [ARTICLES 5, 6 AND 16]

1. Rape and Sexual Crimes

Laws & Policies

The regulation of sex-related crimes falls within the jurisdiction of the states. Most states in Mexico legislate rape in conjunction with crimes against decency and seduction. At the same time, sex-related crimes that involve adolescents and minors are specifically classified, such as statutory rape, incest and the corruption of minors.¹⁹⁷ Some states categorize as sex crimes peculiar situations such as an individual who has sexual relations with a woman by pretending to be her spouse or common law spouse.¹⁹⁸

In the Federal District, rape is a crime against “freedom and normal psychosexual development.”¹⁹⁹ The crime of rape is committed when a person uses violence or the threat of

violence to engage in “intercourse” with another person of either sex.²⁰⁰ The penalty in these cases is eight to fourteen years imprisonment.²⁰¹ The Penal Code also categorizes as rape when an adult engages in intercourse without the use of violence with a person under the age of 12, as well as an adult who, without using violence, engages in intercourse with a person who does not understand the meaning of the sexual act or who is incapable of refusing the person’s advances.²⁰² These crimes are penalized with eight to fourteen years imprisonment.²⁰³ Raping a minor of thirteen or fourteen years of age is considered an “improper act” in most state criminal codes.²⁰⁴ In such cases, the convicted person receives a harsher penalty when the victim is a female virgin or has not yet reached puberty.²⁰⁵

Some states recognize certain exceptions to crime of seduction, which is considered a sexual crime, because they categorize seduction as a crime against freedom and personal security.²⁰⁶ In such states, seducing a woman over the age of 18 is criminalized only when it involves the actual use of or the threat of violence.²⁰⁷ Few states even classify seduction of a minor male by a woman.²⁰⁸ The Penal Code of the Federal District classifies kidnapping as the act of an individual who “takes control over a woman through the use of violence or the threat of violence, seduction or trickery to satisfy some erotic or sexual desire or to marry the woman.” Such an act is penalized with six months to six years imprisonment and a fine of 50 to 500 pesos.²⁰⁹

The Penal Code of the Federal District establishes that the conduct of a person who engages in intercourse with a person under the age of 12 is committing the equivalent of rape, and imposes a penalty of eight to fourteen years imprisonment.²¹⁰ A crime against decency is committed when an aggressor engages in a sexual act other than intercourse with a person under the age of 18. Some states gradate the penalty depending on whether the victim had reached puberty.²¹¹ The same crime is named differently in some states: in some states it is denominated as “lustful acts,”²¹² while others call it “dishonest abuse.”²¹³ In the Federal District, if acts against decency are committed against a minor under the age of 12, the author of the crime is penalized with six months to three years imprisonment.²¹⁴

The Penal Code also includes the crime of statutory rape, which involves intercourse with a woman between the ages of 12 and 18 through seduction or trickery.²¹⁵ Some states identify this crime as one of many crimes “against sexual freedom and inexperience.”²¹⁶ Statistics define differently the characteristics of the woman who may be the victim of such crimes. While some establish that the woman’s age range between 12 and 18, most also say that she must have reached puberty and that she also be honest and a virgin.²¹⁷ Some Mexican experts consider that statutory rape as it is currently defined by the country’s criminal law has no valid purpose, as there is no object that the law should protect in this way, and that “Women do not require the legal protection that the laws defining statutory rape pretend to give them.”²¹⁸ The Penal Code of the Federal District requires that the victim or her representatives denounce an aggressor.²¹⁹

The regulation of sexual harassment falls within the jurisdiction of the states. The FD Penal Code classifies the crime of sexual harassment as the conduct of a person who “with lustful intentions repeatedly harasses a person of any sex, taking advantage of his or her position of authority, derived from their job-related, teacher/student or domestic relationship, or any other relationship that implies some form of subordination.”²²⁰ The penalty for such conduct established in the Penal Code is a fine.²²¹ When the aggressor is a public employee who uses his or her position to engage in harassment, the law mandates that he or she be fired.²²² The penal legislation establishes that for sexual harassment to be considered a crime, it must have caused damage or prejudice.²²³ Only the victim may bring charges against the aggressor.²²⁴

Reality

In Mexico, violence against women has not been systematically studied.²²⁵ Nor is there information about the incidence of violence against women due to the fact that few women report sexual crimes.²²⁶ It is estimated, for example, that only one of every ten rapes is reported to the authorities.²²⁷ A study carried out in the Federal District revealed that if the total number of complaints brought before the attorney general's office, 87% of the victims are women. Another study, also in the Federal District, revealed that one of the main motives behind violence against women is to have sexual relations with them against their will.²²⁸ Approximately half of the rapes and other sexual crimes in Mexico are committed against girls and adolescent women.²²⁹ In 60 percent of the cases of rape of minors that are reported, the aggressors are close relatives of the victim, including the victim's father.²³⁰ In 90 percent of such cases, there was either implicit or explicit consent or tolerance by the mothers of the victims.²³¹

Few statistics on rape are available in Mexico, although some NGOs working in the field have carried out studies based on the number of victims they see. In 1993, 85 rape survivors were seen by the Mexican Association Against Violence Against Women (COVAC). These women requested the following forms of assistance from COVAC: 75% asked for emotional support; only 1% requested legal assistance; and 24% wanted both emotional support and legal assistance. 65% of the women had been attacked by strangers. An unfortunately high percentage (26%) became pregnant. In the majority of cases attended to by COVAC, namely 59%, no legal proceedings were brought.²³² This can be understood by examining the treatment women receive when they report a sexual crime to the Attorney General's Office, at least in Mexico City. The aim of one study carried out by the Attorney General's Office in the Federal District²³³ was to show how victims of rape are effectively prevented by various procedural obstacles from going beyond the first phase of criminal proceedings. 93.33% interviews were conducted in local offices of the Attorney General in the Federal District; 71.42% of the agents surveyed were men and 28.57% were women. The answers to the questions posed to these employees demonstrate the agent's widespread disbelief of rape victims when they first present a complaint. For example, 85.36% of those interviewed considered it necessary for the victim to undergo a medical examination before making an official complaint. On asking the purpose of questioning the victim about her sexual life, 47.61% of the officers considered such information to be determinant, regardless of its particular relevance to the complaint. The replies included: "it is important to know what kind of person she is;" "it's important to know if she has had sexual relations as this determines her good or bad sexual reputation;" and, "through questions related to her sexual life it is possible to tell if the woman is responsible for the attack, because in most cases, it is the woman who provokes the aggression."²³⁴ Further proof of the insufficiency of the victim's own word is that 30.96% of officers consider it necessary to also have the confession of the aggressor or a witness.²³⁵ 64.28% of the officers questioned believe that there are cases in which the woman files a complaint in order to cover up an unwanted pregnancy that has resulted from intercourse that does not constitute rape.²³⁶

