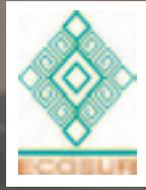


PHR

Physicians for
Human Rights



A report by:

Physicians for Human Rights

El Colegio de la Frontera Sur

Centro de Capacitación en Ecología y
Salud para Campesinos-Defensoría del
Derecho a la Salud

**EXCLUDED PEOPLE,
ERODED COMMUNITIES**
Realizing the Right to Health
in Chiapas, Mexico



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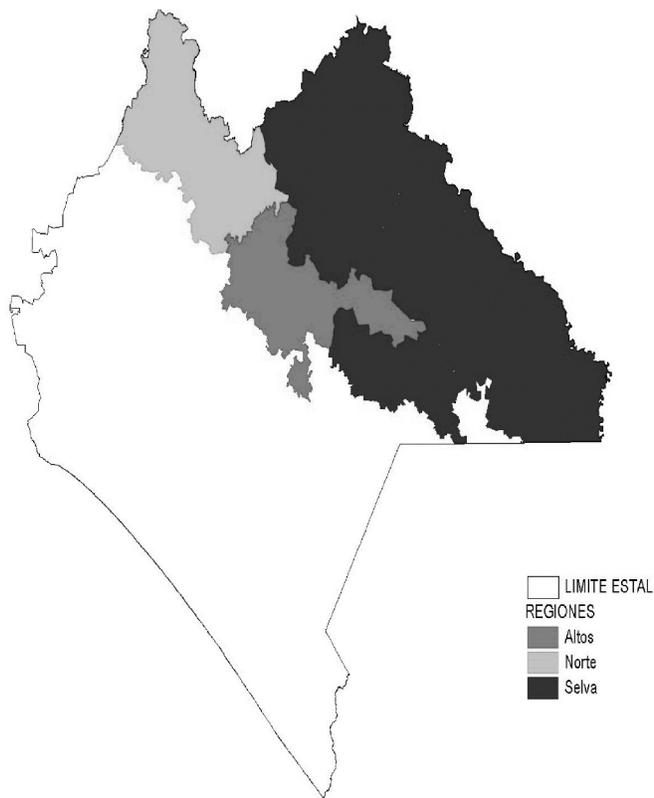
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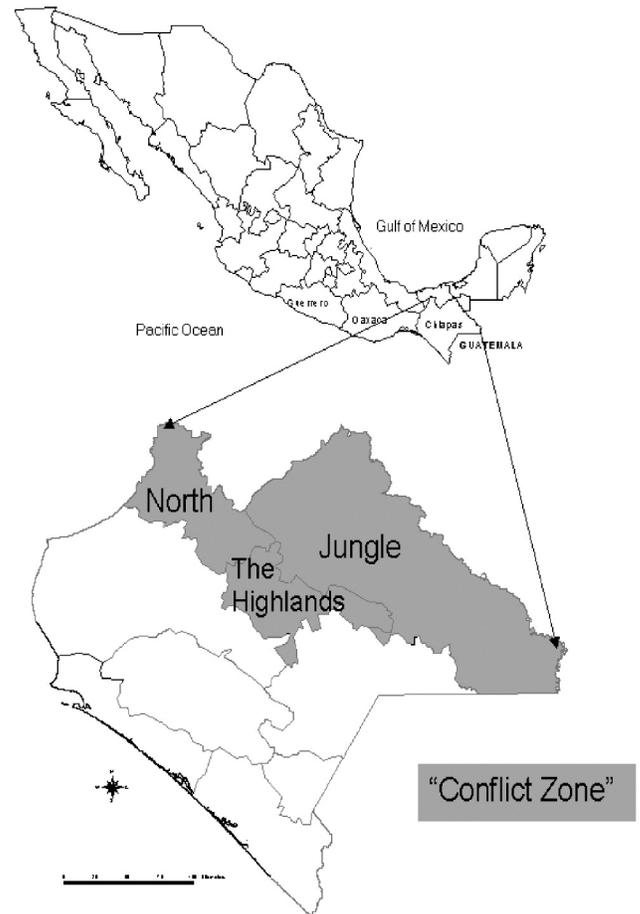
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MAPS



Areas of Chiapas in which Study Occurred ("conflict zone")



Chiapas, in Relation to Mexico (with conflict zone enlarged)

GLOSSARY OF TERMS AND ACRONYMS

Autonomous Councils: Governing councils of the “autonomous” EZLN-supporting communities.

Campesino: Rural worker, typically agricultural, often translated as “peasant.”

CCESC: Center for Training in Ecology and Health for *Campesinos* (Centro de Capacitación en Ecología y Salud para Campesinos).

CDHFBC: Fray Bartolomé de las Casas Center for Human Rights.

CIEPAC: Centre for Research on Economic and Political Community Action (Centro de Investigaciones Económicas y Políticas de Acción Comunitaria).

CONAPO: National Council on Population (Consejo Nacional de Población).

CONPAZ: Coordinating Body of Non-Governmental Organizations for Peace (Coordinación de Organismos no gubernamentales por la Paz).

DDS: Right to Health Defense Group (Defensoría del Derecho a la Salud).

ECOSUR: The College of the Southern Border, an academic and research institution (El Colegio de la Frontera Sur).

ENAL: National Survey on Food and Nutrition (Encuesta Nacional de Alimentación y Nutrición).

ENN: National Survey on Nutrition (Encuesta Nacional de Nutrición).

EZLN: Zapatista Army for National Liberation (Ejército Zapatista de Liberación Nacional).

ICRC: International Committee of the Red Cross.

IMSS: Mexican Institute for “Social Security” or work-related health insurance (Instituto Mexicano del Seguro Social).

IMSS-OPORTUNIDADES: Government health program aimed at providing health care to people living in extreme poverty in rural areas. This program is administered through IMSS, although it targets the uninsured population. This program was first created as IMSS-COPLAMAR and, under President Salinas, it was then renamed IMSS-Solidaridad in the late 1980s. President Fox changed the name to IMSS-OPORTUNIDADES after taking office in 2000.

IMSS-SOLIDARIDAD: The health branch of Solidaridad, it is managed by the Mexican Institute for Social Security and funded by general government revenues. IMSS provides administrative direction.

INEGI: National Institute for Geographic Statistics and Information (Instituto Nacional de Estadística Geografía e Informática).

ISECH: State of Chiapas Health Institute, responsible for providing health services to the uninsured population of Chiapas (Instituto de Salud del Estado de Chiapas).

OPORTUNIDADES: Former name of PROGRESA. A government anti-poverty program providing households with cash transfers linked to regular school attendance and health clinic visits.

PAN: National Action Party, center-right political party which President Fox represented in the 2000 presidential elections (Partido Acción Nacional).

PHR: Physicians for Human Rights.

PRD: Party of the Democratic Revolution, center-left opposition political party (Partido de la Revolución Democrática).

PRI: Institutional Revolutionary Party, party that ruled Mexico for seventy-five uninterrupted years and still governs in many state and local areas (Partido Revolucionario Institucional).

PRONASOL: National Solidarity Program (Programa Nacional de Solidaridad), successor of COPLAMAR, was established by President Salinas in 1988 and also

served as an umbrella organization to promote health care, education and basic infrastructure.

PROGRESA: Program for Education, Health and Nutrition for Rural and Urban Poor (Programa de Educación, Salud y Alimentación); was implemented in 1997 by President Zedillo's government as a program for developing the human capital of poor households.

PTB: Pulmonary Tuberculosis.

Región Altos: Mountainous region in the central highlands of Chiapas. It has the highest concentration of indigenous people in Chiapas and the highest levels of poverty in the country.

Región Norte: A mostly Chol-speaking area in the north of Chiapas that borders the state of Tabasco; formerly jungle, it is now largely used for cattle grazing.

Región Selva: Region of Chiapas close to the border with Guatemala, which previously was almost entirely rainforest.

Resistance: The Zapatista form of civil disobedience, which emerged after political negotiation between the

EZLN and federal government failed. In its pure form, it calls for the refusal of collaboration with the Government and rejection of official programs, including those for health and education.

SSA: Ministry of Health (Secretaría de Salud).

Seguro Popular: Popular Insurance. The new federal program to provide health insurance coverage to the uninsured, created by the Fox administration.

SOLIDARIDAD: Solidarity for Social Well-being (Solidaridad para el Bienestar Social) was previously the service aspect of PRONASOL. It contained a wide range of programs that included education, health care, water, sewerage, and electrification projects; urbanization improvements; and low-income housing.

UNDP: United Nations Development Programme.

UNICEF: United Nations Children's Fund.

WHO: World Health Organization.

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Physicians for Human Rights

Physicians for Human Rights (PHR) mobilizes health professionals to advance the health and dignity of all people through action that promotes respect for, protection of, and fulfillment of human rights.

Since 1986, PHR members have worked to stop torture, disappearances, and political killings by governments and opposition groups and to investigate and expose violations, including: deaths, injuries, and trauma inflicted on civilians during conflicts; suffering and deprivation, including denial of access to health care, caused by ethnic and racial discrimination; mental and physical anguish inflicted on women by abuse; exploitation of children in labor practices; loss of life or limb from landmines and other indiscriminate weapons; harsh methods of incarceration in prisons and detention centers; and poor health stemming from vast inequalities in societies.

As one of the original steering committee members of the International Campaign to Ban Landmines, PHR shared the 1997 Nobel Peace Prize.

www.phrusa.org

El Colegio de la Frontera Sur

El Colegio de la Frontera Sur is a multidisciplinary public research and post-graduate educational institution, which focuses on development and cross-border issues on the southern border of Mexico. Its programs are oriented towards the generation of scientific knowledge, training human resources, and the design of techniques and strategies that contribute to sustainable development.

Centro de Capacitación en Ecología y Salud para Campesino

CCESC-DDS (Centro de Capacitación en Ecología y Salud para Campesino) was created in 1985 to support the work of physicians and researchers during the humanitarian emergency that followed the eruption of the Chichonal volcano, and to attend to the health needs of Guatemalan refugees and internally displaced populations. The Right to Health Defense Group merged with CCESC more recently. In 2005, CCESC received the Sasakawa Award at the World Health Assembly for its more than 20 years of work on behalf of the indigenous communities of Chiapas.

I. EXECUTIVE SUMMARY

This report analyzes health conditions and access to care in the conflict zone in the southern state of Chiapas, taking into account the Mexican government's obligations to respect, protect and fulfill the right to health of all its citizens — including its most marginalized indigenous populations. The report found alarmingly high rates of childhood malnutrition, pulmonary tuberculosis and maternal mortality, inadequate living conditions, lack of access to potable water and basic sanitation, and significant barriers to care. Ensuring the right to health in Chiapas for people of all political affiliations is not a peripheral or merely humanitarian concern. Rather, it is a matter of justice. As the United Nations (UN) Millennium Project Task Force Report on Child Health and Maternal Health states: "health claims—claims of entitlement to health care and enabling conditions—are assets of citizenship."¹ With the approach of the 2006 elections, Mexico has a historic opportunity to confront the unacceptable health and social situation in the conflict zone in Chiapas as well as to revisit reforms to enable indigenous people in Chiapas and elsewhere in Mexico to participate as truly equal citizens in a substantive democracy.

Although the report discusses findings of a particular study conducted by Physicians for Human Rights (PHR), El Colegio de la Frontera Sur (ECOSUR) and el Centro de Capacitación en Ecología y Salud para Campesinos-Defensoría del Derecho a la Salud (CCESC-DDS) in the conflict zone, many of the findings of this report are directly related to central human rights issues facing Mexico today. The conflict zone in Chiapas dramatically illustrates the effects of militarization and violence on the provision and use of health care services, as well as on health status. Guerrero, Oaxaca and other states of Mexico have also suffered from the impact of militarization and violence. The discriminatory allocation and exploitation of health and other social services for political ends, which is documented in this report, is not exclusive to Chiapas and continues to pervade Mexican society even after the end of more than seventy years of uninterrupted rule by the PRI party. Finally, the multiple dimensions of exclusion faced by indigenous peoples in Chiapas are mir-

rored in the health and social conditions of indigenous peoples across the country. This exclusion reflects the challenges the country faces in building a genuinely inclusive, equitable democracy.²

Historical Background

On New Year's Day in 1994, the Zapatista Army for National Liberation (EZLN or Zapatistas) staged an armed uprising in Chiapas, Mexico on behalf of the indigenous populations of the state whose rights, in particular economic and social rights, they claimed to be defending. Poor health conditions and services for the indigenous communities of Chiapas were an underlying cause of the Zapatista rebellion. After the intense combat that took place between the EZLN and the Mexican Federal Army during the first twelve days of 1994, a low-intensity conflict evolved and essentially has remained in force over a decade later. As documented in PHR's 1999 report, health care came to be held hostage between the Zapatistas' practice of "resistance," which was a concerted policy of rejecting governmental programs, including health programs, on the one hand, and the government's politicized provision of health services on the other.³

In 2000-01, the Mexican institutions, El Colegio de la Frontera Sur (ECOSUR) and el Centro de Capacitación en Ecología y Salud para Campesinos-Defensoría del Derecho a la Salud (CCESC-DDS), joined together on a collaborative study with Physicians for Human Rights (PHR), which had issued three previous reports relating to Chiapas since the EZLN uprising. ECOSUR, CCESC-DDS and PHR carried out a population-based study to assess health conditions, nutrition, and access to and use of health services, as well as to evaluate how the intra- and inter- community tensions spawned by the low-intensity conflict affected people's health and attitudes about health services. It was beyond the scope of

¹ "Who's got the power: transforming health systems for women and children." *Millennium Project Task Force Report on Child Health and Maternal Health*; 2005. 11.

² See e.g. Lozano R, Zurita B, Franco F, Ramírez T, Hernández P, Torres JL. "Mexico: Marginality, Need, and Resource Allocation at the Country Level." In: Evans T, Whitehead M, Diderichsen F, Bhuiya A, Wirth M, eds. *Challenging Inequities in Health: From Ethics to Action*. New York: Oxford University Press; 2001:271-295.

³ Yamin AE, Penchaszadeh V, Crane T, *Health Care Held Hostage: Violations of Medical Neutrality and Human Rights in Chiapas, Mexico*. Boston: Physicians for Human Rights, 1998.

this study to determine the precise impact of the conflict per se on health status. Subsequently, data collected in the study has been supplemented by more recent national statistics, human rights and policy information to help examine health conditions, as well as availability and use of services, in light of Mexico's obligations under international law with respect to the right to health.⁴

Allocation of Health Resources and Health Indicators

Mexico is a middle-income country and a member of the Organization for Economic Cooperation and Development (OECD). However, Mexico's total health spending accounted for 6.2% of Gross Domestic Product (GDP) in 2003, which places it among the OECD countries with the lowest expenditure on health. Of all OECD countries, Mexico has the second lowest share of health spending paid for by public sources, which means that people are paying out-of-pocket for their health care.⁵ Moreover, Mexico is highly unequal in terms of both income distribution and allocation of health resources. For example, Mexico is ranked as the 15th most unequal country in the world according to the United Nations Development Programme's GINI index, which makes it more unequal than Mali, Niger and Zambia.⁶

⁴ While this report emphasizes the violations of the right to health of all the indigenous people living in the conflict zone, articles based on a more in-depth review of the study findings have been published.: Sánchez Pérez HJ, Hernán M, Ríos-González A, Arana-Cedeño M. et al. "Malnutrition among children under five years of age in conflict zones of Chiapas, Mexico." *American Journal of Public Health*. forthcoming 2006; Brentlinger P, Sánchez-Pérez HJ, Arana-Cedeño M, Vargas HG, Hernán MA, Micek M, Ford D. "Pregnancy Outcomes, Site of Delivery, and Community Schisms in Regions Affected by the Armed Conflict in Chiapas, Mexico; A Community-based Survey." *Social Science and Medicine*. 2005;61:1001-1014.

⁵ It was 46.4 percent in 2003, after the United States. See "OECD Health Data 2005: How Does Mexico Compare?" *OECD Health Data 2005: Statistics and Indicators for 30 Countries*. June 8, 2005. Available at: <http://www.oecd.org/dataoecd/16/2/34970198.pdf>. Accessed March 15, 2006.

⁶ "Inequality in Income or Consumption." *Human Development Reports 2005*. United Nations Development Programme. Available at: <http://hdr.undp.org/statistics/data/indicators.cfm?x=14&8&y=2&z=2>. Accessed March 15, 2006.

⁷ Lavielle B, Lara G, Diaz D, *Curitas para la Salud: El mapa de la inequidad*. Fundar. 2001, pp. 48-62; Lozano R, Zurita B, Franco F, Ramirez T, Hernandez P, Torres JL. "Mexico: Marginality, Need and Resource Allocation at the County Level." In: Evans T, Whitehead M, Diderichsen F, Bhuiya A, Wirth M, eds, *Challenging Inequities in Health: From Ethics to Action*. New York: Oxford University Press; 2001:277-295, 290.; Hernandez-Peña P, Zapata O, Leyva R, Lozano R. "Equidad y salud: necesidades de investigación para la formulación de una política social." *Salud Pública de México*. 1991;33:9-17.

The country's allocation of health resources, rather than alleviating inequities, is inversely correlated with poverty and marginality.⁷ Other studies have found that public health expenditures are as much as twelve times higher per capita for the insured—who are formally employed—than the uninsured in Mexico.⁸

Chiapas is the Mexican state that receives the lowest amount of health resources per capita.⁹ Apart from the federal district, where tertiary care hospitals dramatically increase health care per capita spending, there are stark differences between Chiapas (581 pesos per capita) and other states, such as, Baja California Sur (2255 pesos per capita).¹⁰ Chiapas also has the lowest number of inhabitants covered by some form of social security (i.e., employment-related health insurance): barely 17.6% versus 40.1% for the entire country.¹¹ In this study, the proportion of inhabitants without any insurance was over 92% for all types of communities studied.

In Chiapas, which is one of the poorest states in the country as well as one of the most highly indigenous, marginalization and lack of health care resources are reflected in poor health indicators. According to official government statistics, Chiapas ranks toward the bottom among all Mexican states in terms of both infant and child mortality and has the country's highest maternal mortality ratio and the highest proportion of mortality due to infectious diseases.¹² Sixty-eight percent of the population lives without access to potable water and 62.3% does not have adequate sanitation. In 2003, Chiapas had the highest mortality (among both women and men) associated with diarrheal diseases, acute respiratory infections, and pulmonary tuberculo-

⁸ Lozano R, Zurita B, Franco F, Ramirez T, Hernandez P, Torres JL. "Mexico: Marginality, Need, and Resource Allocation at the Country Level." In: Evans T, Whitehead M, Diderichsen F, Bhuiya A, Wirth M, eds. *Challenging Inequities in Health: From Ethics to Action*. New York: Oxford University Press; 2001:271-295.

⁹ Lavielle B, Lara G, Diaz D, *Curitas para la Salud: El mapa de la inequidad*. Fundar. 2001: 48-62.

¹⁰ Numbers reflect entire health "Función 08" federal spending, The "Ramo 33" federal spending within Función 08 is also highly inequitable. Lavielle, B, Lara G, Diaz D, *Curitas para la Salud: El mapa de la inequidad*, Fundar. 2001: 48-62, at 49, 52.

¹¹ Sánchez-Pérez HJ. *Tuberculosis pulmonar en zonas de alta marginación socioeconómica de Chiapas, México: Problemas y retos a superar: El caso de la Región Fronteriza*. Doctoral thesis. Barcelona: Universidad Autónoma de Barcelona, 1999; Consejo Nacional de Población (CONAPO). 2001. Available at: <http://www.conapo.gob.mx>. Accessed November 7, 2005.

¹² Rankings are done according to least mortality to greatest and therefore, Chiapas ranks among the worst states. *Perspectiva Estadística*. Chiapas. September 2005. Available at: <http://www.inegi.gob.mx/lib/buscador/busqueda.asp?s=inegi&texto=mortalidad%20de%20ni%F1os&seccionB=docit&i>. Accessed November 6, 2005.

sis, as well as among women with cervical cancer.¹³ Virtually a quarter (24.5%) of people die without receiving medical care. Chiapas, together with Oaxaca, rank highest in this regard.¹⁴ As this report shows, however, the regions of Chiapas most affected by the conflict have fared even worse than the rest of Chiapas state.

The investigation in the conflict zone consisted of a household survey and in-depth structured questionnaires for community leaders. The household survey yielded information on health indicators (including mortality, morbidity, nutrition) and the access and use of health services for 2,997 households from forty-six communities in the Altos, Selva, and Norte regions of Chiapas. The study compared health conditions, access to health services, and attitudes about health services among three types of communities: 1) opposition communities, 2) pro-government communities, and 3) divided communities fragmented along political lines related to the conflict, which contained both opposition and pro-government groups. The results of the two surveys of households and community leaders were combined with other qualitative data to provide a picture of the health conditions in the areas that have been most affected by the conflict in Chiapas.

The study drew on information from human rights and non-governmental organizations, churches, newspapers, and official sources to identify the political affiliation of all the communities with between 300 and 2,500 inhabitants in the designated regions. From this list, eighteen opposition communities, eighteen pro-government communities, and eighteen divided communities were randomly selected from each region, yielding a sample of fifty-four communities. In addition, eighteen additional communities were randomly chosen to serve as alternates for communities that might refuse to participate. Ultimately, forty-six communities in the three aforementioned regions participated in the study. Within the selected communities, households were chosen according to two criteria: one randomly systematic (one out of every three), and the other based

on the households identified with possible cases of pulmonary tuberculosis or where a death had occurred in the two years prior to the study.¹⁵ In all, information from 17,931 individuals was obtained from 2,997 households surveyed.

Findings

The findings of the study that are included in this report and analyzed in regard to Mexico's right to health obligations relate to selected demographic and socio-economic conditions, selected social determinants of health, maternal health (including prenatal care, obstetric care and maternal mortality), child health (including vaccination coverage and malnutrition), pulmonary tuberculosis in persons aged fifteen and above, and the availability and use of health services for self-perceived morbidity in the month prior to the study.

Demographics/Education

The population of the regions studied is very young, with 47% under age fifteen. Between 80% and 99% of the people are indigenous and nearly half of them do not speak Spanish. Of the population surveyed, 36% did not know how to read or write. Among the population that was of school age when the conflict began, only one out of five had gone beyond primary school. Females over fifteen had an average of 2.68 years of education and almost half of women and girls over fifteen (43%) had no schooling at all. In contrast, national statistics claim that 88.6% of women in Mexico are literate.¹⁶

Living Conditions

Dwelling conditions were precarious in all three groups, although certain negative characteristics such as greater crowding and dirt floors were more prevalent in the divided communities. Half of the opposition communities lacked access to clean water, while one in three lacked this service in the other two types of communities.

Vaccination Schemes

In the conflict zone, 23% of the children have not completed their vaccination schemes, a number far higher than the official figures, which is under 5%. This disturbingly low coverage is attributable to lack of

¹³ Secretaría de Salud (SSA), Dirección General de Información en Salud. "Estadísticas de mortalidad en México: muertes registradas en el año 2003." *Salud Pública de México* 2005;47(2):171-178. The comparisons between Chiapas and the national averages are telling. The rates for women (per 100,000) were as follows: diarrheal diseases: national (5.0) v. Chiapas (17.8); acute respiratory infections: national (15.6) v. Chiapas (23.7); pulmonary tuberculosis: national (2.2) v. Chiapas (6.7); cervical cancer: national (11.2) v. Chiapas (18.5). The rates for men (per 100,000) were as follows: diarrheal diseases: national (5.6) v. Chiapas (22.5); acute respiratory infections: national (21.0) v. Chiapas (32.0); pulmonary tuberculosis: national (5.1) v. Chiapas (11.1).

¹⁴ Secretaría de Salud (SSA), Dirección General de Información en Salud. "Estadísticas de mortalidad en México: muertes registradas en el año 2003." *Salud Pública de México* 2005;47(2):171-178. Oaxaca had 23.0 percent.

¹⁵ All households were asked about members exhibiting certain symptoms and those identified households were then surveyed with respect to PTB.

¹⁶ Instituto Nacional de Estadística Geografía e Informática (INEGI). *XII Censo General de Población y Vivienda, 2000. Tabulados Básicos Nacionales y por Entidad Federativa. Base de Datos y Tabulados de la Muestra Censal*. Aguascalientes: INEGI 2001. Available at: <http://www.inegi.gob.mx/est/contenidos/espanol/rutinas/ept.asp?t=medu25&c=3293>. Accessed November 7, 2005.

knowledge about the importance of vaccinations, lack of access to health services, and for almost one quarter of the respondents, distrust towards government health services or reasons related to the conflict. In addition, 4% cited the government's placing of conditions on the granting of health services.

Malnutrition

The overall rate of malnutrition according to the height-for-age index (stunting) was an alarming 54.7%, which is among the highest found in any study within the country and places the area studied in line with low human development countries.¹⁷ According to the weight-for-age index (underweight), the level of malnutrition was 21%. The overall rate of wasting (weight-for-height) was 3%.

Maternal Health

With respect to maternal health, the investigation documented the death of eight women in the previous two years. The gross estimated rate of maternal mortality was 607 per 100,000 live births, a number at least seven times higher than that calculated by the health sector for Chiapas and for the whole country. This high maternal mortality ratio can be considered an indicator of the inadequate organization and operation of health services in the region, as well as the marginalization of women.

The majority of women (60%) only received prenatal care from traditional birth attendants. Approximately one-third sought prenatal care by some form of personnel in the health system, and 6.5% either received no prenatal care whatsoever or were attended by persons other than health personnel. Only 16% of all child-births occurred in public health facilities, while 74% were attended by traditional birth attendants, 7% by family members or neighbors, and 1.4% delivered on their own. Women in divided communities used government health services the least. Nearly nine out of ten deliveries took place in women's homes (85%). The high rate of home birth is due not only to cultural reasons, but also to obstacles to care related to the conflict and to the perception of the low quality of care in health services. The study found nine cases in which health services refused to attend births (0.7%).

Pulmonary Tuberculosis

In the forty-six studied communities, pulmonary

tuberculosis (PTB) was detected in 29 people, of whom only 13, or fewer than half, had been identified by health services and were being treated. The unadjusted overall rate of PTB for the population, taking into account estimated total inhabitants, was at least 85.3 per 100,000 and 161.2 for those age 15 and older, almost three times the rate reported for the entire state.

Of the 29 PTB-positive cases identified, four had not received any medical care. Of the 25 who had received it, 22 had done so in government health services and three in private services. Of these 25 cases, 10 had not received any diagnosis, 13 had been diagnosed with PTB, and two had received a diagnosis other than PTB. Of the 13 cases which had been diagnosed by health services, one had not received any anti-tuberculosis treatment, six were receiving it, and six had stopped compliance with their anti-TB treatment. In short, severe deficiencies were found in the detection and anti-tuberculosis treatment of PTB patients.

Access to Health Care

In cases of self-reported illness within the last month, three out of every ten persons did not seek any health care (government or other), while six out of every ten sought government-provided health care. As to the reasons for not using government health facilities, members of opposition communities most often mentioned lack of medicines and problems related to the conflict, such as receiving treatment only if certain conditional demands were met, or being denied treatment all together. People in pro-government communities repeatedly noted their distrust of services as well as the lack of care and transportation. In divided communities, economic constraints on using any health service were most often mentioned. The investigation determined that communities divided by the conflict have diminished capacity to respond collectively to serious health needs, such as arranging for transportation for women in the event of obstetric emergencies.

Social Polarization and Marginalization

The findings of the study suggest that during the first six years of the conflict, the politicization of government services, including those related to health, on the one hand, and the civil resistance, on the other, functioned in unfortunate synergy to create ever greater social polarization within regions, communities, organizations, and even families. Profound divisions increasingly arose within and among hundreds of communities in Chiapas, which had previously been distinguished for their high level of social cohesion and organization. Among other things, the use or rejection of specific health services presupposed a specific political sympha-

¹⁷ The UN Development Programme Human Development Report for 1995-2003 shows that Mexico has 18% of children under height for their age. Mexico lags behind Libya (15%), Thailand (16%), and United Arab Emirates (17%), scores the same as Algeria, and comes in just ahead of Congo (19%). Available at: <http://hdr.undp.org/statistics/data/indicators.cfm?x=66&y=1&z=1>. Accessed November 6, 2005.

thy or militancy. As the report discusses, this erosion of communities has persisted and intensified throughout the duration of the conflict.¹⁸

Social erosion in communities in Chiapas illustrates the effect of national policies that exclude entire sectors of the Mexican population from participation in democratic decision-making, including decisions on health services. On the macro-level, the information reported in this study reflects the profound degree of marginalization of the overwhelmingly indigenous people residing in the conflict zone. This marginalization can be found elsewhere in the country, which has been documented by others.¹⁹ This trend of marginalization, in turn, reflects failures of governance and democracy.²⁰ According to the UNDP: "Participating in the rules and institutions that shape one's community is a basic human right *and* part of human development. More inclusive governance can be more effective. When local people are consulted about the location of a health clinic, for example, there is a better chance it will be built in the right place."²¹ Human and economic development in Chiapas will require meaningful participation by all citizens, including improved health conditions, that recognize indigenous autonomy and self-determination. Such inclusiveness and democratic participation is required by international instruments to which Mexico has voluntarily bound itself.

Compliance with Right to Health Obligations

Currently, the Mexican government is not meeting its obligations under international law with respect to the right to health. Realizing the right to health requires not only avoiding retrogression but deliberate steps to make adequate progress. It also demands non-discrimination and equality; meaningful popular participation in all levels of decision-making about health,

accountability and multi-sectoral strategies that link questions of health to sustainable development and active citizenship.

First, the Mexican government is not complying with minimum core obligations or making adequate progress toward the realization of the right to the highest attainable standard of physical and mental health. The deplorable health conditions and egregious inequities that in some ways gave rise to the Zapatista uprising are still in effect. The largely indigenous people in the study are often deprived of available, accessible, acceptable, and quality health facilities, goods and services, including preconditions to health. Providing access to such health services and goods constitute state obligations in accordance with General Comment 14 issued by the United Nations Committee on Economic, Social and Cultural Rights.²² Governmental health programs have not adequately addressed these failures, and for the majority of the population in the conflict zone, whether engaged in resistance or not, health conditions remain alarmingly sub-standard.

Second, the study highlighted some of the effects of discrimination and structural inequalities faced by the largely indigenous populations in the conflict zone. The fragmentation of communities and politicization of care and other governmental services over the years since the conflict began has had grave implications for the accessibility and utilization of health services in the region. The investigators also learned of repeated allegations of individual health practitioners discriminating against patients on the basis of political affiliation and, more frequently, on the basis of indigenous ethnicity. Indeed, the investigation reveals that the health status and conditions of all of the communities in the conflict zone are far worse than national averages, which is in part attributable to inequitable patterns of health care resource allocation which are tied to ethnicity, as well as insurance status.²³ Further this inequality affects the pre-conditions for health as well as to access to care — particularly living conditions, food security, educational opportunities, basic sanitation and water. These inequitable conditions directly affect people's health and have a devastating affect on child health and nutrition, which are documented in this report. Women in these communities also experience gender discrimination, as evidenced by the lack of attention to women's health priorities in the region.

Third, Mexican law and institutions do not provide for

¹⁸ In some areas of Chiapas, as is the case in the Altos region, this situation is exacerbated even further by religious conflicts between Catholics and evangelical churches, making the social problem even more difficult.

¹⁹ CONAPO (1998). *La situación demográfica de México 1998*. México: 2a.ed. CONAPO (1995). *Índices de Marginalidad, 1995*. México: CONAPO, 1995.

²⁰ In 2002 the UN Development Report noted that "studies in a range of countries and regions hold weak governance responsible for persistent poverty and lagging development" which is evidenced in part in poor public services. United Nations Development Programme (UNDP). *Human Development Report 2002: Deepening Democracy in a Fragmented World*. New York: Oxford University Press; 2002:51. Available at: <http://hdr.undp.org/reports/global/2002/en/>. Accessed January 8, 2006.

²¹ *Id.*, UNDP. 2002:51. Emphasis added.

²² UN CESCR. "General Comment 14." August 2000; para 12.

²³ See also Lozano R, Zurita B, Franco F, Ramírez T, Hernández P, Torres JL. "Mexico: Marginality, Need, and Resource Allocation at the Country Level." In: Evans T, Whitehead M, Diderichsen F, Bhuiya A, Wirth M, eds. *Challenging Inequities in Health: From Ethics to Action*. New York: Oxford University Press; 2001:271-295.

adequate accountability in the event of violations of the right to health. National and local human rights commissions do not have the capacity or the authority to sanction violators or enforce recommendations to institutions. Article 60 of the General Health Law fails to provide for claims regarding the accessibility or adequacy of health services as an institutional or systemic issue. Moreover, the *amparo* (protection writ) which is commonly used in civil and political rights violations cases, currently does not provide people and groups with a collective remedy; nor does it establish precedent for other related cases. Even in individual cases, Mexican judges have been inappropriately reluctant to use the *amparo* to enforce the right to health under the apparent misconception that “programmatically” rights are not actionable. Although aspects of the right to health entail programmatic obligations, violations of specific regulations relating to the government’s obligations with respect to health give rise to individual rights and should be enforced according to the same criteria as other constitutionally protected rights.²⁴

Fourth, although Mexico’s General Health Law sets out an integrated, multi-sectoral approach to health, in practice this does not occur.²⁵ The alarmingly high rates of malnutrition that this study found among all types of communities are the result of a failure of the Mexican government to institute coherent rural development and food security policies, which incorporate health concerns. The investigation also found inadequate living conditions, lack of access to sufficient safe drinking water, lack of access to basic sanitation for disposal of excreta, lack of access to educational opportunities (especially for women) across all communities in the study. The process of fragmentation and dispersion exacerbates difficulties in establishing basic preconditions of health, such as adequate water, sewage and housing.²⁶

Finally, the government has not granted indigenous communities, including but not limited to opposition communities, meaningful rights to participate in the

design and management of their health care services, as set forth under relevant international law. The Mexican government is a party to international instruments calling for genuine participation of indigenous people’s in their own affairs, including health. The San Andrés Accords, which the federal government agreed to with the EZLN in 1996, but never implemented, would have provided some self-determination. Mexico, however, in contrast to other states in the region, has never adopted national legislation to incorporate its international obligations into domestic law. Nor has it recognized some meaningful degree of autonomy for indigenous communities, including those in opposition, in relation to the organization and delivery of social services.²⁷

Demands for social participation and control over the decisions affecting health and well-being are at the core of the conflict in Chiapas and underlie the Zapatista resistance. The devolution of some meaningful decision-making power to the communities whose well-being is at stake is a precondition to realizing the right to health in Chiapas, as well as fostering opportunities to resolve the conflict. As has been noted before, it is also fundamental to the fulfillment of human rights and democracy more broadly.²⁸

Yet in the conflict zone in Chiapas, the ability to participate in collective decision-making on health matters or to effectively assert health claims through the health system are glaringly absent, especially in divided communities. In communities in resistance, disease may be treated as everyone’s problem; in pro-government communities, it is the government’s problem, but in divided communities, it is essentially no one’s problem.

²⁷ In the 1990s, Colombia, Bolivia and Paraguay reformed their constitutions to incorporate the rights of indigenous peoples, in keeping with ILO Conventions 107 and 169 and as a part of the standards included in the International Convention on the Elimination of All Forms of Racial Discrimination. The movements for constitutional reforms later inspired similar efforts in Ecuador, Peru and Venezuela.

²⁸ Immediately before Mexico’s last national elections in 2000, Erica-Irene Daes, the Chairperson-Rapporteur of the UN Working Group on Indigenous Populations issued a report in which she “welcomed the good functioning in certain areas of self-administered indigenous communities...” but expressed concern over “allegations of governmental interference in other areas, particularly in Chiapas... including the removal of indigenous authorities and their replacement by others selected by the government...” Daes considered “genuine participation by indigenous communities in the political life of the country to be crucial for their own development and for Mexico’s development, and for democracy overall.” Erica-Irene Daes, Chairperson-Rapporteur of the Working Group on Indigenous Populations. “Human Rights of Indigenous Peoples.” UN Document E/CN.4/Sub.2/2000/40. United Nations: Geneva; 3 August 2000. para 12. Available at: <http://www.unhchr.ch/Huridocda/Huridocda.nsf/0/c13d59b7cd0997b0c1256990004abe0e?Opendocument>. Accessed January 8, 2006.

²⁴ *Ley General de Salud*. (Mexico General Health Law). Art. 60. February 7, 1984. In this vein, the Constitutional Court of Ecuador, e.g., has stated that “positive social rights ... are norms to be enforced immediately with full juridical effect and are binding on the authorities who have obligations in their capacity as obligors; [they are also rights that must] be implemented by courts such as this one for which the defense of human dignity is a fundamental mainstay of contemporary constitutional development.” “Jofre Mendoza et al v. Minister of Health,” Ecuador (Constitutional Court of Ecuador [2003] [failure to consistently provide full triple cocktail of ARVs in accordance with Ministry of Health regulations could produce viral resistance and lead to opportunistic infections and eventually death].

²⁵ Title III, ch 4, Art. 60. *Ley General de Salud*. (Mexico General Health Law). February 7, 1984.

²⁶ CESCR Concluding Observations, 1999, para 27.