A dramatic case that shows the consequences of such treatment by the authorities caught the attention of the press in 1997 and took place in the city of Durango (in the State of Durango). Yéssica Yadira Díaz, a young woman of 19, reported being raped by two men. At the Attorney General's office where she went with her family to lodge the complaint, Yéssica Yadira was subjected to mistreatment and coercion to force her to retract her statement. The suspects, who had been held in prison, were released. A few days later, Yéssica Yadira committed suicide. The National Commission for Human Rights intervened to charge the Attorney General's officers

involved (8 civil servants and 5 agents in all) with abuse of authority, although only two agents were found guilty. The President of the National Commission for Human Rights, Mireille Roccatti, sent a letter to the Governor of Durango, in which she stated that the official response to the Commission's recommendation regarding Yéssica Yadira's case, was "inadequate" and emphasized that merely assigning responsibility to two agents of the Attorney General's Office was to "tolerate impunity and pretend to apply the law." Citing the most serious breaches in the case, Roccatti mentioned the moral coercion to which Yéssica and her family were subjected to force her to withdraw her complaint, describing it as "torture," in which the various officials were involved to varying degrees.²³⁷

2. Domestic Violence

Laws & Policies

Rape between spouses is not classified as a crime under Mexican law. In June 1997, the Mexican Supreme Court of Justice established that sexual relations between spouses that are the result of violence do not constitute a crime but the "undue exercise of a right."²³⁸ This judgement affirms a prior decision of the Supreme Court on the same issue in 1994.²³⁹ In 1995, only the Penal Code of the state of Querétaro penalized rape between spouses.²⁴⁰

Domestic violence against children is tolerated legally. In 1995, 11 Mexican states permitted the physical punishment of children by their parents or guardians. Injuries caused "while exercising the right to reprimand," and when the judge considers that this right is not abused by "reprimanding with cruelty or unnecessary frequency" are not punishable²⁴¹ if they do not endanger the victim's life, if they are cured within 15 days, and if they involve no other consequences that are punishable by law.²⁴²

In 1996, the Federal District promulgated the Law of Assistance and Prevention of Domestic Violence,²⁴³ whose objective is to establish nonjudicial procedures to protect victims of domestic violence and to develop strategies to prevent such violence.²⁴⁴ This law defines violence as an "act of power or omission that is recurring, intentional and cyclical, and is aimed at dominating, subordinating, controlling or harming any member of the family through physical, verbal, psycho-emotional, or sexual violence."²⁴⁵ The forms of sexual mistreatment mentioned include denying "sexual-affective" needs and inducing sexual practices that are not desired or that harm the victim.²⁴⁶ This law "may only be used as a means to secure prevention" in respect of the provisions of the FD Penal Code, particularly those related to sexual crimes.²⁴⁷ The procedures established for cases of domestic violence include conciliation,²⁴⁸ friendly settlement, and arbitration.²⁴⁹ The failure to respect the orders generated by this process is penalized with a fine of 30 to 180 days' of the minimum salary in the Federal District, or its equivalent, and the incommutable administrative arrest of the offender for a period of no more than 36 hours.²⁵⁰

The penal codes in only a few states treat violent crimes or homicide committed among family members as aggravating circumstances.²⁵¹ In 1995, only one state treated an assault committed by one spouse or partner against the other as an aggravating circumstance.²⁵² In the Federal District, domestic violence is penalized by the criminal law, specifically within the provisions related to assault.²⁵³ Assault includes wounds, bruises, fractures, burns, and in general, any damage that leaves marks on the human body, when they are caused by an external force.²⁵⁴ Penalties for such crimes range from three months imprisonment for minor injuries to ten years for serious injuries.²⁵⁵

Reality

No systematic data regarding the dimension of domestic violence in Mexico are available. However, existing information reveals that it is a serious problem that demands attention from the legal system and the health authorities.²⁵⁶ A study carried out by the Ministry of Health of the Federal District among women between the ages of 14 to 57 who were beaten by their partners revealed that most victims were mothers between the ages of 22 and 29, and that 90 percent were beaten in front of their children.²⁵⁷ Twenty-two percent of the battered women were illiterate or had not completed primary school; 44 percent had finished primary school and/or some secondary school; and the remaining 34 percent had some post-high school education or were professionals.²⁵⁸ Other common forms of domestic violence in Mexico include verbal aggression, confinement to the home, prohibitions on seeing family members or working, and forced sexual relations.²⁵⁹

The Center for the Prevention of Inter-Family Violence (CAVI), under the Federal Ombudsman, is the only governmental institution that deals directly with cases of domestic violence. It has seen more than 100,000 people in the 7 years it has been functioning.²⁶⁰

The activities of NGOs to prevent and eradicate domestic violence against women have drawn attention to this social problem and have influenced governmental action. For example, in the legislative and judicial field such action has included the 1984 amendment of the Criminal Code for the Federal District so as to maximize punishment for rape; the creation, in 1989, of the Attorney General's Special Agencies to deal with sex offenses, which operate within various bodies around the country; and the various amendments and repeals made to the Criminal Code and the Criminal Procedural Code for the Federal District in 1990 and 1991 relating to sex offenses.

However, despite the steps taken by the government to address the phenomenon of domestic violence, various factors impede the efficacy of such efforts. In a governmental analysis of women's status, it states that among the serious obstacles are "women's ignorance of their rights and of the law designed to safeguard these; the barriers that exist to their recognizing, filing, and following up on a complaint with the relevant judicial bodies; the lack of enforcement of the laws; and the scarcity of mechanisms and institutions to protect the rights of potential and actual victims of violence."²⁶¹ Thus, the authorities realize the need for information campaigns to "raise awareness about the repercussions of violence for the integral development of the woman and the family."²⁶² However, the government's report fails to mention the urgent need to train the people working for the Attorney General's Office, including those who receive complaints, whose treatment of women is generally insensitive. When, because of the seriousness of the injuries, a woman goes to the Attorney General's Office or a judge, she discovers not only that she is not understood, but that in most cases, she cannot prosecute her husband because domestic violence is not classified as a crime. For many public officials, "this" is part of peoples' private lives and nothing more.²⁶³ It is also necessary to educate the general public about the rights of victims and to promote a clearer and stricter definition of these kind of crimes.

A broad group of NGOs and civil institutions has promoted a proposal for legal reform which was submitted to legislators during their session last September. This group asserted that the lack of clear guidance within the civil and criminal law in Mexico on the phenomenon of inter-family violence lies in the fact that the law does not recognize the psychological effects which are an integral part of domestic violence. Moreover, they argued that this is an area which concerns a particular kind of behavior which the criminal law has not addressed.

3. Violence and/or Coercion in Health Services

Laws & Policies

These practices are not sanctioned in any law or written government policy.