Recommendations to the Mexican Government

1. The government should encourage a broad dialogue at the local, state, and national levels about the meaning of an inclusive democracy in Mexico, which fully recognizes its multiple constituent cultures. The dialogue should examine how health services should be designed and delivered and how the indigenous population's health needs could be addressed. Such a dialogue would need to be supported by and include non-governmental actors and civil society, as well as relevant governmental actors.
2. The Mexican government should take immediate steps to implement the San Andrés Accords, as well as its obligations under international law, including ILO Convention 169. This would confer some degree of autonomy on indigenous communities, including opposition communities, with respect to the organization of their affairs and health services.
3. The government should permit and promote the creation of local health care systems in the autonomous regions in Chiapas. These systems should be structurally independent and capable of responding to the specific health care needs of each community, but operationally coordinated with the state and national health system to provide vaccinations, medicines, and patient referrals. An autonomous technical support system, based at least in part on universities, could promote communication among all parties and facilitate better relations.
4. All federal, state, and municipal government activities related to health should be carried out without discrimination. All levels of government should display the highest degree of coordination and commitment to prevent programs and activities from provoking or aggravating internal conflicts. Programs that are functioning well in terms of reducing communal conflict and improving health status should be supported and expanded. As part of this commitment, all clinics should be required to attend to all members of a community, regardless of political affiliation or religion.
5. The government should improve its surveillance and detection systems, and should collect health data on a disaggregated basis, so that disparities based on gender, socioeconomic indicators, and ethnicity may be detected and addressed. When the best available evidence indicates the importance of process indicators, such as the availability and use of essential obstetric care, the government should collect such indicators to be able to review its progress in addressing maternal health on an ongoing basis.
6. The government should establish an autonomous institution, made up of independent experts, to monitor governmental compliance with indigenous peoples' economic, social, and cultural rights, including their health rights, in Chiapas and beyond. This institution should be equipped to promote education and dialogue among groups and actors in society. It should also be authorized to receive and act upon individual and collective complaints and to hold the government accountable for violations.
7. The government should initiate amendments to Mexican law to allow the *amparo* mechanism (writ of protection) to provide for adequate remedies and accountability in the event of violations of the right to health, including providing for collective remedies and binding precedents. Lawyers and judges should be sensitized and trained in the enforcement and enforceability of the right to health.
8. Government social programs such as the *Oportunidades* program should actively foster and incorporate meaningful community participation in the design, implementation, and evaluation of activities, which includes providing communities with authority in allocating resources and auditing projects.
9. The government should increase and re-allocate health resources per capita to and within Chiapas based on the best evidence available of priority health needs for the populations affected.
10. The Program of Tuberculosis Prevention and Control should be re-structured to include investment in more resources, sensitizing, training, supervising, and evaluating a comprehensive DOTS program in Chiapas and beyond. The emphasis in this program should be placed on universality and free access without conditionality, as well as mechanisms to ensure follow-up of patients in accordance with international standards.
11. In keeping with the fulfillment of its obligations under the International Covenant on Economic, Social and Cultural Rights, the government should take the following steps to improve the availability, accessibility, acceptability and quality of health facilities, goods and services in Chiapas:
 - a. train health personnel at all levels about human rights and the principles of medical neutrality with respect for cultural differences;
 - b. incorporate a basic working knowledge of the local indigenous language as part of the prerequisites for working in indigenous regions;

- c. promote and reinforce community-based mechanisms for the management of health-related issues;
 - d. foster community-based mechanisms for monitoring and addressing health conditions, including rotating funds for obstetric emergencies;
 - e. develop intensive campaigns regarding the right to health in Spanish and the principal indigenous languages;
 - f. broaden and diversify options with respect to family planning methods for indigenous women and men, and ensure informed consent as well as their right to decide freely the number and spacing of their children;
 - g. revise and restructure the activities of food assistance and nutritional monitoring in accordance with local conditions and the consumption habits of the population;
 - h. provide available and accessible emergency obstetric care to the population in the conflict zone;
 - i. improve the mechanisms of patient referral and transfer to hospitals, especially in obstetric emergencies;
 - j. promote greater structural and functional integration of services of the different government institutions (Ministry of Health and the IMSS-Oportunidades program), which provide medical care to the majority of the population in the study area;
 - k. improve the supply of medicines to health facilities; and
 - l. modify staffing policies to avoid frequent and long absences of health personnel, in particular physicians, from rural facilities and ensuing ruptures in relations with communities, due to rotations, attendance at meetings, participation in courses, paperwork, and the like.
12. Fragmented federal and state nutrition programs should be integrated to establish a stable policy oriented toward promoting the population's capacity for self-sufficiency in food production and food security. In the context of these three regions in the conflict zone, this includes the following:
- a. providing secure conditions so that the population, independent of their political or religious affiliation, can move about freely and engage in their productive activities;
 - b. providing guarantees for an honorable and secure return of displaced people to their communities and agricultural lands;
 - c. promoting local production and regional exchange through a policy that stimulates the production and consumption of local products and avoids the "dumping" effect, which results in the widespread distribution of food acquired outside the region;
 - d. establishing regional supply centers to regulate the availability and price of food in less accessible regions; and
 - e. implementing a program of nutritional monitoring in the most vulnerable communities, with the participation of community members as well as civil society institutions to promote arrangements for the care of malnourished children, and foster local capacities.

II. CONTEXT

More than ten years after the Zapatista Army for National Liberation (EZLN, or Zapatistas) launched their New Year's Day rebellion, Chiapas continues to be one of the most backward states in Mexico in terms of the economic, social, political, and health conditions of the majority of its heavily indigenous population. However, after the first years following the 1994 uprising that generated widespread publicity and attention to the Zapatista movement as well as to Chiapas, the lives of the people residing in the so-called conflict zone—those areas of the state most affected by the initial armed combat between the EZLN and the army, as well as the ensuing paramilitary violence and low-intensity conflict—faded from national and international attention. Further, there was virtually no systematic information about how the families trapped in the protracted conflict and tension had fared, or the conditions affecting their children.

In October 2000, PHR, together with El Colegio de la Frontera Sur and CCESC-DDS, undertook the first comprehensive population-based health study in the conflict zone, which took fourteen months to complete due in large measure to the ongoing tensions and climate of mistrust. A primary purpose of the study was to document the health status, conditions, and access to health services in communities exposed to the ongoing military presence, the tensions and divisions between and within communities, and the civil resistance of Zapatista sympathizers. The study also sought to analyze the findings in light of the populations' rights to health under international law.²⁹ Quantitative and qualitative data gathered during this study have been supplemented with updated national and local statistics, together with direct observation and recent policy and human rights information, in order to provide a more

complete picture of the state of the right to health in the conflict zone.

Chiapas and the Study Area

Mexico is a middle-income country with a per capita GDP of close to \$10,000 USD³⁰ and is a member of the Organization for Economic Cooperation and Development (OECD). It is however a country of extreme income inequality. According to the UNDP's GINI Index, Mexico ranks 115 out of 124 in terms of income equality, making it more similar in that respect to countries such as Zimbabwe and Zambia than any other OECD country.³¹

Mexico's total health spending (6.2% of GDP in 2003) is also significantly lower than any other OECD country. Its total health spending per capita is only 25% of the OECD average (adjusted for purchasing power parity).³² Further, the public share of health spending in Mexico is well below the OECD average, meaning that private financing—overwhelmingly in the form of out-of-pocket payments—is required to fund most health care.³³

The progress that Mexico has made in its national health indicators demonstrates that improvements in the preconditions of health as well as in access to care are not only possible but can be significant in terms of producing better outcomes. However, as Lozano et al write,

The allocation of health resources in Mexico is inversely related to marginality and to county

³⁰ 2005 estimate according to the CIA World Factbook. Available at: <http://www.cia.gov/cia/publications/factbook/geos/mx.html>. Accessed March 23, 2006.

³¹ GINI Index: "Inequality in income or consumption." *Human Development Report 2005*. United Nations Development Programme, 2006. Available at: <http://hdr.undp.org/statistics/data/indicators.cfm?x=148&y=2&z=2> Accessed March 15, 2006.; and "OECD Health Data 2005: How Does Mexico Compare?" *OECD Health Data 2005: Statistics and Indicators for 30 Countries*. June 8, 2005. Available at: <http://www.oecd.org/dataoecd/16/2/34970198.pdf>. Accessed March 15, 2006.

³² \$583 USD compared with \$2,307 USD. "OECD Health Data 2005: How Does Mexico Compare?" *OECD Health Data 2005: Statistics and Indicators for 30 Countries*. June 8, 2005. Available at: <http://www.oecd.org/dataoecd/16/2/34970198.pdf>. Accessed March 15, 2006.

³³ 46.4 percent, see "OECD Health Data 2005: How Does Mexico Compare?" *OECD Health Data 2005: Statistics and Indicators for 30 Countries*. June 8, 2005. Available at: <http://www.oecd.org/dataoecd/16/2/34970198.pdf>. Accessed March 15, 2006.

²⁹ While this report emphasizes the violations of the right to health of all the indigenous people living in the conflict zone, other journal articles based on the study findings analyze in greater depth differences among communities in terms of health status. See e.g. Sánchez Pérez HJ, Hernán M, Ríos-González A, et al. "Malnutrition among Children Under Five Years of Age in Conflict Zones of Chiapas, Mexico." *American Journal of Public Health*. forthcoming 2006; Brentlinger P, Sánchez-Pérez HJ, Arana-Cedeño M, Vargas HG, Hernán MA, Micek M, Ford D. "Pregnancy Outcomes, Site of Delivery, and Community Schisms in Regions Affected by the Armed Conflict in Chiapas, Mexico; A Community-based Survey." *Social Science and Medicine*. 2005;61:1001-1014.

GNP in Mexican counties. Physicians concentrate in areas with little deprivation and higher per capita wealth [] and are relatively scarce [] in very high marginality counties []. The more deprived or poorest counties also have fewer public hospital beds (1 bed per 10,000 in marginalized counties compared with 12 beds per 10,000 inhabitants in better off counties)...Hence, health resources appear to increase in proportion to per capita GNP in Mexican counties.³⁴

Another study showed that public health expenditures are twelve times higher per capita for the insured—who are formally employed—than the uninsured in Mexico.³⁵ At the same time, indigenous persons in Mexico disproportionately live in rural and marginalized areas and are uninsured. A study by Hernandez-Peña found that these disadvantages are coupled with a lower availability of health care resources in highly indigenous communities.³⁶

The state of Chiapas lies in the southeast of Mexico and extends over an area of 75,634 square kilometers. Its population in the 2000 census was 3,920,892 inhabitants, distributed among 19,453 communities, located in 118 municipalities (seven of which were created by the Chiapas government after 1994).³⁷ For administrative purposes, the state is divided into nine regions, three of which—the Altos, Selva, and Norte regions—were the most directly affected by the armed conflict. The study was conducted in these three regions, all of which have important ethnographic, social, and historical characteristics.³⁸

³⁴ Lozano R, Zurita B, Franco F, Ramírez T, Hernández P, Torres JL. "Mexico: Marginality, Need, and Resource Allocation at the Country Level." In: Evans T, Whitehead M, Diderichsen F, Bhuiya A, Wirth M, eds. *Challenging Inequities in Health: From Ethics to Action*. New York: Oxford University Press; 2001:290-291.

³⁵ Hernandez-Peña P, Zapata O, Leyva R, Lozano R. "Equidad y salud: necesidades de investigación para la formulación de una política social." *Salud Pública de México*. 1991;33:9-17 cited in Lozano R, Zurita B, Franco F, Ramírez T, Hernández P, Torres JL. "Mexico: Marginality, Need, and Resource Allocation at the Country Level." In: Evans T, Whitehead M, Diderichsen F, Bhuiya A, Wirth M, eds. *Challenging Inequities in Health: From Ethics to Action*. New York: Oxford University Press; 2001:291.

³⁶ Hernandez-Peña P, Zapata O, Leyva R, Lozano R. "Equidad y salud: necesidades de investigación para la formulación de una política social." *Salud Pública de México*. 1991;33:9-17, cited in Lozano R, Zurita B, Franco F, Ramírez T, Hernández P, Torres JL. "Mexico: Marginality, Need, and Resource Allocation at the Country Level." In: Evans T, Whitehead M, Diderichsen F, Bhuiya A, Wirth M, eds. *Challenging Inequities in Health: From Ethics to Action*. New York: Oxford University Press; 2001:291.

³⁷ INEGI. *XII Censo General de Población y Vivienda, 2000. Tabulados Básicos Nacionales y por Entidad Federativa. Base de Datos y Tabulados de la Muestra Censal*. Aguascalientes: INEGI; 2001. Available at: <http://www.inegi.gob.mx/est/default.asp?c=703>. Accessed November 5, 2005.

The Altos region lies in the center of the state and its name derives from its location at altitudes greater than 1,600 meters above sea level. This region has the largest concentration of the indigenous population in Chiapas and has been an administrative and commercial enclave since the colonial period. Its principal city, San Cristóbal de Las Casas, was founded in 1528 and, in many ways continues to be symbolic of Spanish and subsequent *ladino*³⁹ dominance in a predominantly indigenous area. The Altos region also has the greatest number of municipalities in Chiapas in conditions of extreme poverty. The combination of enormous demographic pressure, along with political and religious issues and a system of subsistence agriculture in this region has led to the occurrence of inter- and intra-community conflicts, migrations, and expulsions since the second half of the twentieth century.

Moreover, during the last forty years the conversion of the population to religions other than Catholicism has accelerated. Conflicts over land and economic and political control have been expressed through the lens and rhetoric of religious intolerance, and have become increasingly violent. Since 1970, more than 35,000 indigenous people from the Altos region have been violently expelled from their communities as a result of power conflicts that evolved into religious divisions.⁴⁰

Although Mexico is an overwhelmingly Catholic country, Chiapas is one of the least Catholic states in Mexico and the Altos region has been particularly affected by religious divisions. Conversion to other religions (in particular, Protestant churches) has disrupted communal activities, such as the appointment of local leaders to political and administrative positions, the consumption of alcohol for medicinal and ritualistic purposes, the participation in civil acts and religious events (e.g. those tied to the harvest cycles). In turn,

³⁸ As described more fully in the section on methods, communities were chosen to participate in the study after thorough consultations with human rights groups, governmental institutions (including the Ministry of Health, Ministry of Public Works, Ministry of Education), and non-governmental organizations in the region as well as newspaper reports. The consultations provided information on communities in which one or more of the following events had occurred since the beginning of the conflict: combat between the EZLN and the Mexican army; paramilitary activities; assassinations of leaders or families of *campesinos* associated with the EZLN; displacement of persons due to presumed affiliation with the EZLN or with paramilitary groups; and public protests and organized appearances by the EZLN. Consultations proved that the vast majority are located in the Altos, Selva, and Norte regions.

³⁹ *Ladino* is a term used to refer to non-indigenous people.

⁴⁰ Martínez-Velasco G. "Apreciaciones generales sobre la situación del desplazamiento en Chiapas." In *Regional seminar on internal displacement in the Americas, Mexico City, Mexico, February 18-20, 2004*. Washington, DC: Brookings Institution-SAIS Project on Internal Displacement; 2004.

traditional Catholic community leaders have rejected these new religions and have expelled members of non-Catholic sects from their communities, arguing that these religions disrupt participation in communal activities. Property abandoned by the expelled families or groups is then allocated among those who remain. Each religious group has developed ways to entice conversion as well as to punish those who choose not to follow.⁴¹

The Selva region was for centuries the least known and least populated region of Chiapas. For the Spaniards it was "the great desert populated by the Lacandón Indians,"⁴² and until the 1960s it was a vast area of national territory covered by tropical rain forest with a few Indian communities.⁴³ For over a century, the presence of non-indigenous people was limited to representatives of foreign logging companies. As a result of the great demographic pressure in the Altos region, the government actively promoted the colonization of national lands in the Selva region in the 1960s. By offering land in this area, the government sought to alleviate agrarian pressure and conflicts in the Altos and other regions in Chiapas, as well as elsewhere in the country.⁴⁴

As a result, the Selva region experienced accelerated demographic growth and became a vast multiethnic area. For many years it was neglected by government social programs. Life in this region turned out to be exceedingly difficult for indigenous *campesinos* arriving from more temperate climates, both because of the presence of many unknown tropical diseases and because of the difficulties involved in growing their traditional foods. These difficulties forced the new arrivals to unite in very well-organized, cohesive communities, which became a fundamental characteristic of this region up until the beginning of the armed conflict. The Selva region also emerged as the destination of many non-Catholics expelled from their communities in the Altos region. However, as there was less conflict over land in the Selva region, there was also less conflict among members of different religions. In the two decades prior to the Zapatista uprising, strong independent *campesino* organizations were formed in this

region and became decisive in the expansion of the EZLN.

The Norte region is an area, which extends from the highlands of Chiapas to the plains of the state of Tabasco. It is made up of municipalities that were previously covered by dense vegetation (originally rainforest), which gave way to agricultural activity and ranching. As another preferred destination for migrants from the Altos region, it became an area where different ethnic groups, including the Chol who were the original settlers of these lands, came into contact with each other and were forced to coexist, though not always peacefully.

Although the state's largest cities have greatly increased in size, more than half (54.3%) of Chiapas' population continues to live in a rural environment, in great contrast to 25.4% for all of Mexico.⁴⁵ In these overwhelmingly rural areas, farming small parcels of collectively owned land or working as day laborers on larger plots offers a poor and precarious existence for most residents. Historically people have lived in small villages of 2,500 inhabitants or less, and dependence on social support from the community has been a distinguishing factor of life.

The enduring conflict has greatly eroded these small communities. The number of rural settlements (population less than 2,500) has dramatically increased since the conflict erupted. In 1990, there were 16,422 settlements;⁴⁶ in 2000 the number had increased to 19,453;⁴⁷ and according to various sources,⁴⁸ there were more than 22,000 settlements by 2003. These numbers reflect the process of dispersion and fragmentation that the rural population of the state of Chiapas is undergoing. This process has accelerated since 1994 and has been strongly influenced by the polarization of communities around political as well as religious affiliations.

In addition to tensions between different political

⁴¹ Id., Martínez-Velasco G. 2004

⁴² Ballinas J. *El desierto de los lacandones*. Tuxtla Gutiérrez: Ateneo de Ciencias y Artes de Chiapas, Gobierno del Estado de Chiapas; 1951; García de León A. *Resistencia y utopía*. México: Era; 1985.

⁴³ De Vos J. *Oro verde. La conquista de la Selva Lacandona por los madereros tabasqueños, 1822-1949*. México: Fondo de Cultura Económica, Instituto de Cultura de Tabasco; 1988.

⁴⁴ Arana-Cedeño, M. "Educación y gestión ambiental en la selva de Chiapas." In: Leff E, Carabias J. *Recursos naturales, técnica y cultura. Cuadernos de Centro de Investigaciones Interdisciplinarias en Humanidades de la UNAM*. México: Universidad Nacional Autónoma de México; 1990.

⁴⁵ INEGI. *XII Censo General de Población y Vivienda, 2000. Tabulados Básicos Nacionales y por Entidad Federativa. Base de Datos y Tabulados de la Muestra Censal*. Aguascalientes: INEGI; 2001. Available at: <http://www.inegi.gob.mx/est/default.asp?c=703>. Accessed November 5, 2005.

⁴⁶ INEGI. *XI Censo General de Población y Vivienda, 1990. Tabulados Básicos Nacionales y por Entidad Federativa. Base de Datos y Tabulados de la Muestra Censal*. Aguascalientes: INEGI; 1990. Available at: <http://www.inegi.gob.mx/est/contenidos/espanol/proyectos/coesme/programas/ficha.asp>. Accessed November 6, 2005.

⁴⁷ INEGI. *XII Censo General de Población y Vivienda, 2000. Tabulados Básicos Nacionales y por Entidad Federativa. Base de Datos y Tabulados de la Muestra Censal*. Aguascalientes, Mexico: INEGI; 2001. Available at: <http://www.inegi.gob.mx/est/default.asp?c=703>. Accessed November 5, 2005.

⁴⁸ Defensoría del Derecho a la Salud. "La atomización demográfica en Chiapas, un obstáculo para el ejercicio de los derechos económicos, sociales y culturales," in Mexican Human Rights NGOs Shadow Report to the United Nations Committee on Economic, Social and Cultural Rights, 2006 (on file with authors).

and religious groups, harassment by armed paramilitary groups and the presence of the Federal Army have been important factors in accelerating the dispersion and fragmentation of communities. For decades, expulsion has been an extreme form of expressing religious as well as political intolerance, and expulsions are often conducted in a violent manner. As a result of religious and political conflicts, families and groups are forcibly displaced from communities. Without counting the more than 20,000 people estimated to have been displaced for religious reasons,⁴⁹ conservative estimates for those displaced by the conflict at different times have ranged between 10,000 and 20,000.⁵⁰ Thus, forced displacement has played a significant role in the high degree of population and small rural settlement dispersion in the state of Chiapas, and in the study area in particular.

The federal and state programs to buy land for the population affected by the conflict are also a central cause of population resettlement in Chiapas. Between 1994 and 1999, as a way of curbing the Zapatista movement, the Chiapas government invested 764 million pesos (US\$76.4 million) to buy and distribute more than 260,000 hectares of land to 1,430 *campesino* groups.⁵¹ For example, ranchers who owned land that had been invaded by Zapatista supporters were compensated and the land was re-distributed to *campesino* groups sympathetic to the government. In her 2000 report to the Commission on Human Rights, the Chairperson-Rapporteur of the Working Group on Indigenous Populations specifically noted her concern over indigenous communities being deprived of their traditional lands and of indigenous lands being fragmented in a situation that has often created tension and conflict, including within and between indigenous communities.⁵²

Besides fostering direct conflicts, this community fragmentation has inevitable social, economic, and environmental costs. The growth of health and educational services and infrastructure lags far behind the increase in need. Consequently, the number of commu-

nities in extreme poverty without such services is growing. At the same time, the destruction of forests to clear lands for dwellings and agriculture accelerates deforestation, puts pressure on natural resources, and contributes to environmental degradation.⁵³

According to official government statistics, today Chiapas ranks among the states with poorest indicators on child and infant mortality, and ranks worst in terms of maternal mortality.⁵⁴ Over two-thirds (68%) of the population lives without access to potable water and 62.3% does not have adequate sanitation. In 2003, Chiapas ranked 1st in mortality (among both women and men) associated with diarrheal diseases, acute respiratory infections, pulmonary tuberculosis, as well as among women in cervical cancer.⁵⁵

The majority of the overwhelmingly impoverished population in Chiapas is treated by the two main institutions responsible for providing health services to the uninsured population: the Ministry of Health (SSA) and the IMSS-Oportunidades (previously IMSS-Solidaridad) program. In Chiapas, 80% of the population lacks health insurance and in rural communities the figure is over 95%. However, evidence indicates that access to health care is inadequate. According to official statistics, virtually a quarter (24.5%) of people die without receiving medical care, which makes Chiapas, together with Oaxaca, rank highest in this regard.⁵⁶

As this report demonstrates, the regions of Chiapas most affected by the conflict have fared even worse than the rest of Chiapas. The population in the conflict zone is overwhelmingly indigenous and their margin-

⁴⁹ Martínez-Velasco G. "Apreciaciones generales sobre la situación del desplazamiento en Chiapas." In *Regional seminar on internal displacement in the Americas, Mexico City, Mexico, February 18–20, 2004*. Washington, DC: Brookings Institution–SAIS Project on Internal Displacement; 2004.