Reality

In addition to the numerous complaints of mistreatment and poor medical care which were presented to the Tribunal for the Defense of Reproductive Rights, the type of coercion most commonly found in Mexico's reproductive health services is the pressure exerted on a patient to use a particular method of contraception. In this respect, in 1993, the United Nations Population Fund made two visits to evaluate the programs it supports in Mexico which confirmed that pressure is exerted by those providing health care when discussing contraceptive methods. In addition, UNFPA found a failure to cater to the needs of patients. For example, it was discovered that information about the IUD tends to underestimate the possible side effects and to emphasize how easy it is to use, while information about birth control pills tends to focus on the side effects and difficulties in using them.²⁶⁴ Another indicator is the National Survey on Fertility and Health (1987), which shows that a third of the women interviewed regarding the moment in which they chose a contraceptive method said that someone else had made the decision for them. In rural areas, 18.1% of women did not directly make the decision.²⁶⁵

One of the cases of the Tribunal for the Defense of Reproductive Rights²⁶⁶ is that of Dora Luz Pérez Santos, 39 years of age. She testified that she went to a prenatal consultation at the Gynecologic Clinic of the Tlatelolco Medical Union (a government clinic). At the final consultation, the doctor asked her if she wanted to have her tubes tied, to which she replied that she did not. Dora commented that the doctor pressured her to accept sterilization in light of her age; when she refused, he proposed inserting an IUD which she also refused. Dora's decision was written on the form prepared for the birth. After giving birth by cesarean, Dora said that she was constantly harassed, pressured and even scolded by the doctors for not having had her tubes tied and was referred to as being "irresponsible." From the doctors' comments and the discharge form they gave her, she was certain they had not fitted an IUD. However, at home while bathing, she could feel the wires of the IUD and was filled with indignation. Dora went immediately to see her family doctor at the IMSS, who doubted her ability to identify the presence of an IUD, saying "you couldn't know that and it says on your discharge sheet that none was fitted." Because of Dora's insistence, the doctor referred her back to the family planning service since it was not his job to remove the IUD, but they refused to attend to her for lack of staff. Dora, aware of her reproductive rights, feels increasingly more vehement. She is pursuing legal proceedings in which she will have to be examined by court doctors to prove that the IUD has been fitted.

D. EDUCATION AND ADOLESCENTS (ARTICLE 10)

1. Access to Education

Laws & Policies

The Constitution establishes the right of all individuals to an education.²⁶⁷ The federal government, the states and the municipalities are required to provide pre-school, primary and secondary education, which are all free of charge.²⁶⁸

Reality

While the participation of women in secondary and post-secondary education has increased considerably in the last few decades,²⁶⁹ the rate of illiteracy among women was 15.2 percent in 1995.²⁷⁰ Approximately two of every three adults who are illiterate are women.²⁷¹ Women with lower educational levels tend to live in rural areas.²⁷² There are no marked differences in the access of girls and boys to primary school, but by the age of 14, 32.5% of girls and 27.5% of boys stop attending school.²⁷³

The government²⁷⁴ states that while school attendance, particularly for women, tends to decrease with age, the gap which separates the sexes has narrowed in the last decade, especially at the intermediate level: from 89 women for every 100 men at the beginning of the 1980s, to 94 women for every 100 men in the 1990s. It also indicates that women are increasingly participating in higher education: in the academic year 1994-5, for every 100 men registered at this level, there were 82 women. This number decreases to 64 women for every 100 men at the postgraduate level. This tendency towards the narrowing of the gender gap is confirmed by other studies.²⁷⁵

One qualitative study carried out by UNICEF²⁷⁶ shows some of the conditions and the cultural context which drive a family's daughters, rather than its sons, to leave school in Mexico. The study was carried out in one of the most marginal areas of Mexico City, La Independencia, in the Valle de Chalco, where there is no sewage system, water and electricity have been recently installed in only part of the zone, the houses are humble, the roads are unpaved, and the streets are strewn with garbage. The population of the neighborhood is 282,940 people (INEGI 1990) and there is one primary school, one secondary school and one kindergarten. The original objective of the study was to find out how children between the ages of 7 and 14 spend their time to determine if this reflected any discrimination on the basis of gender. The researchers worked with four families with children aged 7-14 years and one family with children aged 14-21 years.

The results relevant to the children's education were as follows: The children aged 7-11 years went to the primary school for 4 and a half hours, seated on old benches and in dark, damp rooms. The teachers claimed to treat girls and boys equally, although the observers noticed that there were different games for boys and girls. They did not find there to be any difference in the level of participation of either sex: both boys and girls took the initiative in answering the teachers' questions. On going home after school, the girls helped with the household chores (setting the table, looking after younger siblings) while the boys ran errands or played in the street. The world of the boys extends to outside the home, while if girls played, they did so inside the home.

Among the group of 12-14 year olds, the differences were more marked. Of the 4 girls observed as part of the study, 2 did not attend school. Those that did study did so in dark, damp classrooms and sit separately from the boys. Again, the teachers asserted that they do not differentiate between boys and girls, although it was still observed that at play, there was a

difference in roles depending on each sex. On arriving home after school, the girls had household tasks to perform, as helpers and supervisors for their mothers, while the boys went out to play.

The girls that left school did so at critical times for the family: when the father lost his job, in one case, and, in the other, when the father went to prison. On the other hand, the brothers of these girls did not leave school even when they needed to work. One of the mothers told the researchers that the boys needed to study for a profession so that they could support their families when they grow up, while the girls would be maintained by their husbands.

2. Information and Education on Sexuality and Family Planning

Laws & Policies

There is no government-sponsored program of sexual education for adolescents in Mexico. The government's Program of Educational Development for the period 1995-2000 does not mention the inclusion of sexual education as part of the curricula of educational institutions.²⁷⁷ Information and educational programs for reproductive health and family planning are developed as part of the government's health policies and, more specifically, as an aspect of the policies on reproductive health and family planning.²⁷⁸

Reality

According to the government, the Program for the Promotion of Health²⁷⁹ is strategically designed to have a significant impact on the population's health. Its objective is to increase individuals' knowledge of, aptitude for and attitudes toward health and to encourage them to adopt healthy lifestyles. This in turn will improve the state of individual, family and collective health. One of the Program's conceptual strategies is "education for health." In respect of sexual and reproductive health, there is a gap in the program, as well as in its six components: "family health" - aimed at the family and particularly at women as mothers and, according to its words, "with its gendered aspects"; "the student's holistic health"; "holistic health of adolescents"; "healthy municipalities"; "exercises for health care"; and, "development of educational programs". There is no separate section addressing sexual and reproductive health. Undoubtedly, it is thought that the need for information on sexuality and family planning falls under the categories of "family health" and "adolescent health", but it is nonetheless significant that there is no specific section which deals with these issues. It is the responsibility of the Program for the Promotion of Health to provide information to enable citizens "to feel able to control different areas of their health, reproduction and sexuality, fostering an educational process which generates the exercise of personal, autonomous decisions in the fields of sexuality and reproduction."²⁸⁰

As far as the actions undertaken by the government are concerned, various press campaigns aimed at promoting family planning stand out. One of the most recent of these is called Planning is a question of wanting, which is carried out by the National Population Council (CONAPO, 1995), and targets "groups that have been left behind": women, men, young people and adults, whether single or in relationships, who live in rural areas or in the marginal urban areas of 11 states (Chiapas, Guanajuato, Guerrero, Hidalgo, Mexico, Michoacán, Oaxaca, Puebla, Querétaro, Veracruz and Zacatecas). The campaign is made up of four stages, each with its own theme: delaying a relationship, delaying the birth of a first child, timing of births and limiting fertility. Between June 1995 and May 1996, the campaign appeared on the national television channels 5,900

times, amounting to 49 hours of continuous transmission time. To determine the impact of the campaign, a national survey²⁸¹ was carried out between October and December 1995 on 12,700 women of reproductive age, of whom 55% remembered having seen or heard some message about family planning during the month preceding the interview. The message which received the greatest acceptance is the one which sets out the advantages of delaying the birth of a first child. However, it was also clear that there are huge challenges: only 37% of women between the ages of 15-29 who are in a relationship and who have never used contraception and who live in the targeted states, remember having seen or heard any message about family planning.

E. EMPLOYMENT RIGHTS (ARTICLE 11)

Maternity Leave and Protection in Pregnancy

Laws & Policies

The Constitution recognizes that all individuals have “the right to dignified and socially useful employment”²⁸² and establishes the principle of equal pay for equal work, prohibiting discrimination based on sex or nationality.²⁸³ It also provides for special protection for pregnant women,²⁸⁴ noting that a pregnant woman should not engage in labor that implies a risk to her health.²⁸⁵ The Constitution also mandates that pregnant women workers have the right to prenatal and a postnatal leave of six weeks each, during which periods they are entitled to be paid at the same salary as that paid prior to her taking leave.²⁸⁶

The Federal Work Law²⁸⁷ establishes that women enjoy the same rights and have the same duties as men.²⁸⁸ A woman has the right to extend prenatal or postnatal leave when she is unable to work due to pregnancy or childbirth, in which case she is to be paid 50 percent of her salary for a period of no more than sixty days.²⁸⁹ Women have the right to return to work after their period of leave is over.²⁹⁰ The employer is also required to allow the worker two breaks during the workday, consisting of thirty minutes each, to breastfeed her child.²⁹¹

Reality

A Human Rights Watch report²⁹² on the situation of women working in so-called “maquilas” – export processing companies – in Mexico illustrates the type of discrimination experienced by women who work in the private sector in Mexico. The “maquila” owners require that the women undergo pregnancy tests as a condition of employment: if they are pregnant, they are refused work; and if they become pregnant while working in the maquila, they are pressured into resigning or are mistreated. Despite the government’s responsibility for guaranteeing the protection of these workers, Human Rights Watch maintains that the Mexican government has neither admitted nor resolved any of the violations of women’s rights to non-discrimination and to privacy. Furthermore, the government’s failure to intervene to remedy this situation damages the woman’s right to freely and responsibly decide on the number and timing of children she wants. At least half of the 500,000 people working in maquilas are women. The Human Rights Watch report investigated this type of discrimination in five cities: Tijuana (Baja California), Chihuahua (Chihuahua), Matamoros, Reynosa and Rio Bravo (Tamaulipas), interviewing women who were currently working in the maquilas or had worked there recently. Women were advised during interviews that they were required to undergo a pregnancy test performed by company medical staff. The interviewers often

try to find out intimate information about the woman, such as whether she is sexually active or what type of contraception she uses. When a women maquila worker gets pregnant, management frequently places them in jobs that are more physically demanding to pressure them into resigning. The women affected by this kind of discrimination are the poorest, least experienced and least educated within the workforce.

At the Tribunal for the Defense of Reproductive Rights,²⁹³ various governmental entities, including the Political Subdivisions of Benito Juárez and Tlalpan, the Institute for Training and Development for Urban Transportation, the Training Institute of the Office of the Ombudsman of the Federal District, and the Centers for Infant Development, were denounced on grounds that they require women applying for jobs not to be pregnant and subject them to the above-mentioned practices.

ENDNOTES

¹ The right to health care was granted in 1983; it was published in the official record of the federation, February 3, 1983; *see also* NATIONAL POPULATION COUNCIL (CONAPO), LA DEMANDA DE ATENCIÓN DE SALUD EN MÉXICO [THE DEMAND FOR HEALTH CARE], at 29 (Mexico, 1995). *See also* MEX. CONST., art. 4.

² This program was adopted by the federal government in accordance with MEX. CONST., arts. 4 and 26, Organizational Law of the Federal Civil Service, art. 9, and Planning Law, arts. 9, 17, 22, 23, 27, 28, 29 and 32. FEDERAL EXECUTIVE BRANCH, PROGRAMA DEL SECTOR SALUD 1995-2000 [REFORM PROGRAM OF THE HEALTH SECTOR 1995-2000], at i (Mexico, 1995).

³ *Id.*, at 14.

⁴ *Id.*, at 27-45.

⁵ THE DEMAND FOR HEALTH CARE, *supra*, at 29.

⁶ *Id.*

⁷ *Id.*, at 32.

⁸ *Id.*

⁹ *Id.*

¹⁰ *Id.*

¹¹ *Id.*, at 31.

¹² *Id.*

¹³ Grupo de Información en Reproducción Elegido (Free Choice Information Group) (GIRE), Interinstitutional communication. Mexico D.F., Memorandum from August 13, 1997, at 2. On file with the Center for Reproductive Law and Policy (CRLP).

¹⁴ The Penal Code Governing the Federal District and other Federal Jurisdiction, PENAL CODE OF THE FEDERAL DISTRICT, arts. 288-293 (Hereinafter, PENAL CODE (DF)).

¹⁵ *Id.*, art. 228.

¹⁶ THE DEMAND FOR HEALTH CARE, at 29.

¹⁷ *Id.*, at 32..

¹⁸ *Id.*, at 29.

¹⁹ *Id.*, at 30.

²⁰ REFORM PROGRAM, *supra*, at 7.

²¹ *Id.*

²² *Id.*

²³ FEDERAL EXECUTIVE BRANCH, PROGRAMA NACIONAL DE LA MUJER 1995-2000 [NATIONAL WOMEN'S PROGRAM 1995-2000], at 28 (Mexico, 1996).

²⁴ *Información Básica de los Estados Unidos Mexicanos [Basic Information about the United States of Mexico]* (visited July 30, 1997), <<http://cenids.ssa.gob.mx/>>.

²⁵ REFORM PROGRAM, *supra*, at 7.

²⁶ ASA CRISTINA LAURELL AND LILIANA RUÍZ, *PODEMOS GARANTIZAR EL DERECHO A LA SALUD? [CAN WE GUARANTEE THE RIGHT TO HEALTH?]*, at 9 (UAM Xochimilco, Friedrich Ebert Foundation, Mexico, 1996).

²⁷ *Id.*

²⁸ *Id.*, at 10.

²⁹ CONAPO, *SITUACIÓN DE LA MUJER: DESAFÍOS PARA EL AÑO 2000 [THE STATUS OF WOMEN: CHALLENGES FOR THE YEAR 2000]* (Mexico, 1995).

³⁰ *Id.*, at 48.

³¹ MEX. CONST., art. 4.

³² MEX. CONST., art. 123.

³³ General Health Law, art. 27.

³⁴ *Id.*, art. 61.

³⁵ Daily Gazette of the Federation, May 30, 1994.

³⁶ FEDERAL EXECUTIVE BRANCH, PROGRAMA DE SALUD REPRODUCTIVA Y PLANIFICACIÓN FAMILIAR 1995-2000 [REPRODUCTIVE HEALTH AND FAMILY PLANNING PROGRAM 1995-2000], (Mexico, 1995).