⁵⁰ Centro de Investigaciones Económicas y Políticas de Acción Comunitaria (CIEPAC). Hidalgo O, Gustavo C. *Población desplazada en Chiapas*. Chiapas: CIEPAC; 1999.

⁵¹ This action was part of the programming of a short-lived governmental institution called "Vocalía de Compromisos por la paz" which was formed by the federal government during the first dialogue with the EZLN. Shortly after the peace talks failed, this body was dismantled.

⁵² Daes El. "Human Rights of Indigenous Peoples." 2000. para 8.

⁵³ Villafuerte Solís D. *La cuestión ganadera y la deforestación: viejos y nuevos problemas en el trópico y Chiapas*. Tuxtla Gutiérrez: Universidad de Ciencias y Artes del Estado de Chiapas, Gobierno del Estado de Chiapas; 1997:182.

⁵⁴ Perspectiva Estadística. Chiapas. September 2005. Available at: <http://www.inegi.gob.mx/lib/buscador/busqueda.asp?s=inegi&texto=mortalidad%20de%20ni%F1os&seccionB=docit&i+> Accessed November 6, 2005.; Secretaría de Salud (SSA), Dirección General de Información en Salud. *Salud Pública Mex* 2005; 47(2):171–187.

⁵⁵ Secretaría de Salud. Dirección General de Información en Salud. "Estadísticas de mortalidad en México: muertes registradas en el año 2003." *Salud Pública de México* 2005;47(2):171–187. The comparisons between Chiapas and the national averages are telling. The rates for women (per 100,000) were as follows: diarrheal diseases: national (5.0) v. Chiapas (17.8); acute respiratory infections: national (15.6) v. Chiapas (23.7); pulmonary tuberculosis: national (2.2) v. Chiapas (6.7); cervical cancer: national (11.2) v. Chiapas (18.5). The rates for men (per 100,000) were as follows: diarrheal diseases: national (5.6) v. Chiapas (22.5); acute respiratory infections: national (21.0) v. Chiapas (32.0); pulmonary tuberculosis: national (5.1) v. Chiapas (11.1).

⁵⁶ Secretaría de Salud (SSA), Dirección General de Información en Salud. "Estadísticas de mortalidad en México: muertes registradas en el año 2003." *Salud Pública de México* 2005;47(2):171–187. Oaxaca had 23.0 percent.

alization reflects the extreme exclusion faced by indigenous populations across Mexico. In Mexico, there are fifty-six officially recognized ethnic groups concentrated in four states, including Chiapas. In a country that boasts over a 90% national literacy rate, astoundingly almost half of the indigenous population is illiterate. Studies have estimated that municipalities with over 70% indigenous populations contain approximately 80% of the population living below the poverty line.⁵⁷

Yet, the indigenous groups represented in the conflict zone face even greater degrees of poverty than others.⁵⁸ For example: 58% of the Mixtec population (in Central Mexico) lives in municipalities classified as having “very high” marginalization, compared with 93% of the Tseltal population in Chiapas. Similarly, in 1995, the infant mortality rate for speakers of Tojolabal and Tsotsil in Chiapas was 87 and 81, respectively, per 1,000 live births, compared with forty for Chinanteca and Zapotec groups, and thirty-three among the Chontal population, who are from other states in Mexico.⁵⁹

Historical Context: Pre-1994

Health—and the lack of health care infrastructure and public health services—has long been a symbol of the Mexican state’s historic neglect of the largely indigenous rural population of Chiapas. In the 1980s and early 1990s, independently organized social service groups in the state, in particular in the Selva region, sprang up and began to play important roles. The growth of these social organizations was accompanied by the development of independent *campesino* political organizations. Health was a central priority for these organizations, as it later became for the EZLN.

Thus, when the Mexican state began to establish health services in the most remote regions of Chiapas, health programs were already in place which had been promoted by churches, non-governmental service organizations (NGOs), universities and other higher educational institutions, as well as by political organi-

zations.⁶⁰ The governmental programs to extend the coverage of health services to isolated regions rarely coordinated with existing non-governmental programs and often forced the population to choose between the state health services and those provided by the church or another civic organization. These “choices” were, in turn, heavily politicized, which only served to exacerbate polarization within the communities.⁶¹

Expansion of government health services favored populations with greater affinity to the state government and to the then-ruling Institutional Revolutionary Party (PRI). As former *New York Times* Mexico correspondents, Sam Dillon and Julia Preston wrote, the PRI exercised “an oppressive hold on every aspect of Mexican life [which] made it the world’s longest-ruling political organization.”⁶² Health services, and the possibilities that they offered for patronage, were no exception.

During the years prior to the Zapatista uprising in 1994, health was one of the issues that the EZLN promoted most actively, in order to establish a relationship with the indigenous communities and gain their trust. It has been suggested that the EZLN leader himself, Subcomandante Marcos, first arrived in Chiapas in order to participate in a course for health providers.⁶³ The expectation of improving the health and nutritional status, as well as the living conditions of the population, were central driving forces behind the widespread participation in the Zapatista uprising.

In the *First Declaration of the Lacandón Jungle*, which was made public on January 1, 1994, the EZLN declared war against the Mexican Army and announced a military advance toward Mexico City. In that document, the EZLN points to hunger and death from curable illnesses as the principal reasons that gave rise to the armed uprising and mentions in their basic demands, health and nutrition, as well as labor condi-

⁵⁷ See E.g., Psacharopoulos G, Patrinos H. *Indigenous People and Poverty in Latin America: An Empirical Analysis*. Washington, DC: World Bank; 1994 cited in Lozano R, Zurita B, Franco F, Ramírez T, Hernández P, Torres JL. “Mexico: Marginality, Need, and Resource Allocation at the Country Level.” In: Evans T, Whitehead M, Diderichsen F, Bhuiya A, Wirth M, eds. *Challenging Inequities in Health: From Ethics to Action*. New York: Oxford University Press; 2001:271-295, 280.

⁵⁸ Secretaría de Salud (SSA), Instituto Nacional Indigenista (INI). *La salud de los pueblos indígenas*. México: SSA, INI, 1992; Consejo Nacional de Población (CONAPO). *La situación demográfica de México, 1998*. 2ª edición. México: CONAPO, 1998.

⁵⁹ CONAPO. *La situación demográfica en México, 1998*. 2ª. edición. México: CONAPO; 1998.

⁶⁰ For example, beginning in 1980, el Instituto Politécnico Nacional (National Polytechnic Institute) developed the Plan Tojolabal and the Plan de la Selva health programs, which, in coordination with the Comitán General Hospital (public hospital run by Ministry of Health), created an extensive network of community health services and training for health promoters. The Universidad Autónoma Metropolitana, also had successful training programs relating to human resources in health, which contributed to the medical care of populations in extreme poverty.

⁶¹ Arana-Cedeño M, Loyola E. “Transición epidemiológica en la población de la Selva Lacandona, Chiapas.” In: Vázquez-Sánchez MA, Ramos Olmos MA, eds. *Reserva de la Biósfera de Montes Azules, Selva Lacandona. Investigación para su conservación*. México: Publicaciones especiales ECOSFERA 1992;1:322-341.

⁶² Preston J, Dillon S. *Opening Mexico: The Making of A Democracy*. New York: Farrar, Strauss and Giroux; 2004: ix.

⁶³ Tello-Díaz C. *La rebelión de las cañadas*. Mexico City: Editorial Cal y Arena; 1995.

tions, land, education, autonomy, democracy, justice, and peace with dignity.⁶⁴

Post-Uprising: The Emergence of Civil Resistance

The military actions in January 1994 lasted only twelve days, but the fighting was only the first phase of a protracted conflict. Throughout 1994 and early 1995, more than 6,000 people were evacuated from their communities by the Mexican military. At the same time, the government emptied the schools and health clinics of those communities that had been supportive of the Zapatistas. This displacement, which was promoted as a “protective measure,” facilitated the identification of those who sympathized with the EZLN and those who did not.⁶⁵

By June 1994, after numerous violent clashes with the military and the failure of the dialogue with the government, the EZLN adopted a posture and strategy of “resistencia” (resistance). In the *Second Declaration of the Lacandón Jungle*, issued in June 1994, the EZLN emphatically called upon its sympathizers to refuse all collaboration with the government and to reject all official programs, including those for health:

*...We will accept nothing that comes from the rotten heart of the bad government, not a single coin, nor a medicine, nor a stone, nor a grain of food, nor a crumb from the handouts that it offers in exchange for our dignity. We will take nothing from the supreme federal government. Even if our pain and our grief deepen, though death may still be with us, at the table, in the land, and on the roof; though we may see that others sell themselves to the hand that oppresses them; though everything might ache and grief weeps even from the stones, we will take nothing from the government. We will resist . . .*⁶⁶

Resistance came to be a central element of the Zapatistas’ political stance as well as of their strategy.

Civil resistance went beyond health care to other social services, such as education which was expressed

through the rejection of public schools. At the beginning of the conflict, a large proportion of schools had closed their doors. During 1994, nearly all public school activity in the regions affected by the conflict ceased. After February 1995, schools gradually reopened and the children who returned to these schools were from families hostile to the EZLN, and those who had not been displaced during the first year of the conflict. The opposition communities rejected the official teachers from the state and federal government. Gradually, in some regions, national and international civil society organizations developed (and continue to maintain) primary and secondary education programs for the boys and girls of the Zapatista movement as well as their sympathizers. The EZLN’s negotiating power quickly grew stronger through their capacity to maintain resistance, rather than through military activity.⁶⁷ Although resistance was a response to governmental policies, one consequence of this strategy was to foster further polarization between communities that were aligned with the resistance—and therefore the EZLN—and those that were not.

1995-2000: The Government’s Response

In February 1995, the Mexican Army engaged in a major offensive to re-take portions of territory under Zapatista control and re-settle pro-government villagers, effectively displacing thousands of Zapatistas to more remote and inaccessible areas. Following intense public outcry about the military offensive, the government entered into negotiations with the Zapatistas and approximately one year later, on February 16, 1996, the EZLN and the federal government, jointly issued the “San Andrés Accords.” These Accords did not specifically address the organization of health care but they did set out a new “inclusive social contract based on a consciousness of the fundamental plurality of Mexican society and the contribution of indigenous peoples to national unity.”⁶⁸ The Accords also recognized indigenous peoples’ rights to “free determination” as set forth in Convention 169 of the International Labor Organization, to which Mexico is a party, and asserted that autonomy in the organization of their affairs was the concrete expression of such free determination. In signing the San Andrés Accords, the government assumed a core commitment to improve the health conditions and care of the indigenous peoples of Chia-

⁶⁴ EZLN. “Segunda Declaración de la Selva Lacandona.” In *Primera y segunda “Declaración de la Selva Lacandona:” Comunicados del 1 de enero al 23 de marzo de 1994*. Mexico City: EZLN; 1994. Available at: <http://www.ezln.org/documentos/1994/19940610.es.htm>. Accessed November 6, 2005.

⁶⁵ Centro de Derechos Humanos Fray Bartolomé de Las Casas (CDHFBC). “Informe para el Relator Especial de la Organización de las Naciones Unidas para los Derechos Humanos y las Libertades Fundamentales de los Indígenas.” Chiapas: CDHFBC. San Cristóbal de Las Casas; June 12, 2003.

⁶⁶ EZLN. “Segunda Declaración de la Selva Lacandona.” 1994. Available at: <http://www.ezln.org/documentos/1994/19940610.es.htm>. Accessed November 6, 2005.

⁶⁷ The efficacy of this strategy largely rests on the incapacity of the federal, state and local governments to confront or control it. The EZLN was thus able to reframe the terms of the confrontation.

⁶⁸ Global Exchange. “The San Andrés Accords.” 2004. para 2. Available at: <http://www.globalexchange.org/countries/americas/mexico/SanAndres.html> Accessed November 6, 2005.

pas, in accordance with the principles of self-determination and autonomy.⁶⁹ However, this vision was never to materialize. Then-President Zedillo took no steps to implement the San Andrés Accords and by September of 1996, peace talks had collapsed.

During and after the negotiations, far from the autonomy called for under the San Andrés Accords, the Mexican army was heavily involved in providing health and other social services within the small rural communities that lay in the conflict zone. The army has repeatedly justified its presence in indigenous communities as part of its “social work,” which in large measure consists of medical care and public health services. Investigations, including PHR’s previous report on the subject, have found, however, that this social work in the context of low-intensity warfare, promotes distrust of health services generally, as well as social polarization.⁷⁰ Any population that rejected the military’s medical services or any other activities was automatically labeled Zapatista and became subject to suspicion.⁷¹ In its 1999 review of Mexico’s compliance with its obligations under the International Covenant on Economic, Social and Cultural Rights (ICESCR), the United Nations Committee on Economic, Social and Cultural Rights (ESC Rights Committee) stated that it was particularly concerned about “the presence of numerous military and paramilitary forces within the indigenous communities of Chiapas, and in particular about the allegations made by civil society organizations that these elements interfere with the supervision and implementation of development programs and the distribution of economic and social assistance, and about the lack of consultations with the communities concerned.”⁷² In 2000, in part as a response to pressure from civil society organizations that followed up on the ESC Rights Committee’s recommendations, Federal Army health posts were removed, although testimonies indicate that there are residual effects on social polarization which remain.

Coinciding with the heightened military presence in communities during 1995 and 1996, further internal displacements were provoked by fear of burgeoning irregular armed forces which the army promoted among *campesinos* opposed to the EZLN. It is now known that members of the Mexican military financed,



Soldiers outside of a primary school in the municipality of Chenalhó, in the Altos region, where a military medical post was installed as part of the “social work” of the Federal Army (1998).

armed, and trained these “paramilitary” groups, as they later came to be called, with the aim of containing the Zapatistas. These groups have been and continue to be the main perpetrators of human rights violations in the region.⁷³

The government has also turned to other tactics to undermine social cohesion in Zapatista communities. For example, since 1995, both the federal military and other groups opposing the EZLN have promoted the massive introduction of alcoholic beverages to undermine Zapatista resistance. EZLN communities are “dry”, which is a policy that has garnered widespread support from women in those communities who claim that this policy has led to a reduction in domestic violence.⁷⁴ The systematic introduction of alcoholic beverages has aggravated divisions and conflicts in the region.

As documented in PHR’s previous report, *Health Care Held Hostage*, the civilian health sector in Chiapas was itself deeply politicized in the years following the EZLN uprising. *Health Care Held Hostage* revealed that patients were routinely asked politically motivated questions at public health care centers affiliated with IMSS-Solidaridad as well as the Ministry of Health. Zapatista sympathizers alleged persistent discrimination by

⁶⁹ Global Exchange. “The San Andrés Accords.” 2004. Available at: <http://www.globalexchange.org/countries/americas/mexico/SanAndres.html> Accessed November 6, 2005.

⁷⁰ Yamin AE, Penchaszadeh V, Crane T, *Health Care Held Hostage: Violations of Medical Neutrality and Human Rights in Chiapas, Mexico*. Physicians for Human Rights, Boston: 1998; 25-26, 31.

⁷¹ Arana-Cedeño, M. “La labor social del ejército.” *La Jornada*: February 20, 1998.

⁷² CESCR, Concluding Observations: Mexico, E/C.12/1/Add.41. CESCR Session February, 21 1999. para 25.

⁷³ Hidalgo O, Castro G. *Militarización y paramilitarización en Chiapas*. Chiapas: Centro de Investigaciones Económicas y Políticas de Acción Comunitaria (CIEPAC). San Cristóbal de Las Casas, Chiapas, December 1997.

⁷⁴ Misión Civil Nacional e Internacional de Observación por la Paz. San Cristóbal de las Casas, Chiapas, December, 1997.

⁷⁵ At the time of PHR’s previous report, this program was called IMSS-Solidaridad and it was subsequently named IMSS-Oportunidades for a short time. Yamin AE, Penchaszadeh V, Crane T, *Health Care Held Hostage: Violations of Medical Neutrality and Human Rights in Chiapas, Mexico*. Physicians for Human Rights, Boston: 1998; 25-29.

individual providers and institutions managed by both IMSS-Solidaridad and the Ministry of Health.⁷⁵ The findings of that study were corroborated by other studies.⁷⁶

After the Acteal massacre on December 22, 1997, in which PRI-aligned paramilitary gunmen killed forty-five unarmed people, including two infants and sixteen other children, as they were praying, the government further shifted its counterinsurgency strategy, with notable implications for health. According to several sources, then-President Zedillo and Labastida, his new Secretary of Government, developed a two-pronged strategy: to entice indigenous communities back “into the fold” by investing \$3.5 billion pesos in Chiapas social programs while destroying the Zapatistas’ autonomous municipalities one by one.⁷⁷

Within these social programs, health care and public health figured prominently. In 2003, Chiapas was still receiving the greatest share of national funds for the IMSS-Oportunidades program (22%), although its share of the overall health budget was small.⁷⁸ Accountability for how the monies were spent or ensuring non-discrimination was virtually non-existent. For example, through programs such as the “Cañadas Development Program” (Programa de Desarrollo de las Cañadas), the government funded some social programs, such as Paz y Justicia (“Peace and Justice”)⁷⁹ which had strong ties with the Federal army, and operated as a paramilitary wing that conducted activities in the Norte region of Chiapas.⁸⁰

During these years, the EZLN and its autonomous communities became increasingly insular. As Preston and Dillon write of this period:⁸¹

the Zapatistas, seeing that the Zedillo government was determined to destroy their alternative forms of self-rule, went into a defensive withdrawal. Their autonomous authorities went into hiding, and they closed the townships to most visitors. The differences between the priista and Zapatista villagers hardened into hatred. The gov-

ernment’s strategy also forced new privations on the Zapatistas who remained dedicated to their townships. Besieged by army troops, the towns were cut off from regional commerce, and the flow of international aid was large but not reliable enough to compensate. Since the Zapatistas refused to pay taxes, the authorities cut off their electricity, which was supplied by a state-owned company.

Construction of water distribution systems and other basic services, as well as access to government credits, were also systematically terminated. For their part, the Zapatistas blocked the construction of roads that might facilitate commerce, arguing that they would give the army access. The communities in resistance refused many directly provided governmental health services, including vaccinations.