³⁷ The National Population Council is an interinstitutional public entity created in 1974. It is responsible for the demographic planning of the country and its main objective is to incorporate the concepts of "volume, dynamic structure, and distribution throughout the national territory, and the social, economic, and ethnic composition of the population in

the government's programs of economic and social development." (visited July 16, 1997), <<http://unam.mx.conapo/info/>>

³⁸FEDERAL EXECUTIVE BRANCH., PROGRAMA NACIONAL DE POBLACIÓN. [NATIONAL POPULATION PROGRAM] at 1, 12 and 60. (Mexico, 1995.) See also the General Population Law.

³⁹REPRODUCTIVE HEALTH PROGRAM, *supra*, p. ii.

⁴⁰REFORM PROGRAM, *supra*, at 31.

⁴¹*Id.*, at 31-34.

⁴²REPRODUCTIVE HEALTH PROGRAM *supra* 115, at 2, 8, and 19-23.

⁴³THE STANDARDS ON FAMILY PLANNING SERVICES [ORFPS], § 5.1

⁴⁴*Id.*, § 5.1.4; REPRODUCTIVE HEALTH PROGRAM, *supra*, at 27.

⁴⁵ORFPS, *supra*, § 5.5.

⁴⁶General Health Law, art. 67.

⁴⁷REPRODUCTIVE HEALTH PROGRAM, *supra*, at 14-15.

⁴⁸SECRETARY OF HEALTH AND CONAPO, ANÁLISIS DE LA SITUACIÓN DEL PROGRAMA DE PLANIFICACIÓN FAMILIAR SEGÚN DATOS DE LA ENCUESTA NACIONAL DE PLANIFICACIÓN FAMILIAR [ANALYSIS OF THE FAMILY PLANNING PROGRAM BASED ON DATA FROM THE NATIONAL SURVEY OF FAMILY PLANNING] at 8-9 (Mexico, Oct. 1996).

⁴⁹*Id.*

⁵⁰*Id.*, at 9.

⁵¹*Id.*

⁵²REPRODUCTIVE HEALTH PROGRAM, *supra*, at 7.

⁵³BLANEY, CAROL, POSTPARTUM AND POSTABORTION FAMILY PLANNING IN LATIN AMERICA: INTERVIEWS WITH HEALTH PROVIDERS, POLICY MAKERS AND WOMEN'S ADVOCATES IN ECUADOR, HONDURAS AND MEXICO (Pan-American Health Organization, Family Health International, Washington, 1997).

⁵⁴*Id.*, at 32.

⁵⁵Yolanda Varela Chávez, *Opciones anticonceptivas en el Programa de Planificación Familiar de la Secretaría de Salud* [Contraceptive Options within the Ministry of Health's Family Planning Program], IBOLETÍN DE SALUD REPRODUCTIVA, Jan.-Feb.1997, at 23.

⁵⁶POSTPARTUM AND POSTABORTION FAMILY PLANNING, *supra*, at 32.

⁵⁷*Id.*, at 34.

⁵⁸P. Nájera Aguilar, E. Lazcano, P. Alonso, et.al, *Factores asociados con la familiaridad de las mujeres mexicanas con la función del Papanicolau* [Factors Associated with the Familiarity of Mexican Women with the Function of the Papanicolaou Test]; *Cáncer del cuello del útero* [Cancer of the Cervix], Issue on cervical cancer of the 121 BULLETIN OF THE PAN-AMERICAN HEALTH OFFICE Dec. 1996 (No.6).

⁵⁹General Health Law, art. 51.

⁶⁰*Id.*, art. 300.

⁶¹*Id.*, art. 303.

⁶²*Id.*, art. 54.

⁶³The decree establishing the National Commission of Medical Arbitration was promulgated on June 3, 1996.

⁶⁴The NCMA is a decentralized entity of the Ministry of Health which has technical autonomy to emit its opinions, agreements and judgments. *Id.*, art. 1.

⁶⁵*Id.*, art. 2.

⁶⁶*Id.*, art. 4.

⁶⁷ORFPS, § 5.4

⁶⁸General Health Law, art. 310.

⁶⁹*Id.*

⁷⁰*Id.*

⁷¹Daniel Hernández Franco, *La búsqueda del ejercicio pleno del derecho en la planificación familiar* [The Search for Full Exercise of Rights in Family Planning], DEMOS, no. 9, 1996.

⁷²Romero Guerrero Xóchitl, et al., *Calidad de la atención del aborto: percepción de las usuarias* [Quality of Care for Abortion: Perception of the Service Users], in CALIDAD DE LA ATENCIÓN EN SALUD SEXUAL Y REPRODUCTIVA, , at 201. (Committee for the Promotion of Maternity Without Risks in Mexico, 1997).

⁷³NETWORK FOR WOMEN'S HEALTH IN MEXICO FEDERAL DISTRICT, TRIBUNAL FOR THE DEFENSE OF REPRODUCTIVE RIGHTS: DOSSIER OF CASES, at 8-10 (May 1996).

⁷⁴The Penal Codes of the different states provide that abortion is a crime; it is not penalized only in specific limited circumstances.

⁷⁵General Health Law, art. 68, § 5, and arts. 144 and 204.

⁷⁶*Id.*, art. 204.

⁷⁷*Id.*, art. 205, in accordance with art. 194, 2.

⁷⁸ANALYSIS OF THE FAMILY PLANNING PROGRAM, at 1.

⁷⁹CONAPO, SITUACIÓN DE LA PLANIFICACIÓN FAMILIAR EN MEXICO. INDICADORES DE ANTICONCEPCIÓN [STATUS OF FAMILY PLANNING IN MEXICO. CONTRACEPTIVE INDICATORS], at 3 (Mexico, 1994).

⁸⁰*Id.*.

⁸¹*Id.*

⁸²ANALYSIS OF THE FAMILY PLANNING PROGRAM, *supra*, at 4-5.

⁸³STATUS OF FAMILY PLANNING, *supra*, at 8.

⁸⁴Ricardo Aparicio and Yvon Angulo, *Demanda insatisfecha de planificación familiar* [The Unmet Demand for Family Planning], in DEMOS, no. 9, 1996.

⁸⁵Jorge Martínez Manatou, *Algo anda mal en planificación familiar* [Something is Wrong with Family Planning], CARTA SOBRE POBLACIÓN, Year 4, No.22 (Academic Support Group for Population Programs, August 1997).

⁸⁶*Id.*, p. 2.

⁸⁷*Id.*, p. 1.

⁸⁸PENAL CODE (DF), arts. 329-334. *See* also the Penal Codes of Oaxaca, Chiapas, Nuevo León, Baja California Sur, Morelos and Durango.

⁸⁹The conduct of the woman and the person who performs the abortion are penalized in all states, including the Federal District.

⁹⁰Ibanez y Garcia Velasco, José Luis. *Situación Legal del Aborto* [Legal Status of Abortion], in NUEVAS ESTRATEGIAS PARA ABORDAR EL TEMA DE LOS DERECHOS REPRODUCTIVOS [NEW STRATEGIES TO ADDRESS THE ISSUE OF REPRODUCTIVE RIGHTS] 54 (GIRE ed., 1995).

⁹¹*Id.*

⁹²*Id.*

⁹³These exceptional circumstances are recognized in the states of Guerrero and Chihuahua. *See* GIRE, CAUSALES SOBRE EL ABORTO NO PUNIBLES EN LOS CÓDIGOS PENALES DE LA REPÚBLICA MEXICANA [EXPLAINING NONCRIMINALIZED ABORTION IN THE PENAL CODES OF THE MEXICAN REPUBLIC]. Tables by Eugenia Martín Moreno. (Mexico, Oct. 1995).

⁹⁴NEW STRATEGIES, *supra*, at 54.

⁹⁵*Id.*

⁹⁶*Id.* This exception circumstance is recognized only in the Penal Code of Yucatán.

⁹⁷Comparative analysis of the Penal Codes of Chihuahua, the Federal District, Chiapas, Aguascalientes, Baja California Sur and Campeche. Most states establish a penalty of one to three years imprisonment.

⁹⁸*See* the PENAL CODE (DF), and the Penal Codes of the states of Yucatán, Jalisco, Nayarit and Zacatecas, among others.

⁹⁹*See* the PENAL CODE (DF), and the Penal Codes of the states of Yucatán, Jalisco and Nayarit, among others.

¹⁰⁰MATERNIDAD SIN RIESGOS EN MÉXICO [Maternity without Risk in Mexico], at 86 (Elu, Ma. Del Carmen and Langer, Ana (editors), Mexican Institute for Social Studies, Mexico, 1994).

¹⁰¹*Id.*

¹⁰²Chambers, Virginia (Subdirector of Programs in Latin America, IPAS, 1993), cited in LA LVI LEGISLATURA ANTE LA ÉTICA, EL DERECHO Y EL ABORTO [THE LVI LEGISLATURE ON ETHICS, LAW AND ABORTION], at 22-23 (GIRE, Mexico, 1995).

¹⁰³Mexican Institute for Social Security (IMSS), 1982-1985, cited in GIRE, *supra*, at 22.

¹⁰⁴“Características de las mujeres con un aborto en la población derechohabiente del IMSS” (Characteristics of Women Who Abort within the Population Entitled to Access to the IMSS), 1991, cited in GIRE, *supra.*, at 23.

¹⁰⁵Statistics of the National Fertility Survey (ENFES) 1987, cited in ABORTO CLANDESTINO: UNA REALIDAD LATINOAMERICANA [Clandestine Abortions: A Latinamerican Reality] (Alan Guttmacher Institute, New York, 1994).

¹⁰⁶Lucero González M., *La penalización del aborto en México* [The Criminalization of Abortion in Mexico], MUJERES Y POLÍTICA, UAM Xochimilco, No.1, Autumn 1992, México.

¹⁰⁷*Id.*, at 53.

¹⁰⁸*Id.*, at 54.

¹⁰⁹*Id.*, at 55.

¹¹⁰GIRE.

¹¹¹ORFPS, *supra*, § 6.5.7.

¹¹²STATUS OF FAMILY PLANNING, *supra*, at 3.

¹¹³ J.G. Figueroa Perea, *Anticoncepción quirúrgica, educación y elección anticonceptiva* [Surgical Contraception, Education and Contraceptive Choice], work presented to the Fourth National Meeting on Demographic Investigation in Mexico, 1990.

¹¹⁴ *Id.*

¹¹⁵ Juan Guillermo Figueroa, P., Margarita Ganado Aguilar, B. and Maía Gabriela Hita, *Una aproximación al entorno de los derechos reproductivos por medio de un enfoque de conflictos* [An Approximation of the Climate for Reproductive Rights through Focusing on Conflicts], ESTUDIOS SOCIOLÓGICOS XII:34 (1994).

¹¹⁶ *Id.*, at 141.

¹¹⁷ TRIBUNAL FOR THE DEFENSE OF REPRODUCTIVE RIGHTS, *supra* at 4-5.

¹¹⁸ Published in the Daily Gazette, Jan. 17, 1995.

¹¹⁹ For more detail on the establishments that comprise the NHS, see the section on the Infrastructure of Health Services.

¹²⁰ Regulation for the Prevention and Control of HIV Infection, § 1, on the objectives and areas of application.

¹²¹ *Id.*, § 5, on prevention measures.

¹²² *Id.*, § 6, on control measures.

¹²³ *Id.*, § 6.11.1.

¹²⁴ *Id.*, §§ 6.8-6.15. It also establishes that treatment of HIV patients must be carried out by trained personnel and that they follow the recommendations outlined in the Outpatient and Inpatient Treatment Guide for Patients with HIV/AIDS. *Id.*, § 6.11.

¹²⁵ *Id.*, § 1.3.

¹²⁶ REPRODUCTIVE HEALTH PROGRAM, *supra*, at 22.

¹²⁷ REFORM PROGRAM, *supra*, at 34.

¹²⁸ REPRODUCTIVE HEALTH PROGRAM, *supra*, at 16.

¹²⁹ *Id.*, at 23.

¹³⁰ REFORM PROGRAM, *supra*, at 34.

¹³¹ REPRODUCTIVE HEALTH PROGRAM, *supra*, at 10.

¹³² STATUS OF WOMEN, *supra*, at 48.

¹³³ *Id.*

¹³⁴ *Id.*

¹³⁵ REPRODUCTIVE HEALTH PROGRAM, *supra*, at 6.

¹³⁶ *Programa de VIH-sida y otras enfermedades de transmisión sexual* [Program for HIV/AIDS and other Sexually Transmitted Diseases], in EPIDEMIOLOGÍA, National System for Overseeing Epidemiology, Vol.14, No. 37, (September 7-13, 1997).

¹³⁷ *Id.*

¹³⁸ TRIBUNAL FOR THE DEFENSE OF REPRODUCTIVE RIGHTS. DOSSIER OF CASES, at 17-18 (Network for Women's Health in the Federal District, May 1996).

¹³⁹ MEX. CONST., art. 4.

¹⁴⁰ REPRODUCTIVE HEALTH PROGRAM, *supra*, at 14-15.

¹⁴¹ *Id.*

¹⁴² ANALYSIS OF THE FAMILY PLANNING PROGRAM, *supra*, at 6.

¹⁴³ REPRODUCTIVE HEALTH PROGRAM, *supra*, at 5.

¹⁴⁴ NATIONAL POPULATION PROGRAM, *supra*, at 3.

¹⁴⁵ ANALYSIS OF THE FAMILY PLANNING PROGRAM, *supra*, at 6.

¹⁴⁶ REPRODUCTIVE HEALTH PROGRAM, *supra*, at 5.

¹⁴⁷ *Id.*

¹⁴⁸ *Id.*

¹⁴⁹ *Id.*

¹⁵⁰ Ministry of Health, 1995.

¹⁵¹ FECUNDIDAD [Fertility] (National Institute for Geography, Statistics and Information, Mexico, 1993).

¹⁵² LA MUJER ADOLESCENTE, ADULTA, ANCIANA Y SU SALUD [The Adolescent, Adult and Elderly Woman and her Health] (Head Office for Infant Maternal Health, Ministry of Health, Mexico, 1992).

¹⁵³ *Id.*, at 110.

¹⁵⁴ MEX. CONST., art. 4.