2000-2005: Change in the Government and More of the Same

On July 2, 2000, Vicente Fox, the candidate of the National Action Party (Partido de Acción Nacional, or PAN) was elected president of Mexico, breaking the over 70-year PRI stranglehold on the Mexican presidency. The election of Fox was hailed as a “real opening of the political system” in Mexico and a chance for authentic democracy.⁸² Among other things, Fox promised to seek a negotiated solution to the conflict with the Zapatistas, which at the time he estimated would take fifteen minutes.⁸³

During the first months of Fox’s administration, public expectations rose that a solution to the conflict was near. A Zapatista delegation marched peacefully to Mexico City, attracting a vast participation of civil society and left wing political parties. The climactic moment of the march came when an indigenous woman, the Comandante Esther,⁸⁴ gave a speech addressing the National Congress about the rights of the indigenous people and autonomy. Over the course of the following days, President Fox introduced a bill that recognized the autonomy of indigenous people, the most critical aspect of the San Andrés Accords. This bill had been drafted by a non-partisan Congressional commission (COCOPA).⁸⁵

However, the national Congress passed this law with

⁷⁶ Arvide I. “La guerra de los espejos: La desconfianza en instituciones oficiales, se traduce en enfermedad y muerte.” *México: Océano*;1998:140-144.

⁷⁷ See e.g., Preston J, Dillon S. *Opening Mexico: The Making of A Democracy*. New York: Farrar, Strauss and Giroux; 2004:454.

⁷⁸ Secretaría de Salud (SSA), Dirección General de Información en Salud. “Estadísticas de recursos financieros públicos para la salud en México, 2003.” *Salud Pública de México*. 2005;47:90-98, 91.

⁷⁹ Paz y Justicia is an elite paramilitary group active in the Altos and in the northern part of the Selva region of Chiapas. It serves as a pilot program in the paramilitary-counterinsurgency project.

⁸⁰ Fazio C. “La guerra invisible.” *La Jornada*. February 14, 2005; Mariano Granados Chapa Miguel Ángel. “Chiapas, todavía.” *Diario Reforma*: February 13, 2005.

⁸¹ Preston J, Dillon S. *Opening Mexico: The Making of A Democracy*. New York: Farrar, Strauss and Giroux; 2004: 455.

⁸² Id., Preston J, Dillon S. 2004: 19.

⁸³ Gómez M. Fox “Frente a Chiapas y a los pueblos indígenas” *La Jornada*, June 1, 2000: p.3.

⁸⁴ “Discurso de la Comandante Esther ante el Congreso” *La Jornada* March 29, 2001:p.5.

a number of amendments that distorted the original aim of the concept of autonomy included in the San Andrés Accords. The EZLN broke ties with the Party of the Democratic Revolution (PRD) and other left-wing parties as some of their representatives had taken part in passing what the EZLN perceived as a betrayal of the intent of the San Andrés Accords. This debacle ushered in a period of renewed tensions together with a radicalization of EZLN resistance.⁸⁶ Consequently members of communities that supported the EZLN were condemned to a stance of permanent opposition with respect to the pro-government communities in order to retain their identity. Maintaining such a stance created ever greater tensions and consumed ever greater resources of the communities involved.

In 2000 an agreement was signed between the Mexican government and the Office of the High Commissioner for Human Rights (OHCHR) for the establishment of a sustained presence of the OHCHR in Mexico. The OHCHR felt such a presence was necessary for several reasons: the Mexican government was at an impasse on the implementation of the San Andrés accords; the human rights conditions of the indigenous peoples in Chiapas and other states had not improved and many people still lived in conditions of "extreme poverty and marginalization" and forced migration; the increasing militarization of the region; and the land disputes in which indigenous peoples were being deprived of their land and livelihoods. Daes, the Chairperson-Rapporteur of the OHCHR Working Group, also signaled the need for independent monitoring of the situation.⁸⁷

At the state level, the 2001 election of the alliance candidate Pablo Salazar Mendiguchía as governor of Chiapas appeared to bring about more openness and remedial actions, such as the dismantling of various

former PRI programs, including the above-mentioned "Cañadas Development Program."⁸⁸ As a result of this governmental shift, numerous civic organizations and communities that had maintained a posture of resistance progressively reinitiated participation in some of the government's health and development programs. Others, however, have continued to follow the strategy of resistance and have become increasingly radicalized. Consequently, those communities and groups supporting a hard-line Zapatista resistance position have pulled away from those who have assumed a more flexible attitude with respect to the government. In some instances, violent confrontations have occurred between groups that were allies until recently.⁸⁹

Forms of resistance, such as the non-payment of electricity bills, have also created confrontations. In many cases, the government-owned electricity company has responded by cutting the supply of electricity to opposition communities. As an effort to expand resistance, the EZLN has called upon other political and social organizations to adhere to the non-payment of electricity bills.⁹⁰

Although tensions between the state government and the EZLN have decreased, evidence suggests that internal community divisions and confrontations remain almost unchanged and are still potentially dangerous. Despite the fact that the number of cases has declined since 2001, human rights organizations still denounce cases of arbitrary arrests, extrajudicial executions and military invasions of community lands. Indeed, the violence that pervades the conflict zone has persisted and even worsened in recent months.⁹¹

At the same time, communities have increasingly

⁸⁵ Commission on Concordance and Pacification, (Comisión de Concordia y Pacificación, COCOPA).

⁸⁶ After issuing a press release stating that it refused to recognize the new law, the EZLN broke off talks with the government and maintained a public silence for almost twenty months.

⁸⁷ OHCHR. "Human Rights of Indigenous Peoples." Submitted by Erica-Irene A Daes, Chairperson-Rapporteur of the Working Group on Indigenous Populations. E/CN.4/Sub.2/2000/CRP.1. August 3, 2000; paras 1, 2, 6, 8, 10. Available at: <http://www.hri.ca/fortherecord2000/documentation/commission/e-cn4-sub2-2000-40.htm>. Accessed November 8, 2005.

⁸⁸ Salazar was the candidate of a seven-party coalition, including the Partido de la Revolución Democrática (PRD, Party of the Democratic Revolution), Partido Acción Nacional (PAN, National Action Party), Partido del Trabajo (PT, Work Party), Partido Verde Ecologista de México (PVEM, Green Ecologist Party), Convergencia para la Democracia (CD, Democratic Convergence), Partido de la Sociedad Nacionalista (PSN, National Society Party), Partido del Centro Democrático (PCD, Center Democratic Party), and Partido de la Alianza Social (PAS, Social Alliance Party).

⁸⁹ Numerous violent confrontations have occurred between EZLN supporters and PRD members in recent years, some of which have led to fatalities, including those in Pasté, San Juan Chamula, San Isidro and Nuevo San Rafael. Ambushes, assassinations and incursions by armed men also occur frequently. The government has also continued to cut electricity to opposition communities, such as municipalities of Yajalón, Flor de la Alianza, Tumbalá, Tila and Sabanilla. There have been arbitrary arrests, extrajudicial executions and military invasions of community lands, such as in the Zona Norte of Chiapas, zona baja de Tila, Ejido Emiliano Zapata; and San José Bascán, municipio de Salto de Agua. See e.g. www.enlacecivil.org.mx. Accessed January 10, 2006.

⁹⁰ *Diario Reforma*, Jan. 9, 2006.

⁹¹ See e.g. allegations of reactivation of militarization and paramilitarization by the Centro de Derechos Humanos Fray Bartolomé de las Casas. *Boletín Informativo Diario de la Comisión Mexicana de Defensa y Promoción de los Derechos Humanos*, January 15, 2006. In other events, on February 17, 2005 in an operation in the municipality of Tila, in the Norte region of Chiapas, police beat and arbitrarily detained at least 54 people according to Heriberto Cruz Vera, the parish priest of Tila. On March 20, 2005, the Center for Human Rights, Fray Bartolome de las Casas, received word that at least one person had been assassinated in the community of Masojá Grande in

shifted from being in opposition to being politically divided. However, this has not fostered a solution to the “insurgency”; on the contrary, it has led to the map of the conflict zone being covered with ever increasing numbers of divided communities, with ensuing health consequences.⁹²

Divided communities lose the capacity to speak with one voice, or through a particular leader or spokesperson, and are unable to respond collectively as needed. Building or maintaining a water distribution system, transferring a woman with an obstetric emergency to the hospital, identifying children with malnutrition, or making sure that health services function adequately, are only a few of the important activities that require communities to respond collectively. These activities are difficult or impossible when there are no mechanisms of communication and collaboration. The negative impact of divided communities range from one faction of the population blocking another’s use of services, to pressuring medical personnel to deny care to the opposing group. Moreover, the atmosphere of polarization and division in communities causes a climate of permanent tension that affects a large number of health conditions.⁹³

State health authorities in Chiapas have acknowledged in recent years that community divisions pose enormous difficulties in implementing programs. They have initiated a limited number of programs on health and nutrition that emphasize the importance of social inclusion of all the population, regardless of their political or religious affiliation. However, the positive effects of this new strategy have been stymied due to the lack

of resources, restricted coverage, and the limitations on training health personnel for these programs.⁹⁴

After a long period of relative silence, on June 21, 2005, the EZLN declared a “Red Alert” to call attention to the ongoing tensions in the conflict zone. The EZLN then published the *Sixth Declaration of the Lacandón Jungle*, in which it proposed a national program for peaceful struggle to attain a “new constitution that reincorporates the demands of the people” including health, independence, democracy, justice, liberty, and peace. In order to achieve this goal, the Zapatistas proposed the creation of what they called the “Other Campaign”—alluding to the presidential campaign and other political campaigns already underway. On January 1, 2006, the “Other Campaign” was formally launched in San Cristóbal de Las Casas, Chiapas.

the municipality of Tila. On March 21, gunfire was heard on the outskirts of the community of Nuevo Limar which is also in the municipality of Tila. Following the disturbances, there were heightened rumors regarding people connected to the paramilitary group Paz y Justicia (Peace and Justice) and to the PRI (Institutional Revolutionary Party) in Tila. The rumored paramilitaries were believed to be meeting in various communities and carrying firearms. The displaced communities in Tila have expressed concern about the Tila assassination, particularly since the leaders of these communities in recent months have received threats and have been subject to intimidation. Available at: http://www.laneta.apc.org/cdhbcasas/Boletines/2005/062905_tortura_yabteclum.htm. Accessed February 10, 2006.

⁹² For example, on the morning of November 25, 2005, members of the Junta de Buen Gobierno (Junta for Good Government) de la Realidad accused Zapatistas from the community Lucha Campesina, Altamirano, of firing on members of the Central Independiente de Obreros Agrícolas y Campesinos (CIOAC, Independent Central of Agricultural Workers and Peasants), leaving six dead and several badly wounded. The Junta de Buen Gobierno was closely affiliated with the Partido Revolucionario Democrático (PRD). Shortly after publishing the accusation, the JBG corrected itself, stating that there are no Zapatistas in the community where the shooting took place and that the incident occurred between people not connected to the

EZLN. By November 30, the JBG had researched the problem and identified the shooters as other PRD affiliates. Furthermore, they alleged that a former PRD deputy had falsely accused the Zapatistas for the incident. This incident marks the decline in good relations between former allies in the Zapatista struggle. Available at: <http://www.jornada.unam.mx/2005/11/27/016n1pol.php> and <http://www.jornada.unam.mx/2005/11/30/025n1pol.php>. Accessed December 13, 2005.

⁹³ Although this study did not explicitly address the consequences for mental health, many manifestations of fear, insecurity, and depression suffered by inhabitants in the conflict zone were observed during fieldwork. For example, an extremely worrisome indicator of the disruption of the social tissue in the communities affected by the polarizing effects of the conflict is suicide. Eight cases of suicide were found in the study (seven men and one woman). Seven of these deaths were caused by the ingestion of paraquat (Gramoxone), a powerful herbicide widely used by Chiapas peasants who work on large farms. In the eighth case, death was caused by hanging. Five of these suicides occurred in divided communities.

⁹⁴ See e.g., Programa “Vida Mejor para las mujeres, las niñas y los niños de Chiapas” Available at: http://www.dsosocial.chiapas.gob.mx/Vida_Mejor.htm. Accessed December 20, 2005.

III. METHODS

Given that poor health conditions and care were an underlying source of the Zapatista uprising, the study measured a set of leading health indicators in the conflict zone. The principal research questions included in this report were: 1) What is the maternal mortality ratio (measured by maternal deaths/100,000 live births)? 2) What is the infant mortality rate (deaths of children under one year/1,000 live births)? 3) What is the prevalence of childhood malnutrition? 4) What is the prevalence of smear-positive pulmonary tuberculosis? and 5) Are there significant differences between key health indicators for the study population and for the populations of Chiapas (as a whole) and/or Mexico?⁹⁵ Second, the study set out to examine if there is an association between health status (as represented, e.g., by infant and maternal mortality, malnutrition prevalence, and tuberculosis prevalence), access to and utilization of health services, and conflict-related factors (in particular, political-party affiliations and intra-community division in the areas of Chiapas most affected by the conflict); and analyze the human rights implications of those findings.

Identification of Study Population

Based upon exhaustive consultations with human rights groups, governmental institutions (including the Ministry of Health, Ministry of Public Works, and Ministry of Education), non-governmental organizations in the region, churches, and newspaper reports,⁹⁶ municipalities were identified as “severely affected by the conflict” when one or more of the following events had occurred: combat between the EZLN and the Mexican

⁹⁵ Not all of the study questions or domains of inquiry are presented in this report, which focuses on violations of the right to health; additional areas of study are discussed in journal articles published based on the findings of the study. See: Brentlinger P, Sánchez-Pérez HJ, Arana-Cedeño M, Vargas MG, Hernán MA, Micek M, Ford D. “Pregnancy Outcomes, Site of Delivery, and Community Schisms in Regions Affected by the Armed Conflict in Chiapas, Mexico. A Community-based Survey.” *Social Science and Medicine* 2005;61:1001-1014; Sánchez-Pérez HJ, Hernán M, Ríos-González A. et al. “Malnutrition among Children under Five Years of Age in Conflict Zones of Chiapas, Mexico.” *American Journal in Public Health*. forthcoming 2006. Other issues as vaccination, overall mortality, among others, are in preparation.

⁹⁶ National newspapers consulted: *La Jornada*, *El Financiero*, and *Reforma*; Chiapas newspapers consulted: *Cuarto Poder* and, in San Cristóbal de las Casas, *El Tiempo*.

army; paramilitary activities; assassinations of leaders or families of *campesinos* associated with the EZLN; displacement of persons due to presumed affiliation with the EZLN or with paramilitary groups; and public protests and organized appearances by the EZLN. Virtually all of the identified municipalities fell within the Altos, Norte and Selva regions of the state. Within these three regions, a list was compiled of all communities with populations between 300 and 2,499.⁹⁷ Information from the above-mentioned sources was then used to identify the political affiliation of all the communities on the list. Community status was classified as:

1. Opposition communities sympathizing with the EZLN (some of which were “in resistance”),
2. Pro-government communities (sympathetic to the government), and
3. Divided communities (which according to available information contained two or more groups whose positions toward the EZLN differed).

Fifty-four communities were randomly selected from a total of 524: eighteen in each of the three regions (six opposition, six pro-government, and six divided in each region). Six additional communities from the three regions were also randomly chosen as alternates (two opposition, two pro-government, and two divided communities).

Although multiple political, religious, and other local experts were consulted in order to classify all communities by political affiliation (opposition, pro-government, and divided communities), there was no “gold standard” census with which the investigators could confirm the opinions of local experts. As it would not have been politically, logistically, and financially feasible to visit every community in the study area to determine its political affiliation before the selection of study sites, after the process of classification and random selection of communities to be included in the study sample, community leaders were approached about enrollment in the study. At this stage, investigators determined that the current

⁹⁷ INEGI. *XII Censo General de Población y Vivienda, 2000. Tabulados Básicos Nacionales y por Entidad Federativa. Base de datos y tabulados de la muestra censal*. Aguascalientes: INEGI; 2001.; <http://www.inegi.gob.mx>.; INEGI. *Chiapas. Censo de población y vivienda, 1995. Resultados definitivos. Tabulados básicos*. México: INEGI; 1996. Available at: <http://www.inegi.gob.mx/est/contenidos/espanol/proyectos/coesme/programas/ficha.asp>. Accessed November 6, 2005.

political affiliation of the selected communities was sometimes different than what the experts had believed.

Based on interviews with community authorities and observations made in the field, of fifty-four selected communities, fourteen (26%) differed from their original classification: five pro-government communities had become either opposition or divided, five divided communities had become pro-government, and four opposition communities had become either pro-government or divided. Of the eighteen alternate communities, three (17%) did not correspond to their original classification: two divided communities had become pro-government communities, and one pro-government community suffered division.

Of the fifty-four selected communities, thirty-seven (68.5%) agreed to participate in the study, twelve (22.2%) refused, and five (9.3%) were not visited for the following reasons: three for lack of contact with the EZLN "autonomous governing councils,"⁹⁸ one for reasons relating to the security of the field team,⁹⁹ and one no longer existed when the study took place.¹⁰⁰

Given the non-response rates of opposition and divided communities, four other communities were purposively selected to be included in the sample to create comparative sample sizes among types of communities: one opposition and three divided. In the three divided communities, the opposition faction participated in the survey only under the condition that the "other" faction would not.¹⁰¹

The overall non-response rate at the community level was 23.6% without including the four non-randomly-selected communities. The highest non-response rate came from opposition communities (41.1%), while the lowest negative response rate came from the divided

(9.1%). At the household level, non-response was negligible; the members of only twenty households refused to provide any information for the study.

Consequently, the study was carried out in forty-six communities: thirty-seven chosen randomly, five randomly-selected alternates, and four purposively selected.¹⁰² Of these, twenty were pro-government, six opposition, and twenty divided. Of these twenty divided communities, the political affiliation of households could only be determined in twelve.¹⁰³

Sampling

Within each community, two procedures were used to select households for the study. First, one out of every three households was randomly selected to participate in the cross-sectional survey. The field team went to each community and drew up a census and map of its households.

Second, under the following circumstances, additional people were surveyed:

- When there had been a pregnancy, birth or a death in a household during the two years prior to the study.
- When there was someone age fifteen and older with a chronic cough (lasting more than fifteen days at the time of the study), or when the possibility of PTB was suspected.

Thus, although the health survey was fully conducted in one of every three households, the fieldworkers were instructed to inquire in all households whether either of the aforementioned circumstances applied to anyone there. This information was complemented with data obtained in an in-depth interview with the authorities in order to limit, as much as possible, the possibility of under-reporting cases of interest (i.e., pregnancies, deaths, and probable cases of PTB). Once the information on these aspects had been gathered, either through an in-depth interview with community authorities or through the household survey, the fieldworkers proceeded to verify whether all the reported cases of deaths, pregnancies, or possible PTB had been included in the study.

For the identification of cases of PTB, persons identified with chronic cough were given an additional questionnaire and asked to provide three sputum samples for the purposes of detecting PTB through acid-fast smears and cultures. The sensitivity of such tests varies according to the quality and quantity of samples obtained and the quality of the processing and reading performed. In Mexico, acid-fast smears have been esti-

⁹⁸ In autonomous municipalities, opposition communities are guided by the ordinances of autonomous councils, which have replaced officially designated authorities.

⁹⁹ A few days prior to conducting the study, a murder had occurred in the community.

¹⁰⁰ It is important to mention that in some cases of refusal, the denial to participate in the study did not come from the inhabitants of the villages, but from the autonomous councils. In one case of refusal, the community, in a meeting of the authorities and inhabitants, had already agreed to the study, but a group of five inhabitants did not accept the study. Consequently, a decision was taken not to proceed with the study in order to avoid any confrontation within the community.

¹⁰¹ However, these were not the only communities in which only one political faction was surveyed. In one divided community, for example, one of the two groups in the community refused to participate in the study because shortly before the survey, a man had been murdered and another had been wounded. Both of the victims (EZLN supporters) belonged to the group in the community that participated in the study, while the aggressors belonged to the group that not participated. The study was conducted only among the group that had suffered the aggression, amid considerable fear of further attacks against its members as well as the field team.

¹⁰² Thirteen from the Altos; sixteen from the Selva; and seventeen from the Norte regions, respectively.

¹⁰³ For reasons of safety, the research team did not ask for the political affiliation of some of those surveyed.

mated to permit detection of approximately 70% of positive PTB cases.¹⁰⁴ In the case of Chiapas, various studies have shown that the sensitivity of the test is drastically reduced in highly marginalized populations (as low as 44%).¹⁰⁵ The stigma associated with admitting to symptoms of PTB, combined with the likelihood of false negatives, suggests that reported numbers of PTB cases are almost certainly underestimated.

In cases of self-reported illnesses in the month prior to the study, an additional questionnaire was also given to identify possible barriers of access to health services as a consequence of the conflict.

To ascertain the nutritional status of the under-five population—the 2,704 young children recorded in the household census—weight and height were measured to determine height-for-age, weight-for-age, and weight-for-height parameters.¹⁰⁶ The field team was given intense training to standardize the measurements and data recording. This process was conducted in a theoretical and practical manner, using the standardization exercises developed by Habitch and Martorell.¹⁰⁷ To ensure data quality, a new set of stadiometers and Salter weight scales were employed, which were calibrated before each measurement.

In the forty-six communities studied, information was obtained from 17,931 individuals in 2,997 households: 1,477 households (49.2%) from pro-government communities, 256 (8.6%) from opposition communities, and 1,264 (42.2%) from divided communities (496 pro-government, 168 opposition, and 600 of undetermined political affiliation).

Consent

At the time the study was conducted, there was no functioning institutional ethical review committee in Chiapas.

¹⁰⁴ Llaca Díaz JM. "La baciloscopia y el cultivo en el diagnóstico de la Tuberculosis Extrapulmonar." *RESPYN*. 2003;4(3).

¹⁰⁵ Sánchez-Pérez HJ, Hernán M, Hernández-Díaz S, Jansá JM, Halperin D, Ascherio A. "Detection of Pulmonary Tuberculosis in Chiapas, Mexico." *Annals of Epidemiology* 2002;12(3):166-172.; Sánchez-Pérez HJ, Flores-Hernández JA, Jansá JM, Caylá JA, Martín-Mateo M. "Pulmonary Tuberculosis in Areas of High Levels of Poverty in Chiapas, Mexico." *International Journal of Epidemiology*. 2001;30:386-393.

¹⁰⁶ Birthdates were obtained and corroborated, whenever possible, with a birth certificate or a vaccination record. In keeping with the population's limited access to services, only 65 percent of the children were able to verify their date of birth through documentation. The consistency of the findings for these indicators demonstrated that despite the aforementioned difficulties, the data obtained were adequate for making an evaluation of the nutritional status of children under five.

¹⁰⁷ Habitch JP, Martorell R. "Anthropometric Field Methods: Criteria for Selection in Human Nutrition." In: DG Jelliffe, Edwards EP, eds. *Nutrition and Growth*. New York: Plenum Publishing Corporation; 1979;2:365-387.

However, the protocol was approved by a panel of experts assembled by PHR, and all research was carried out in accordance with the Declaration of Helsinki.¹⁰⁸

Consent for conducting the study in the selected communities was obtained in stages, and is itself reflective of the extreme degrees of mistrust that exists in the conflict zone. First, authorization was obtained from community leaders and institutions of authority. These institutions, for the most part, are made up of a community's general assembly or the assembly's representatives, such as health and education committees. Once permission had been obtained from the community authorities, a meeting was convened at which the study was presented to the entire adult population of each community. Finally, authorization from each head of the household was solicited in order to begin the survey.

Community authorities were shown the questionnaires to familiarize themselves with the questions to be asked in the households, and they were given the opportunity to delete any they considered inappropriate. The authorities of six communities (all in the Altos region) recommended refraining from asking questions about religion. For reasons of security, in eight of the divided communities, household members were not asked about their political affiliation.

In addition to the project co-directors representing ECOSUR and DDS-CCESC and the fieldwork coordinator, the field-work team comprised nine interviewers, four men and five women, who were hired based on their previous work experience with *campesinos* and community health promotion, as well as their language skills: two spoke Tzeltal, two spoke Tsotsil, two spoke both of these languages.

No financial incentive or compensation was provided to the participants, except for the wages paid to the community guides who had knowledge of the location of households in communities, and who helped either with the translation of the questions and answers during the survey, or in the collection of samples to identify possible cases of PTB.

Questionnaires and Survey

The design of the household survey was partially based on surveys that had been used in a series of previous studies conducted in other parts of the state of Chiapas.¹⁰⁹ Specific questions were added that related to conditions resulting from the armed conflict and resistance. The household survey included the following sections, which are discussed in this report: demographic and

¹⁰⁸ World Medical Association (WMA). Declaration of Helsinki. Ethical principles for medical research involving human subjects. Edinburgh, Scotland: WMA, 2000.

socioeconomic characteristics of all inhabitants; household health census (pulmonary tuberculosis, pregnancy outcomes in the last two years, childhood vaccination rates, and nutritional status of children under age five; self-perceived morbidity in the prior month and mortality in the previous two years; and questions about utilization of health services for self-perceived morbidity, vaccination, pre-natal and delivery care, and chronic cough (cough of more than 15 days duration).

In carrying out the survey, interviews were conducted primarily with heads of household and their spouses. However, for a large portion of the interviews, multiple adults in the household participated and field workers were trained in making adjustments for such arrangements.

In addition to the survey, an in-depth, structured questionnaire was designed for the authorities of the communities studied, including legal representatives of municipalities, administrators of communal lands, group representatives, and those in charge of health and education committees. These interviews gathered information on the following aspects of the communities:

1. *Demographic*: languages spoken, number of inhabitants, number of families, and the births and deaths (including maternal) during the two years prior to the study.
2. *Socioeconomic*: religions present, whether internal divisions existed and if so on what basis, whether the armed conflict of 1994 caused the displacement of inhabitants to other communities or if people had come or returned there from other communities, and the availability, quality, and coverage of basic services and programs for the community and improvement of dwelling conditions; and bias in provision of basic services (e.g. provision of services only to members of one faction in a divided community).
3. *Health*: main health problems in the view of community leaders, cases of deaths and injuries

¹⁰⁹ Sánchez-Pérez HJ, Ochoa-Díaz López H, Navarro y Giné A, and Martín Mateo M. "La atención del parto en Chiapas, México: ¿dónde y quién los atiende?" *Salud Pública de México*. 1998;40(6):494-502. Available at: <http://www.insp.mx.salud/40/406-6.pdf>. Accessed November 8, 2005; Sánchez-Pérez HJ, Flores-Hernández JA, Jansá JM, Caylá JA, and Martín Mateo M. "Pulmonary Tuberculosis in Areas of High Poverty in Chiapas, Mexico." *International Journal of Epidemiology*. 2001;30(2):396-393. Available at: <http://ije.oupjournals.org>. Accessed November 8, 2005; Ochoa-Díaz López H, Sánchez-Pérez HJ, Ruiz-Flores M, and Fuller M. "Social Inequalities and Health in Rural Chiapas, Mexico: Agricultural Economy, Nutrition, and Child Health in La Fraylesca Region." *Cadernos Saúde Pública*. 1999;15(2):261-270. Available at http://www.scielosp.org/scielo.php?script=sci_arttext&pid=S0102-311X1999000200011. Accessed November 8, 2005; Palacios-Blanco JC, Sánchez-Pérez HJ, Nieves-Escudero A, Ochoa-Díaz H. "Uso de servicios de salud ante morbilidad percibida en niños menores de cinco años en Chiapas, México." *Bol Med Hosp Infant Mex* 2002;59:6-20.

(wounds or accidents) in the community within the last two years, and cases of chronic cough in persons age fifteen and older or with PTB.

4. *Health Services*: availability, characteristics, and coverage (including the supply of medicines and vaccines) of community health services, along with the distances and problems involved in getting patients to hospitals for treatment. Information was also collected on the presence of midwives in the community, whether there were any training programs for the community health providers or midwives, and whether the institutional health services offered any kind of assistance.

Statistical Analysis

Information obtained in the surveys was organized in databases using the program *Fox-Pro Version 6.0*. For standardization and subsequent inclusion of information, a specific process was developed. For each of the variables analyzed, a manual of coded responses was created. Once entered, data were verified through several procedures: First, a simple frequency analysis (to detect coding errors) was performed using *Statistical Package of Social Sciences* (SPSS), version 10.0. Second, data were verified by physically comparing them against the questionnaires. Finally, programs were designed to verify the congruence and consistency of data using vector methodology, that is, the correlation of two or more variables of interest.

Statistical analysis of the data was done with *SPSS* and *Stata Version 7.0* (College Station, TX: Stata Corp., 2001) to obtain frequencies, proportions, means, and tests of significance (mainly chi-square and t-tests). In all bivariate analyses, statistical significance was defined as $p < 0.05$.

Children's anthropometric data was entered into databases using the program *Fox-Pro Version 6.0* and then copied into the program *Epi Info*.¹¹⁰ This was done to calculate the anthropometric indicators by comparing the values measured for the population studied, with the NCHS reference values included in *Epi Info*. In order to compare this study with others and to conduct bivariate and multivariate analysis, children were classified in two categories: not malnourished (those considered normal or with mild malnutrition, its mean, with less than -1 to at most -2 standard deviation points) and malnourished (those with moderate and severe malnutrition, with Z-scores of -2 or less).¹¹¹

¹¹⁰ *Epi Info 6*, Version 6.04. Centers for Disease Control and Prevention, Atlanta, Georgia, and Geneva, Switzerland: January 2001.

¹¹¹ National Center of Health and Statistics (NCHS), World Health Organization (WHO). *Growth Charts*. Rockville: NCHS, Dew Publications, 2000.

IV. FINDINGS

Selected Demographic, Socio-economic and Ethno-linguistic Indicators

The populations of the regions studied are very young, with 47% under the age of fifteen. The proportion of inhabitants under age fifteen, both overall (47.2%) and by community type, was much higher than figures recorded in the last national population census carried out in 2000 for the studied regions (42%), Chiapas (38%), and all of Mexico (33.4%).¹¹² Chiapas has the second lowest median age (nineteen) among the Mexican states, compared with the median age of twenty-two for the whole country.¹¹³ In this study, the median age of those studied in each of the three community types was approximately sixteen. The high youth population calls to attention the need for child and adolescent health interventions, reproductive health care, education and housing. In a broader sense, it highlights current and future pressure on the region's economy and the over-exploitation of natural resources.

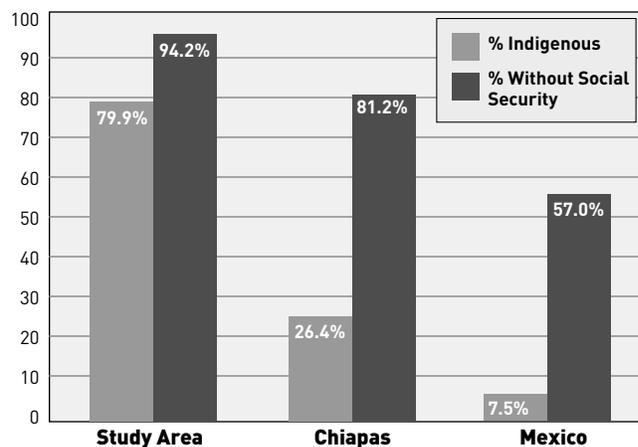
Between 80% and 99% of the population in the conflict zone are indigenous,¹¹⁴ and nearly half (48.4%) do not speak Spanish. Across the three regions, monolingualism in adults is nearly twice as high among females (61%) as males (36%). The communities in the conflict zone belong to various ethno-linguistic groups. In the Altos region, the main languages spoken are Tsotsil and Tseltal; in the Selva region, Tseltal and Tojolabal; and in the Norte region, Chol.

On the other hand, with the exception of the Selva region, the regions affected by the conflict also have a high demographic density. In spite of this, more than 75% live in settlements of fewer than 2,500 inhabitants

(Table 1). This dispersion, which has greatly increased over the last ten years, indicates the difficulty of providing adequate social services to these populations.

The high proportion of inhabitants of the conflict zone who do not speak Spanish, particularly women, means in practice that these people have few possibilities to participate in social and economic decisions and processes. Almost all public services (health, educational, etc.) are provided in Spanish, in spite of interpretations of international law calling for such services, and past efforts to develop programs. Virtually no doc-

FIGURE 1



tors in the formal health system speak the indigenous languages (although some health promoters and non-professional health providers do). This lack of language-appropriate health services constitutes an enormous cultural barrier for people to access health care.¹¹⁵ As noted above, women are more often monolingual and are ordinarily in greater contact with the health system for reproductive and child health care. The lack of language-appropriate health services often deprives them of the ability to effectively communicate their health needs and choices.

Economic barriers to care are also significant. More than 90% of the studied population did not have any

¹¹² INEGI. *XII Censo General de Población y Vivienda, 2000. Tabulados Básicos Nacionales y por Entidad Federativa. Base de datos y tabulados de la muestra censal.* Aguascalientes: INEGI; 2001.

¹¹³ CONAPO (Consejo Nacional de Población). 2001. Available at: <http://www.conapo.gob.mx>. Accessed March 9, 2005.

¹¹⁴ In order to make this study comparable with others conducted in Mexico, those individuals age five and older whose first language was not Spanish were considered indigenous. Government population studies and analyses have considered municipalities or communities eminently indigenous if 40 percent or more of their population age five and older speak an indigenous language. With 80% of those speaking an indigenous language, one can say that all the communities have a predominantly indigenous population.

¹¹⁵ Similarly, bilingual teachers do not always work in communities that speak their own languages. During the survey, the field team observed that several teachers who were Tseltal speakers, were working in Tojolabal communities in the Selva region, and did not speak the language of this community.

TABLE 1. Socio-demographic indicators in Mexico, Chiapas and the studied regions, 2000.

Indicator*	Altos	Selva	Norte	Study Area	Chiapas	México
Population density (per km ²)	109.2	17.7	103.6	76.8	51.8	49.6
% residing in communities of fewer than 2,500 inhabitants	75.6	76.2	87.1	79.6	54.3	25.4
% age five and older who are indigenous	98.8	54.3	86.5	79.9	26.4	7.5
% monolingual Indigenous	62.9	32.1	35.3	40.9	61.2	16.6
% illiteracy (15 years and over)	50.3	66.9	61.5	59.5	22.9	9.5
% population without social security	92.2	94.9	95.6	94.2	81.2 ¹	57.0
Average number of inhabitants per household	5.3	5.5	5.4	5.4	4.8	4.4
% households with running water	39.2	57.3	76.3	57.6	74.4	88.7
% households with dirt floors	89.2	58.8	76.8	74.9	38.4	14.8
% households burning wood for cooking	98.3	84.9	92.1	91.8	54.5	17.5
% households with electricity	75.7	71.6	75.9	74.4	87.9	95.0
Degree of marginalization of its municipalities ²	VH=13 H=2 L=1	VH=7 H=4 L=0	VH=12 H=10 L=1	VH=32 H=16 L=2	VH=44 H=65 M=6 L,VL=2	VH=386 H=906 M=486 L,VL=66 4

Source: Instituto Nacional de Estadística, Geografía e Informática (INEGI). *XII Censo General de Población y Vivienda, 2000. Tabulados Básicos Nacionales y por Entidad Federativa. Base de datos y tabulados de la muestra censal.* Aguascalientes, México: INEGI, 2001.

* In all indicators analyzed, $p < 0.05$ (χ^2 among three groups).

¹ Calculation based on the number of total inhabitants, and the number of people with social security.

² According to: Consejo Nacional de Población (CONAPO). *Indicadores socioeconómicos e índice de marginación municipal, México, 1990.* México: CONAPO, 1993; and CONAPO/PROGRESA. *Índices de marginación.* México: CONAPO, 1998.

Degrees of marginalization: VH = very high, H = high, M = medium, L = low, VL = very low.

form of health insurance. In fact, Chiapas is the Mexican state that receives the lowest amount of health resources per capita and has the lowest number of inhabitants covered by some form of social security (*i.e.*, employment related health insurance): approximately 17% *versus* 40.1% for the entire country.¹¹⁶ In this study, the proportion of inhabitants without any insurance averaged 94.2%.

¹¹⁶ Sánchez-Pérez HJ. *Tuberculosis pulmonar en zonas de alta marginación socioeconómica de Chiapas, México: Problemas y retos a superar: El caso de la Región Fronteriza.* Doctoral thesis. Barcelona: Universidad Autónoma de Barcelona; 1999; Consejo Nacional de Población (CONAPO). 2001: <http://www.conapo.gob.mx>. Accessed November 7, 2005.

Selected Social Determinants of Health

Education

There may be no social determinant of greater importance to health status than education. Female literacy in particular has been linked to better reproductive and maternal health status as well as improved child health outcomes.¹¹⁷ Education is critical to enabling people to navigate health and other social systems, make informed choices, and participate in discussions and plans that may affect their health and well-being, as well as other decisions about their lives.

¹¹⁷ Garza C, de Onis M. "Justificación para la elaboración de una nueva referencia internacional de crecimiento." *Food and Nutrition Bulletin.* The United Nations University; 2004;25(1):6-11.

Chiapas, along with the states of Oaxaca and Guerrero, has the highest levels of illiteracy in the country. The illiteracy rate among the population studied, however, was even higher than the rate recorded for the state as a whole; according to official statistics, 23% of the population of Chiapas age fifteen and older has not had any schooling, compared to over 30% among the three groups studied. The difference between the study population and the national average is, however, far more striking; official government statistics claim that Mexico has a national illiteracy rate of 9.5%.¹¹⁸ Of the population surveyed, 36% did not know how to read or write. The average number of years of schooling was found to be 3.4, which is functionally illiterate.

Gross gender inequalities were reflected in the education level data. The average number of years of study for men over fifteen in the study population was 4.19; 22.3% had no schooling whatsoever. Females over fifteen, in contrast, had an average of 2.68 years of education and almost half of women and girls over fifteen (43%) had no schooling at all. In contrast, national statistics claim that 88.6% of women in Mexico are literate.¹¹⁹

By specifically analyzing educational indices for the children who were of school age during the first years of the conflict, the investigation observed how this population was affected by the closing of schools and subsequent re-opening only for pro-government communities and families. For the children who were age seven in 1994, at the time of the study (2000–2001) six to seven years later, nearly 9% still had no schooling, and only 22% had any post-primary education. Children from divided and pro-government communities were the most affected, with 7% and 11% of their children, respectively, without any schooling and only one in five having gone beyond primary school. Children in opposition communities appear to have been the least affected, with none without schooling, and nearly 37% with some secondary education or beyond. For the rest of age groups, the same trends were observed: opposition communities had higher percentages of children having some form of schooling or reaching a post-primary school level, although they were never more than 50%.

The seemingly better educational conditions (lower illiteracy, greater access to post-primary studies) observed in opposition communities, with respect to

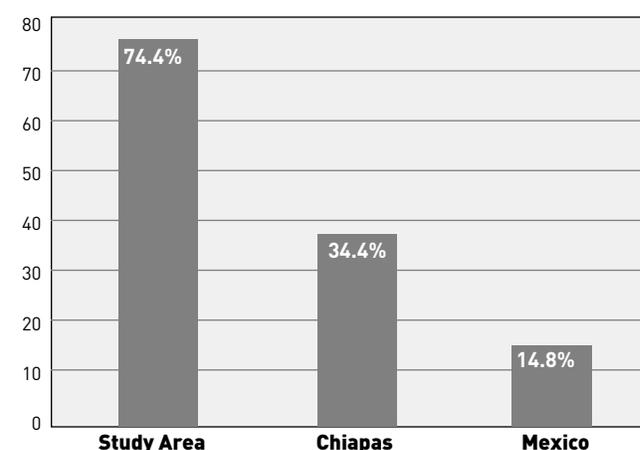
the other two groups, may be attributable to one or more of the following reasons: 1) opposition groups arose from populations with higher educational levels, and the difference has been preserved during the conflict; 2) the lack of participation in this study of communities with highest levels of resistance, where it is likely that less favorable educational conditions exist because of their oppositional stance;¹²⁰ and, 3) the non-governmental educational systems developed by opposition communities are having a positive impact on their population. This differentiates them from pro-government and divided communities which, despite having governmentally-provided educational services, exhibit a lack of resources and reflect the abandonment of the education sector in the state of Chiapas.¹²¹

Shelter and Housing Conditions

Dwelling conditions were observed to be inadequate in all three groups, although certain negative characteristics such as greater overcrowding and dirt floors were more prevalent in the divided communities. (See Table 2).