¹⁵⁵ CIVIL CODE of the Federal District, arts. 146 and 178. (hereinafter CIVIL CODE (DF))

¹⁵⁶ *Id.*, art. 149.

¹⁵⁷ *Id.*, arts. 162 and 164.

¹⁵⁸*Id.*, art. 172.

¹⁵⁹*Id.*, art. 162.

¹⁶⁰*Id.*, art. 164.

¹⁶¹*Id.*, art. 168.

¹⁶² PENAL CODE (DF), art. 273. Adultery is penalized when it is committed in the conjugal household or if it causes a scandal.

¹⁶³ MEX. CONST., art. 4.

¹⁶⁴ Patricia Galeana, *La Violencia Intrafamiliar como Delito Tipificado [Domestic Violence as a Crime]*, in NATIONAL HUMAN RIGHTS COMMISSION, MEMORIA DE LA REUNIÓN NACIONAL SOBRE DERECHOS HUMANOS DE LA MUJER [MINUTES OF THE NATIONAL MEETING ON WOMEN'S HUMAN RIGHTS], at 19 (1st ed., Mexico City, Nov. 1995).

¹⁶⁵*Id.*

¹⁶⁶*Id.*

¹⁶⁷ CIVIL CODE (DF), art. 163.

¹⁶⁸*Id.*

¹⁶⁹*Id.*

¹⁷⁰*Id.*, art. 302. This includes: "food, clothing, shelter and assistance in the case of illness. Regarding minors, food also includes the cost of primary education." *Id.*, art. 308.

¹⁷¹*Id.*, art. 383. This article establishes that the children who fulfill the following conditions are considered the children of the partners in a concubinage: "I. Children born after 180, beginning with the first day of the concubinage period; and II. Children born 300 days after the day that the common law marriage was dissolved."

¹⁷² Ceilia Loría, *La familia mexicana de fin de siglo [The Mexican Family at the End of the Century]*, in AMBITOS DE FAMILIA, at 21-31 (UNICEF/DIF/Colmex, Mexico, 1996).

¹⁷³ Vivane Brachet, *Legislación, divorcio y pensión alimenticia [Legislation, Divorce and Alimony]*, AMBITOS DE FAMILIA, at 33-39 (UNICEF/DIF/Colmex, Mexico, 1996).

¹⁷⁴ CIVIL CODE (DF), art. 266.

¹⁷⁵*Id.*, art. 267.

¹⁷⁶*Id.*, arts. 283-288.

¹⁷⁷*Id.*, arts. 178-218.

¹⁷⁸*Id.*, art. 287.

¹⁷⁹*Id.*, arts. 323 and 288.

¹⁸⁰*Id.*, art. 286.

¹⁸¹ ALICIA ELENA PÉREZ DUARTE, DERECHO DE FAMILIA [FAMILY LAW], at 105-108 (FCE, Mexico, 1994).

¹⁸²*Id.*, at 108.

¹⁸³ STATUS OF WOMEN, *supra*, at 26.

¹⁸⁴ María de la Paz López, *Familias de jefas: los nuevos arreglos domésticos [Families with Women as Bosses: New Domestic Arrangements]*, AMBITOS DE FAMILIA (DIF/UNICEF/COLMEX, Mexico, 1997).

¹⁸⁵ CIVIL CODE (DF), arts. 148 and 149.

¹⁸⁶*Id.*, art. 149.

¹⁸⁷*Id.*

¹⁸⁸*Id.*, art. 148.

¹⁸⁹ REPRODUCTIVE HEALTH PROGRAM, *supra*, at 5.

¹⁹⁰ STATUS OF WOMEN, *supra*, at 66.

¹⁹¹*Id.*

¹⁹² LOS JÓVENES EN MÉXICO [YOUNG PEOPLE IN MÉXICO], at 39 (National Institute for Statistics, Geography and Information, Mexico, 1993).

¹⁹³ Emma Ruffo, *Uso del tiempo por parte de las niñas y niños de 7 a 14 años de edad en la Colonia Independencia del Valle de Chalco, Estado de México [How Children Between the Ages of 7 and 14 Years Use their Time in the Colonia Independencia del Valle de Chalco, in the State of México]*, *Uso del tiempo por parte de las niñas y los niños de 7 a 14 años de edad y su relación con las discriminaciones por razones de género [How Children Between the Ages of 7 and 14 Use their Time and Its Relation to Discrimination on the Basis of Gender]*, at 165-177 (compiled by Nina Chaves de Santa Cruz, UNICEF, Santafé de Bogotá, 1994).

¹⁹⁴*Id.*, at 174.

¹⁹⁵ ORFPS, *supra*, § 6.5.7.

¹⁹⁶ NORMA OFICIAL MEXICANA DE LOS SERVICIOS DE PLANIFICACIÓN FAMILIAR [OFFICIAL STANDARDS FOR FAMILY PLANNING SERVICES], published in the Federation's Official Report, Monday, May 30, 1994, at 353.

- ¹⁹⁷ MARCELA MARTINEZ ROARO, DELITOS SEXUALES, SEXUALIDAD Y DERECHO [SEX CRIMES, SEXUALITY AND LAW], at 232 (4th ed., Mexico, Editorial Porrúa, n.d.).
- ¹⁹⁸ *Id.*
- ¹⁹⁹ See PENAL CODE (DF), tit. XV.
- ²⁰⁰ *Id.*, art. 265.
- ²⁰¹ *Id.*
- ²⁰² *Id.*, art. 266.
- ²⁰³ *Id.*
- ²⁰⁴ Martinez Roaro, *supra*, at 232.
- ²⁰⁵ Por ejemplo, el Código Penal de Puebla (art. 252).
- ²⁰⁶ This is the case, for example, in the states of Mexico, Michoacán and Zacatecas. SEX CRIMES, *supra* note 294, at 248.
- ²⁰⁷ See the Penal Codes of the states of Aguascalientes, Campeche, Puebla and Yucatán.
- ²⁰⁸ See the Penal Codes of the states of Veracruz and Zacatecas.
- ²⁰⁹ PENAL CODE (DF), art. 267.
- ²¹⁰ PENAL CODE (DF), art. 266.
- ²¹¹ SEX CRIMES, *supra*, at 212-213.
- ²¹² Penal Code of the state of Mexico, *Id.*, at 212.
- ²¹³ Penal Codes of the states of Michoacán, Guerrero, Sonora, Tamaulipas and Veracruz. *Id.*
- ²¹⁴ PENAL CODE (DF), art. 261.
- ²¹⁵ *Id.*, art. 262.
- ²¹⁶ SEX CRIMES, *supra*, at 221.
- ²¹⁷ *Id.*
- ²¹⁸ *Id.*, at 229.
- ²¹⁹ PENAL CODE (DF), art. 263.
- ²²⁰ PENAL CODE (DF), art. 259b.
- ²²¹ *Id.*
- ²²² *Id.*
- ²²³ *Id.*
- ²²⁴ *Id.*
- ²²⁵ STATUS OF WOMEN, *supra*, at 38.
- ²²⁶ *Id.*
- ²²⁷ *Id.*
- ²²⁸ *Domestic Violence as a Crime*, *supra*, at 20.
- ²²⁹ STATUS OF WOMEN, *supra*, at 38-39.
- ²³⁰ *Domestic Violence as a Crime*, *supra*, at 22.
- ²³¹ *Id.*
- ²³² PATRICIA DUARTE, LA LUCHA CONTRA LA VIOLENCIA DE GÉNERO EN MÉXICO [THE STRUGGLE AGAINST GENDER VIOLENCE IN MEXICO], at 20 (Committee for the Promotion of Maternity without Risks, Mexico, 1997).
- ²³³ GERARDO GONZÁLEZ ASCENCIO, LA ANTESALA DE LA JUSTICIA: LA VIOLACIÓN EN LOS DOMINIOS DEL MINISTERIO PÚBLICO [THE WAITING ROOM OF JUSTICE: RAPE IN THE DOMAIN OF THE ATTORNEY GENERAL'S OFFICE] (COVAC, Mexico, 1993).
- ²³⁴ *Id.*, at 16.
- ²³⁵ *Id.*, at 19.
- ²³⁶ *Id.*, at 22.
- ²³⁷ The newspaper *La Jornada*, 28/10/97, at 43.
- ²³⁸ InterPress Service News Agency, 5 (103) IPS DAILY J, June 17, 1997, at 5.
- ²³⁹ Jurisprudence 10/94. First Court, 8th stage. Gaceta #77, May 1994, at 18.
- ²⁴⁰ In 1995, only the state of Querétaro recognized, in art. 164, the penalty for rape between spouses. See *Domestic Violence as a Crime*, *supra*, at 21.
- ²⁴¹ *Domestic Violence as a Crime*, *supra*, at 19.
- ²⁴² *Id.*
- ²⁴³ Decree of the Assembly of Representatives of the Federal District, promulgated April 26, 1996 and published on July 9, 1996 in the Daily Gazette.
- ²⁴⁴ *Id.*, art. 1.
- ²⁴⁵ *Id.*, art. 3, § III.