The study found overcrowding among all three groups, which is a contributing factor in the spread of

FIGURE 2: Percentage of Homes with Dirt Floors



infectious diseases such as tuberculosis. A significantly higher than average number of inhabitants per household (5.9) was found in the three groups studied. This figure was higher than the official statistics reported

¹¹⁸ INEGI. *Estadísticas a propósito del día internacional de la alfabetización: datos nacionales*. Available at: www.inegi.gob.mx/inegi/contenidos/espanol/prensa/contenidos/estadisticas/2002/alfabeti02.pdf. Accessed November 7, 2005; The illiteracy rates for men and women are 8% and 11%, respectively. UNFPA, *State of the World's Population 2005: The Promise of Equality; Gender Equity, Reproductive Health and the Millennium Development Goals*. 2005:110.

¹¹⁹ INEGI. *XII Censo General de Población y Vivienda*. 2001. Available at <http://www.inegi.gob.mx/est/contenidos/espanol/rutinas/ept.asp?t=medu25&c=3293>. Accessed November 7, 2005.

¹²⁰ As previously mentioned, based on observations conducted in the field, it is quite feasible that this type of community has less advantageous socioeconomic indicators (including education) than the rest of the groups.

¹²¹ In different educational evaluations, Chiapas has the worst levels of education in the country. See for example: *Periódico Reforma*, January 17, 2006; p.1.

¹²² INEGI. "XII Censo General de Población y Vivienda". Available at <http://www.inegi.gob.mx>. Accessed November 6, 2005.

TABLE 2. Indicators of shelter and housing conditions by political affiliation of communities.

Indicator*	Pro-Govt.	Opposition	Divided	Total
Number of studied households	1,477	256	1,264	2,997
Average number of inhabitants per household (SD)	5.86 (2.53)	6.34 (2.77)	6.10 (2.61)	5.98 (2.59)
% with dirt floors	67.9	74.5	81.9	74.4
% without indoor access to water	27.7	38.8	27.3	28.5
% using wood for cooking	93.2	96.1	98.2	95.5
% without electricity or any type of artificial lighting	10.2	3.9	12.9	10.8
Type of disposal excreta system:				
% with toilet / septic tank	14.9	7.8	10.3	12.3
% with latrine	54.1	76.1	73.2	64.0
% without any type ("at ground level")	31.0	16.1	16.5	23.6

* In all indicators analyzed, $p < 0.05$ (X^2 among three groups)

for the entire state (4.8) and for the entire country (4.4).¹²² Further, these figures are likely to underrate the disparities with the rest of the country, as most of houses in the studied population have only one room, whereas that is not the case on the national level.

The proportion of homes with dirt floors in the study area (74.4%) is nearly two times as high as for the entire state of Chiapas (38.4%), and five times as high as for all of Mexico (14.8%).¹²³ In rural communities, having a dirt floor (as opposed to a cement or other floor) is an indicator of the lack of purchasing power among the population.¹²⁴ Having a dirt floor is also associated with higher incidences of parasitic diseases (such as hookworm) and anemia.¹²⁵

Water and Sanitation

Water and sanitation are among the most important conditions that enable people to be healthy. Almost a third of studied households (28.5%) lacked running water in the household. Opposition communities had the highest proportion (39%) of households without running water, while pro-government and divided communities had a lower percentage without this service (27%). Having access to running water in the household makes it far more likely that families can meet the

World Health Organization (WHO) recommendation of at least 20-40 liters per person per day for drinking, cooking and bathing. Having running water in the household has gender implications because it is usually women who must fetch water for cooking, cleaning and consumption if it is not running in the home. "Running water" does not, however, guarantee the WHO's minimum recommendation with respect to "potable," which is defined as less than 10 fecal coliforms per 100 ml of water. Indeed, other studies have documented that there are significant problems relating to poor quality and bacteriological content of drinking water in areas with high poverty levels in Chiapas.¹²⁶

With respect to sanitation, almost two thirds of the studied population (64%) uses latrines. However, even though pro-government communities had the highest proportion of toilets or septic tanks (15%), they also had the highest proportion without any sanitation system. In the opposition and divided communities, the proportion of households using latrines was more than 70%, compared to 54% in pro-government communities. What is most important to note however, is that almost a quarter of the entire population surveyed had no sanitation system whatsoever (23.6%). This is in a country which claims to be at the verge of achieving high human development according to its national indicators.¹²⁷ As poor sanitation is one of the greatest sources of fecal-

¹²³ Id., INEGI.

¹²⁴ Secretaría de Desarrollo Social (Sedesol). *Indicadores de marginación por comunidad*. Tuxtla Gutiérrez, Chiapas: SEDESOL, 2003.

¹²⁵ Dávila-Gutiérrez C, Trujillo-Hernández B, Vázquez C *et al.* "Prevalencia de parasitosis intestinales en niños de zonas urbanas del estado de Colima, México." *Bol Med Hosp Infant Mex* 2001;58(4):34-47; Marcos L, Maco V, Terashima A. *et al.* "Parasitosis intestinal en poblaciones urbana y rural en Sandia, Departamento de Puno, Perú." *Parasitol. Latinoam* 2003;58(1-2):35-40.

¹²⁶ Sánchez-Pérez HJ, Morales-Vargas G, Méndez-Sánchez JD. "Calidad bacteriológica del agua para consumo humano en zonas de alta marginación socioeconómica de Chiapas: ¿apta o no apta?" *Salud Pública Mex* 2000;42:397-406.

¹²⁷ United Nations Development Programme (UNDP). *Human Development Report, 2005*. New York: UNDP. Oxford University Press; 2005:255.

TABLE 3. Provider of delivery care during the latest pregnancy in the previous two years.

Indicator*	Pro-Govt.	Opposition	Divided	Total
Number of women age 12–49 with a pregnancy terminated in the two years prior to the study	582	108	533	1,223
Agent attending birth:	(%)	(%)	(%)	(%)
Governmental	17.0	22.2	13.7	15.5
Non-Governmental	0.7	0.0	0.2	0.4
Private	1.4	0.9	0.2	0.8
Traditional birth attendant	74.3	63.9	76.3	74.2
Non-Health	5.4	9.3	8.5	7.1
None	1.2	3.7	1.1	1.4
Site of delivery:	(%)	(%)	(%)	(%)
Governmental	13.4	20.4	8.3	11.8
Private	1.6	0.9	0.2	0.9
Home of the Woman	80.6	74.1	85.9	82.3
Home of the traditional birth attendant	2.3	2.8	2.1	2.2
Home of a relative	2.3	1.9	3.6	2.85

* In the two indicators analyzed, $p < 0.05$ (χ^2 among three groups).

oral contamination and the spread of numerous diseases, including various gastrointestinal diseases, the WHO has recommended that a national policy on basic sanitation would aim to provide at least one latrine per household.

Maternal Health

Prenatal Care

The investigation documented a total of 1,223 pregnancies for the two years prior to the study, eight (0.7%) of which ended in the mother's death. Of the 1,221 women for whom data was gathered,¹²⁸ over half (53.9%) were seen only by a traditional birth attendant (TBA). Of the remaining women, 8.6% were attended by both a TBA and governmental providers in public health services; 29.7% by government health services exclusively; 1.3% by other services (private or non-governmental), 2.6% by non-health agents (family members, neighbors), and 3.9% did not receive any prenatal care.

Surprisingly, a significantly greater number of women in those opposition communities surveyed received prenatal care from a combination of governmental health services and TBAs (63.9%) than in governmental or divided communities (35.3% and 36.4%,

¹²⁸ It was not possible to obtain any information about prenatal care for two of the pregnancies.

respectively), although this may be an anomaly due to the high rate of non-participation by communities in more hard-line resistance. Furthermore, qualitative information suggests that prenatal consultations in this group are generally done with TBAs while women go to public health facilities to secure certain medicines.

Among the women who did not utilize government health services for prenatal care, the principal reasons for not going were, in descending order: the remoteness of services from their communities (22%), a preference for going to TBAs (21.6%), lack of time, which is related to remoteness as well as household obligations (21.4%), and distrust of these services (including mistreatment and poor care, among others, 20.6%). Of course, poor treatment, among other factors, is also reflected in women's preferences for being attended by TBA's.

Use of Delivery Care Services

Of the women studied, almost three quarters (74%) were attended by TBAs during childbirth. These results confirm the outcomes of other studies in Chiapas, which found that a large proportion of pregnancies and deliveries are assisted by TBAs, who in most cases, do not have a support team for the diagnosis and adequate treatment of possible obstetric complications.¹²⁹ For

¹²⁹ Sánchez-Pérez HJ, Ochoa-Díaz López H, Navarro i Giné A, Martín-Mateo M. "La atención del parto en Chiapas, México: ¿dónde y quién los atiende?" *Salud Publica Mex* 1998;40:494-502.

these reasons, TBAs are not considered skilled birth attendants according to the WHO, World Bank or international standards.

Only 16% of overall births were attended by government health personnel. Of the remaining births, 7% were attended by non-health personnel (family members or neighbors), and 1.4% were not attended by anyone.

Almost nine of every ten births (87.3%) occurred at the home of the woman, the woman's relative or of the TBA, rather than in a health facility. Only 11.8% of births took place in governmental health services. Among the 1,034 women who did not use government services for their delivery, the main reasons they cited were: preferring a TBA (28%), lack of time to get to a health facility (22%), lack of nearby health facility (20%), and distrust of services (16%). However, mistreatment and poor care were cited by 30.5% and 21.4% of women in pro-government and divided communities, respectively, as reasons for not delivering in public health services, compared with 1.9% in opposition communities. On the other hand, "distrust" of services was cited far more commonly by women in opposition communities (14.2%). A number of studies have documented cases of forced sterilization in the region, which may have contributed to women's mistrust of health care providers.¹³⁰

The percentage of women delivering in a public or private health facility was notably lower in divided communities than in either opposition or pro-government communities (8.5% *versus* 15% and 21.3% respectively).¹³¹ Despite fluctuations in community classification, the research team believes these differences to be significant. Qualitative information that supplements the survey data reveals that in communities that lack health services and access to transportation, it is exceedingly difficult to transport women to a health facility with the capacity to provide essential obstetric

care. Arranging for such transportation can often require communal, rotating fund arrangements and collective action to secure transportation. In divided communities, people noted that the possibilities of obtaining economic or material support and assistance (child care, housing, personal belongings, among other aspects) from neighbors, as well as any vehicle able to bring a woman to a hospital (for possible obstetrical complications), are seriously limited.

The study also found that often women from all community types who arrive at the hospital after traveling for several hours find that there are no doctors available (especially on weekends, holidays, or at night) or that there are no medicines or equipment to treat obstetric emergencies. The women must then be transported again for several more hours under wholly unfavorable conditions and often on barely passable dirt roads. In several of the communities studied similar documented cases arose which on some occasions culminated in the death of the mother, the child, or both.¹³²

Maternal Mortality in the Previous Two Years

The investigation documented eight cases of maternal deaths occurring in the two years prior to the study. Six of these women were living in pro-government communities and two in divided communities. All eight women were indigenous and had a maximum of three years of primary education; five were monolingual; and none of them had health insurance.

Further research is needed to better understand all contributing factors that affect the high maternal mortality in the study area, such as intra- and inter-family relations, use of traditional *versus* government services, the cultural practices and representations surrounding maternity among the women (especially indigenous women) in Chiapas, and the relative influence of intra- and inter-community social, political, and religious conflicts.

However, it is clear that three types of delays played a role in these women's deaths.¹³³ First, there were delays in the decision to seek care due to lack of money, lack of transportation, lack of a referral by a doctor or community health promoter and, related to that, lack of awareness of the gravity of the situation. Second, there were delays in the time it took the women to arrive at medical care. Two women died en route and one died while wait-

¹³⁰ In this study, a 35-year-old woman from an opposition community in the Altos region, reported being scolded by a doctor who told her that she must undergo surgery because "you are not an animal needing to have so many children." Because she did not want surgery or to be treated in that manner, she left the health center and was taken to another health facility by her family. See also: Freyer-muth G. *Las mujeres de humo. Morir en Chenalhó. Género, étnica y generación, factores constitutivos del riesgo durante la maternidad*. México: Centro de Investigaciones y Estudios Superiores en Antropología Social (CIESAS), Comité por una Maternidad Voluntaria y sin Riesgos, Instituto Nacional de las Mujeres, Miguel Ángel Porrúa, 2003; Hidalgo O, Castro G. *Población desplazada en Chiapas*. Chiapas, México: CIEPAC; 1999; Kirsch J, Arana-Cedeño M. "Informed Consent for Family Planning for Poor Women in Chiapas, Mexico." *Lancet* 1999;354(9176):419-420. Available at: <http://www.thelancet.com/> Accessed November 7, 2005.

¹³¹ The high percentage from opposition communities may be attributable to sampling bias because the most hard-line opposition communities did not participate in the study.

¹³² For more details, see: Brentlinger P, Sánchez-Pérez HJ, Arana-Cedeño, M, Vargas MG, Hernán MA, Micek M, Ford D. "Pregnancy Outcomes, Site of Delivery, and Community Schisms in Regions Affected by the Armed Conflict in Chiapas, Mexico. A Community-based Survey." *Social Science and Medicine* 2005;61:1001-1014.

¹³³ See D. Maine et al, *Safe Motherhood Programs: Options and Issues*. Center for Population and Family Health. Columbia University School of Public Health. 1991.

ing for transportation. Third, there were delays in receiving care and a lack of capacity to resolve obstetric emergencies upon arrival at health facilities. Four of the deaths occurred at hospitals.

Based on these eight deaths out of the 1,319 live births recorded for the two years prior to the study, the research team found the crude maternal mortality rate to be 607 per 100,000 live births (95% CI = 262–1192). Although the sample size was small, this data indicates a maternal mortality ratio far higher than that calculated by the health sector both for Mexico and for the state of Chiapas, which itself has the highest maternal mortality ratio in the country.¹³⁴

According to official figures, the maternal mortality rate for 1999 was 53 per 100,000 live births for Mexico and 66 per 100,000 live births for Chiapas.¹³⁵ For 2001, the ratio for Mexico was 59 and for Chiapas 84 per 100,000 expected births.¹³⁶ In fact, while the maternal mortality ratio in Mexico remained around 47–59 per 100,000 registered live births during the 1990–2001 period, in Chiapas this indicator has been rising.¹³⁷

Moreover, it is quite probable that this investigation has under-estimated the maternal mortality ratio due to: 1) an under-diagnosis of women who died early on in their gestation from pregnancy-related causes; and 2) the lack of participation in the study of more resistant opposition communities, which have the least access to emergency obstetric care.¹³⁸

While high maternal mortality is an indicator of the

marginalization of the female population, it is also indicative of the inadequate health systems in the area. It is now widely recognized that the keystone to preventing maternal deaths is available, accessible (both physically and economically), acceptable (both scientifically and culturally) and quality emergency obstetric care.¹³⁹ The lack of access to and use of emergency obstetric care indicated by the data on mortality, use of services and reasons for not using services, constitutes both a serious public health problem and a grave human rights issue.¹⁴⁰

Child Health

As children are among the most vulnerable group in a population, child health speaks particularly strongly to a number of different aspects of the neglect of the populations in the areas studied as well as the hardships suffered by those living in the conflict zone. For example, the nutritional status of children under age five is typically an indicator of how general living conditions and changes in them, whether gradual or sudden, affect a population. Poor vaccination coverage, on the other hand, reflects failures in the health care system.

Childhood Malnutrition

Malnutrition is largely associated with preventable deaths in children.¹⁴¹ Chiapas has one of the highest mortality rates associated with nutritional deficiencies in Mexico and is the state with the highest mortality rate for diarrheal diseases in children under age five. In 2000, while the rate for the entire country was 21.4 per 100,000 children under age five, in Chiapas it was more than double that (48.5/100,000). In other states, the rate was far lower (e.g., in Colima, the rate was only 3.8 per

team knows of at least two cases of women dying during pregnancy or delivery in opposition communities that were in the original sample, but refused to participate in the study.

¹³⁹ Berer M, Sundari Ravindran TK, eds. *Safe Motherhood Issues: Critical Issues*. Blackwell Science; Reproductive Health Matters (1999), "Introduction" pp. 3-13.

¹⁴⁰ Although the sample size was small and results cannot be generalized for the entire conflict zone in Chiapas (especially for opposition communities that did not allow participation in the study), in conjunction with qualitative information gathered, they do suggest serious problems regarding the access and use of obstetric services in the area. For an analysis of human rights obligations relating to maternal mortality, see Yamin AE, Maine DP. "Maternal mortality as a human rights issue: Measuring compliance with international treaty obligations." *Human Rights Quarterly*. 1999;21(3): 563–607.

¹⁴¹ Ávila-Curiel A, Chávez-Villasana A, Shamah-Levy T, Madrigal-Fritsch H. "La desnutrición en el medio rural mexicano: Análisis de las encuestas nacionales de alimentación." *Salud Pública de México* 1993;35(6):658–666. Available at: <http://www.insp.mx/salud/35/356-17s.html>. Accessed November 7, 2005.

¹³⁴ CONAPO. "Cuadernos de Salud Reproductiva en Chiapas, México." *Consejo Nacional de Población*; 2000. See also: Freyermuth EG., Jimenez CV, Manca MC. *La muerte materna en Tenejapa, San Cristóbal de las Casas*. Chiapas: Comité por una Maternidad Voluntaria y Sin Riesgos en Chiapas; 1999.

¹³⁵ SSA (Secretaría de Salud). *La situación de salud en los estados, 1999*. Mexico City: Dirección General de Estadística e Informática, SSA: 2001.

¹³⁶ Id., SSA. 2001.

¹³⁷ SSA. Dirección General de Estadística e Informática. *Mortalidad 1990; Mortalidad 1991; Mortalidad 1992; Mortalidad 1993; Mortalidad 1994; Mortalidad 1995; Mortalidad 1996; Mortalidad 1997*. México: SSA, años 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997; SSA. *La situación de salud en los estados, 1999*. México: SSA, 2001; SSA, Dirección General de Información y Evaluación del Desempeño (DGIED). *Coordinación de Planeación Estratégica: Mortalidad, 2001*. México: SSA, DGIED, 2001.

¹³⁸ The proportion of obstetric emergencies that did not receive medical attention documented by this study was higher than in some other studies conducted in the state of Chiapas. For example, while half of the eight maternal deaths documented in this study did not receive any health care, one study conducted in the Altos region found that the proportion of maternal deaths that had medical attention in 1998–99 was 34.5 percent (Freyermuth G. *Las mujeres de humo. Morir en Chenalhó. Género, étnica y generación, factores constitutivos del riesgo durante la maternidad*. México: CIESAS, Comité por una Maternidad Voluntaria y sin Riesgos, Instituto Nacional de las Mujeres, Miguel Ángel Porrúa, 2003). The research

TABLE 4. Malnutrition in children under five years of age, by political affiliation of communities.