²⁴⁶*Id.*, art. 3, § III, sub§ c.

²⁴⁷*Id.*

²⁴⁸This is the responsibility of the police stations in the FD. The official designated as conciliator should seek the conciliation of the parties “by providing them with a series of alternatives and exhorting them to conciliate by informing them of the consequences of persisting in their conflict [...] If the parties reach an agreement a contract will be signed. *Id.*, art. 20.

²⁴⁹This is the responsibility of the police stations in the FD. The official designated as friendly arbiter will listen to the parties, who will offer proof and arguments, after which the official will emit a resolution. *Id.*, art. 22.

²⁵⁰*Id.*, art. 25.

²⁵¹Penal Code of the state of Hidalgo, art. 143. *Domestic Violence as a Crime*, *supra*, at 19.

²⁵²*Id.*

²⁵³PENAL CODE (DF), tit. XIX, Crimes Against Life and Physical Integrity, arts. 288-301.

²⁵⁴*Id.*, art. 288.

²⁵⁵*Id.*, arts. 289-301.

²⁵⁶In 1995, only the state of Querétaro recognized, in art. 164, the penalty for rape between spouses. *See Domestic Violence as a Crime*, *supra*, at 21.

²⁵⁷*Id.*, at 20.

²⁵⁸*Id.*

²⁵⁹STATUS OF WOMEN, *supra*, at 39.

²⁶⁰Patricia Olamendi Torres, *La violencia contra la mujer en México*, FEM, Year 21, No.171, June 1997.

²⁶¹STATUS OF WOMEN, *supra*, at 40.

²⁶²*Id.*

²⁶³Olamendi Torres, Patricia, *supra*.

²⁶⁴Figueroa Perea, J.G., *Algunas reflexiones sobre el ejercicio de los derechos reproductivos en el ámbito de las instituciones de la salud* [Reflections on the Exercise of Reproductive Rights Within the Ambit of the Health Institutions], CALIDAD DE ATENCIÓN EN SALUD SEXUAL Y REPRODUCTIVA, at 20 (Committee for the Promotion of Maternity without Risks in Mexico, Mexico, 1997).

²⁶⁵SURGICAL CONTRACEPTION, *supra*.

²⁶⁶TRIBUNAL FOR THE DEFENSE OF REPRODUCTIVE RIGHTS. DOSSIER OF CASES, *supra*, at 12.

²⁶⁷MEX. CONST., art. 3.

²⁶⁸*Id.*

²⁶⁹NATIONAL WOMEN’S PROGRAM, *supra*, at 15. Between 1981 and 1994, the number of women with secondary education to every one hundred men went from 89 to 95. The number of women with higher education to every one hundred men went from 76 in 1991 to 82 in 1995.

²⁷⁰*Id.*, at 13.

²⁷¹*Id.*

²⁷²*Id.*, at 15-17.

²⁷³*Id.* at 15.

²⁷⁴STATUS OF WOMEN, *supra*, at 12-14.

²⁷⁵LOS JÓVENES EN MÉXICO, *supra*.

²⁷⁶*How Children Between Seven and Fourteen...*, *supra*, at 165-177.

²⁷⁷FEDERAL EXECUTIVE BRANCH, PROGRAMA DE DESARROLLO EDUCATIVO, 1995-2000 [PROGRAM OF EDUCATIONAL DEVELOPMENT, 1995-2000] (Mexico, 1995).

²⁷⁸REFORM PROGRAM, *supra*, at 32.

²⁷⁹*Program for the Promotion of Health*, EPIDEMIOLOGÍA, Vol. 14, Week of October 12-18, 1997, at 1 (National System for the Supervision of Epidemics).

²⁸⁰J.G. HGUEROA PEREA, DERECHOS REPRODUCTIVOS Y EL ESPACIO DE LAS INSTITUCIONES DE SALUD: ALGUNOS APUNTES DE LA EXPERIENCIA MEXICANA [REPRODUCTIVE RIGHTS AND THE ROLE OF THE HEALTH INSTITUTIONS: SOME POINTS ON THE MEXICAN EXPERIENCE] (1994).

²⁸¹Rodolfo, Tuirán, *Comunicación en población y procesos de difusión* [Mass Communication and Processes of Dissemination], DEMOS, No. 9, 1996, at 26.

²⁸²MEX. CONST., art. 123.

²⁸³*Id.*, section VII.

²⁸⁴*Id.*, art. 123.

²⁸⁵*Id.*, section V. *See* also arts. 166-167 of the Federal Work Law.

²⁸⁶*Id.* See also art. 170 of the Federal Work Law.

²⁸⁷Law published in the Daily Gazette, Apr. 1, 1970.

²⁸⁸*Id.*, art. 164.

²⁸⁹*Id.*, art. 170, fractions II and V.

²⁹⁰MEX. CONST., art. 123. See also art. 170 of the Federal Work Law.

²⁹¹MEX. CONST., art. 123, fraction V. See also art. 170 of the Federal Work Law.

²⁹²*No Guarantees. Sex Discrimination in Mexico's Maquiladora Sector*, Vol 8., No.6 (Human Rights Watch, August, 1996, Internet document).

²⁹³TRIBUNAL FOR THE DEFENSE OF REPRODUCTIVE RIGHTS. DOSSIER OF CASES, *supra*.