Indicator*	Pro-Govt.	Opposition	Divided	Total
Prevalence of overall malnutrition (all children)¹				
% Underweight, W/A ²	21.1 (1,259)	17.7 (254)	21.2 (1,191)	20.8 (2,704) ³
% Stunting, H/A	52.2 (1,236)	48.6 (249)	58.6 (1,181)	54.7 (2,666)
% Wasting, W/H	3.0 (1,248)	1.2 (253)	3.5 (1,184)	3.0 (2,685)
Rates of malnutrition in children <= age 1				
% Underweight, W/A	8.3 (302)	6.6 (61)	10.4 (298)	9.1 (661)
% Stunting, H/A	24.9 (301)	21.3 (61)	31.5 (298)	27.6 (660)
% Wasting, W/H	2.0 (297)	0 (61)	4.8 (291)	3.1 (648)
Rates of malnutrition in children > Age 1 <= Age 2				
% Underweight, W/A	28.9 (249)	27.3 (44)	27.4 (230)	28.1 (523)
% Stunting, H/A	62.0 (237)	55.8 (43)	67.4 (227)	63.9 (507)
% Wasting, W/H	7.4 (244)	6.8 (44)	6.8 (230)	5.0 (518)
Rates of malnutrition in children > Age 2 <= Age 3				
% Underweight, W/A	26.0 (265)	22.2 (54)	26.5 (257)	25.9 (576)
% Stunting, H/A	51.5 (260)	66 (53)	63.4 (254)	58.2 (567)
% Wasting, W/H	2.3 (264)	0 (54)	1.2 (257)	1.6 (575)
Rates of malnutrition in children > Age 3 <= Age 5				
% Underweight, W/A	22.6 (443)	17.9 (95)	22.2 (406)	21.9 (944)
% Stunting, H/A	65.8 (438)	53.3 (92)	70.6 (402)	66.6 (932)
% Wasting, W/H	1.6 (443)	0 (95)	2.5 (406)	1.8 (944)

* In all indicators analyzed, $p < 0.05$ (χ^2 among three groups).

¹ The numbers in parentheses indicate the total number of studied children for each one of the analyzed indicators.

² W/A = Weight / Age; H/A = Height / Age; W/H = Weight / Height.

³ The total number of children recorded in the households was 2,838. This does not include 134 (4.7%) children whose some of their anthropometric measures, could not be obtained.

100,000).¹⁴² In the conflict zone, malnutrition is even more dire.

The nutritional state of children under age five was measured using three indicators: height-for-age, weight-for-age, and weight-for-height. The height-for-age indicator describes a chronic phenomenon. It measures the combined effects impact of insufficient

food intake and repeated episodes of infectious disease for a prolonged period. The height of a child under age five is also affected by illness. In the same way that proper health conditions and adequate food intake ensure proper growth, illnesses—especially infectious ones—and insufficient food intake over long periods, also cumulatively affect growth. The stunting effect on height, although it may be observed in all age groups, is most evident in children between age three and five years, because it is in this period of growth in which the children duplicate their size, and in consequence, their nutritional requirements increases. Chronic malnutrition causes a child's body to sacrifice the increase of body size for the more or less adequate functioning of the child's organs and daily activities.

¹⁴² de la Fuente J, Limón-Rojas M, Fuentes-Alcalá M, Guerrero-Villalobos G. *Programa Nacional de Acción a favor de la Infancia*. Secretaría Técnica. Serie de Documentos Técnicos No. 2, México, D.F.: Secretaría de Salud, 1996; Secretaría de Salud (SSA), Dirección General de Información y Evaluación del Desempeño (DGIED). Indicadores para la evaluación de los sistemas de salud. *Salud Pública de México* 2002;44(4):371–380. Available at: http://www.insp.mx/salud/44/444_11.pdf. Accessed November 7, 2005

On the other hand, changes in food intake and health of a child under age five almost immediately translate into changes in weight, because children can lose weight quickly when ill or starved. Thus, the weight for height indicator is very sensitive and describes the immediate situation.¹⁴³

The weight-for-age indicator is commonly used in health programs in Chiapas and the rest of Mexico because weight measurements are easier to obtain than those for height. Although this indicator is less precise, it is useful because it can be easily obtained and can facilitate the monitoring of the child over time.¹⁴⁴ The presence of stunting (low height-for-age) does not exclude that of wasting (low weight-for-height), or vice versa. A child under age five who has suffered a chronic process of malnutrition causing a deficit in height, may also suffer from an infectious illness or an extreme lack of food that causes significant weight loss. In such cases, chronic malnutrition may be aggravated by a recent weight loss.

The prevalence of stunting found in this study was 54.7%, which is among the highest observed in any study in Mexico and is more than double the official national statistics. On the other hand, the differences observed among community types in the prevalence of underweight children, both overall and by age group, were not statistically significant, which may suggest similar levels of unsatisfied health needs in all groups.¹⁴⁵

Children under age one had the lowest prevalence of stunting, as they always do, but had levels exceeding 20% in the three groups studied. The prevalence of malnutrition increases more than twofold in all studied groups after children reach one year of age. Such high

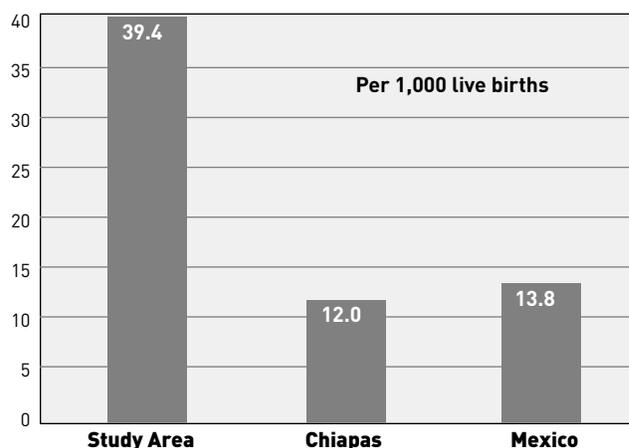
¹⁴³ Phenomena of acute exposure to hunger are clearly identified by variation in weight. The importance of weight and its fluctuations are proportionate to the size of the child. A fluctuation of a few hundred grams carries a different significance in a child with a height of one meter and a few years of age, than in a newborn. The term "wasting" is used to describe this condition.

¹⁴⁴ It is also useful for comparing results with many other studies that also used this indicator. In rural areas, health workers record this index in many communities.

¹⁴⁵ This high prevalence of underweight-for-age, according to the criteria of the World Health Organization, can be considered a reflection of high levels of malnutrition and as such constitutes both a health and a human rights issue that demands urgent attention. World Health Organization (WHO). *WHO Global Database on Child Growth and Malnutrition*. Geneva: WHO; 2000. Available at: <http://www.who.int/nutgrowthdb/index.html>. Accessed November 7, 2005.

¹⁴⁶ These results were similar to those in the ENAL of 1996 (45.6% for the country as a whole and 51% for Chiapas) and were also significantly higher than those in the ENN of 1999, both for all of Mexico (17.8%) and just the southern part (29.2%). The prevalence of stunting (according to the criteria of the World Health Organization) in the studied area is in the highest category of malnutrition levels, which is consistent with that found for the height-for-age indicator.

FIGURE 3: Infant Mortality Rate in 2000



levels of stunting reflect extreme levels of poverty and marginalization and will affect this population's health for at least a generation.¹⁴⁶

The overall prevalence of wasting was 3.0%. This is consistent with findings from other studies in Mexico and with patterns of malnutrition elsewhere in Latin America, where stunting tends to be the predominant reflection of malnutrition.¹⁴⁷ Under the weight-for-age indicator, the proportion of children with malnutrition under five years of age was 21%.

Infant Mortality

The infant mortality rate observed in the study area was 39.4 per 1,000 live births (95% CI = 27.3–54.9), a figure almost three times as high as the rate of 13.8 for the country as a whole, and 12.0 for Chiapas, estimated in year 2000.¹⁴⁸ Infant mortality reflects a combination of poor nutritional status of the mother, poor nutritional status and exposure to illness of the child, and a lack of access to obstetric and neonatal health care. These high rates and disparities with the rest of the state and country provide a clear view of the deplorable inequities faced by the overwhelmingly indigenous families and children in the conflict zone.

¹⁴⁷ The results (3.0% for wasting) are at an intermediary level between the ENAL of 1996 (7.6%) and the ENN of 1999 (2.1% for all of Mexico and 1.7% for the southern part, including Chiapas). The difference in results between our study and the ENAL of 1996 may be attributed to the fact that in 1996 the level of malnutrition was more acute because of the armed conflict that began in 1994. Also, some authors have described the important seasonal variation of wasting in which percentages can differ greatly during rainy season. Arana-Cedeño M. "Educación para la salud con enfoque estacional para culturas con tiempo circular". *Cuadernos de Nutrición* 2005;28(4):154-159; Branca F, Pastore G, Demissie T, Ferro-Luzzi A. "The nutritional impact of seasonality in children and adults of rural Ethiopia." *European Journal of Clinical Nutrition*. 1993;47(12): 840-850.

¹⁴⁸ INEGI. *Estadísticas demográficas: Cuaderno de población, no. 13*. Aguascalientes: INEGI, 2001.

The investigation documented numerous refusals on the part of health services to administer vaccinations. For example:

- In an opposition community in the Norte region, a 34-year-old Chol woman told the field team that she had taken her four-year-old son to be vaccinated, but the nurse at the clinic told her she would not vaccinate her son, because the vaccination campaign had ended a month ago and she would have to take him elsewhere (File 4351).
- A woman was refused vaccinations for her son because “while she was pregnant, she did not go to the clinic for prenatal care.” When asked why she had not gone for check-ups, she answered “because I don’t trust them much, besides the nurses don’t treat you well and are always scolding” (File 4272).
- Another 35-year-old Tsotsil woman commented that health personnel in the clinic would not vaccinate her son because he did not have a vaccination booklet (File 3862).
- On two other occasions, in different divided communities, the team found children who had not been vaccinated because the doctor had told them “he didn’t have time to vaccinate children” (Files 3884, 3621).

Vaccination

Since the early weeks of the conflict before the Zapatista civil resistance began, health workers were concerned about the continuity of services for the prevention of illnesses, and in particular immunizations. In fact, this concern was reflected in the *Declaration of the Neutrality of Health Services During the Armed Conflict in Chiapas*.¹⁴⁹ In practice, various NGOs and some university programs, who had trained community health promoters to give vaccinations in isolated communities before the conflict, maintained and expanded their activities. These networks permitted a

¹⁴⁹ Comisión Médica de CONPAZ. “Declaración por la Neutralidad de los Servicios de Salud durante el conflicto armado de Chiapas.” San Cristóbal de Las Casas, January 1994. The refusal to work in risk areas on the part of health workers and mid-level health authorities, was aggravated by some violent incidents. Worst among these was the attack of six nurses from the Ministry of Health who were vaccinating children in the municipality of San Andrés Larrainzar (in the Altos region). Three of the nurses were beaten and raped by a group of armed men near a military checkpoint in 1995. Coordination of Non-Governmental Organizations for Peace (CONPAZ): “Se recrudece la represión en Chiapas” (Repression intensifies in Chiapas), San Cristóbal de Las Casas, Chiapas: November 13, 1995.

TABLE 5. Completed vaccination schemes in children under five years of age, by political affiliation of communities.

Indicator	Pro-Govt.	Opposition	Divided	Total
	(1,335)	(261)	(1,242)	(2,838)
% of children with complete scheme of vaccination ^{1,2}	74.8	84.2	76.6	76.4
Vaccinating health agent ¹				
Governmental	88.5	95.8	88.4	89.1
Non-Governmental	0	0	1.1	0.5
Private	0.3	0	0	0.1
None	11.2	4.2	10.5	10.2

¹ p < 0.05 among the different studied groups.

² Includes the BCG, polio, DTP, and measles vaccines.

system in which vaccinations originating from official institutions were delivered to the population through civil society organizations. This activity was expanded in an important way in early 1995, when the International Committee of the Red Cross (ICRC) and the Mexican Red Cross, established a vaccination program in the conflict zone.

However, in some opposition communities vaccinations were not permitted: children were not taken to be vaccinated and health workers were not allowed to come and vaccinate in the communities.¹⁵⁰ The investigators also found instances in which government health providers refused to vaccinate children because of the political affiliation of their parents, specifically because they were EZLN sympathizers. During the study, the field team learned of at least ten cases in which community authorities prohibited health personnel from vaccinating children from a different political affiliation. There were also repeated allegations of health providers charging people from communities that did not support the government for vaccinations. A woman from an opposition community in the Selva region asked “for someone to help us vaccinate the children, but not from the government;”¹⁵¹ on other occasions, religious affiliation was a barrier or, at times, more subtle barriers to vaccination were erected. For example, people were allegedly asked to buy the syringes,¹⁵² or health personnel did not vacci-

¹⁵⁰ In opposition community (File 1876).

¹⁵¹ A 32 year-old woman residing in a resistance community (File 1143). Her one year-old daughter had only received one vaccine.

¹⁵² Pro-government community, the Altos Region (File 1761).

nate because parents were not registered in the Progresita Program.¹⁵³

Of the 2,838 children under age five registered in this study, only 76.4% had received their complete schemes of vaccination at the time of the survey. In accordance with WHO and Mexican vaccination schemes, children had received the proper dose for their age of the vaccinations against polio; measles; diphtheria, pertussis and tetanus; and the BCG vaccine against tuberculosis. Contrary to what might be predicted, children in opposition communities had the highest proportion of completed vaccination schemes ($p < 0.05$).

Not only had almost a quarter of the population studied not received their complete vaccination schemes, but the number of those who had not completed their vaccination schemes was far higher than official estimates. According to official figures, Chiapas' vaccination coverage for children under age five was 86% in 1994 and 94% in 1998, while coverage at the national level in these years was 95% and 97%, respectively.¹⁵⁴ In 2000, the official figures for coverage of completed vaccination schemes in Chiapas was 96% for children under age one, and 98.5% for children between age one and four, higher than the respective figures of 94.4% and 98% for all of Mexico.¹⁵⁵

The low vaccination rates were not limited to opposition communities; indeed the study found lower rates among pro-government and divided communities, suggesting that other barriers were at work as well.

Family members of children with incomplete vaccination schemes were asked why they did not take their children to be vaccinated in government health facilities. Over one-fifth (21%) cited reasons relating to the physical and economic inaccessibility of health services: lack of health services in their community, distance and difficulty of obtaining transportation to get to the nearest health clinic, etc. Close to another one-fifth (18%) stated that they distrusted the government health services. Likewise, 6.2% cited reasons attributable to the armed conflict. Some parents pointed out that they were unable to attend health clinics in other communities, particularly if there was a health facility in their own community (albeit one with no health personnel or vaccines). They expressed concern that doctors in the other communities would deny them care,

medicines, and vaccines, since "they have a health facility in their own community" and "they do not belong to that clinic." Such was the case of a Tzeltal woman who belonged to the PRI political party, who told investigators that no one had come to vaccinate children in her community for approximately nine months. She also explained that there were no vaccines in her local health facility and that no one could get vaccinations in the nearest clinic.

Of those parents who did not vaccinate their children, 4% specifically noted that governmental health services had placed conditions on vaccinations.¹⁵⁶ In sixty-six cases, parents recounted direct refusal on the part of health services to vaccinate their children. Refusal to vaccinate can lead to reluctance on the part of communities to attempt future vaccinations in addition to fostering antipathy toward health services generally. It is also in violation of the government's obligations to respect the right to health. The most extreme case was found in a community in the Selva region, where the population was engaged in the official process of building its own health clinic. As a result, the doctor of the clinic where they had been receiving care, withheld treatment and vaccinations because they "did not belong to that clinic anymore." It is worth noting that in the case of this community, the nearest clinic was more than four hours away on foot, and at the time of the study more than nine months had gone by without any inhabitant having received a single vaccination.

The health services erected other administrative and economic barriers for the vaccination of children as well. For example, families in different communities complained that if they were not enrolled in the Progresita/Oportunidades program, a government anti-poverty program that provides families with access to health care as well as some other services, they were excluded from vaccination. In the best of cases, health personnel vaccinated the "Progresita" children first and only if any vaccines were left, they were administered to

¹⁵³ This situation was observed in the three studied regions. For example, in the Altos (File 3026), and Norte region (Files 484, 3840),

¹⁵⁴ Gobierno Federal y Gobierno del Estado de Chiapas. *Chiapas vive, la superación del rezago social, 1995-1998*. Chiapas, México: 1999. Available at <http://www.ser.gob.mx/chiapas/espanol.htm>. Accessed November 10, 2005.

¹⁵⁵ SSA. Dirección General de Información y Evaluación del Desempeño (DGIED). *Indicadores para la evaluación de los sistemas de salud. Salud Pública de México 2002;44(4): 371-80.*

¹⁵⁶ Other prominent reasons involved lack of time on the part of parents, which may be related to the amount of time it takes to get to health facilities, and the religious affiliation of the children's parents. The study noted two ways in which religion influenced the vaccinating of children: 1) some evangelicals (for example, in the Altos region) did not vaccinate their children because, according to their beliefs, the children need not be vaccinated, they merely have to have faith in God; and 2) the leaders of a specific religious affiliation obstructed those belonging to other affiliations from coming to the clinics, so that their children could not receive vaccinations. This situation was encountered mainly in the Altos region. For example, in a community near San Juan Chamula, people of a religious affiliation differing from the one professed by the majority could not attend the local health clinic. If they required any form of health service, they had to go to another community and assume a false name so as not to be identified.

children who were not in program. Conversely, the families who received assistance from Progresa/Oportunidades had to vaccinate their children as a condition to remain in the program.

On other occasions, health service personnel asked parents to buy syringes to vaccinate the children, which, considering the population's limited economic resources and great difficulty getting to pharmacies to purchase them, made the vaccination of their children impossible. Problems with the supply of vaccines were also documented. In such cases, it was not established whether the health services were actually out of vaccines or if this merely was an excuse used by health personnel for not administering these vaccines.

Pulmonary Tuberculosis among Persons Age Fifteen and Older

States party to the International Covenant on Economic, Social and Cultural Rights are expected "to take measures to prevent, treat and control epidemic and endemic diseases."¹⁵⁷ Infectious diseases, by their nature, have the greatest potential for causing epidemics. However, they can also become endemic in many places, as has occurred with pulmonary tuberculosis (PTB) in the studied area. PTB is a disease characterized by its heightened appearance in population groups that are socially and economically disadvantaged, as shown by the eminently social character of its epidemiology.

From a public health perspective, PTB is a preventable and curable disease. However, social inequality and discrimination are directly related to the distribution and prevalence of TB among populations. The poor material living conditions of the majority of the population in various indigenous regions of Chiapas, bring together the principal risk factors for the transmission of PTB: dark and poorly ventilated homes with permanently humid dirt floors and high levels of crowding where more than five people live in one or two rooms. Moreover, the population suffers high levels of malnutrition, a product of a monotonous, insufficient diet, and maintains precarious access to services of detection and treatment.

PTB is an incapacitating disease that, if not detected and quickly treated, condemns patients and their families to a higher level of poverty that often has a negative impact on their living conditions. Under such conditions, it is common that the inability to work reduces access to food, and forces other members of the family into the labor market, often under unsatisfactory conditions (e.g., children drop out of school to work). In areas of high levels of poverty, untreated PTB is commonly

¹⁵⁷ UN CESCR. "General Comment 14." August 2000; para 44.

Four out of five of the PTB positive cases identified in the study who had not been treated by governmental health services cited reasons relating to the inaccessibility (physical and economic) of health services, as well as mistreatment and denials of care:

- A 42-year-old woman had not sought treatment at the clinic in her community because she had previously been denied care there as "her name is not on the list of patients to be treated in the clinic." According to this person, this is the only place she can go because of lack of money (File 4315-02).
- A 34-year-old man had not sought treatment because medical assistance had been previously denied when he took his son to the clinic (File 596-01).
- A 20-year-old man at first went to government health services, but subsequently stopped because "they do not give any treatment," and chose to be treated by traditional healers and itinerant medicine vendors instead (File 3070-03).
- A 35-year-old woman said she had not sought treatment because of lack of money. There is no clinic in her community and the nearest one is ninety minutes away on foot because there is no transportation between the two communities (File 1685-01).

fatal. Untreated PTB leads to the infection (and possible deaths) of other persons. Inadequately or partially treated TB can lead to multiple drug resistant TB (MDR-TB), which greatly exacerbates treatment difficulties in low-resource settings.

In Mexico, PTB is one of the twenty principal causes of death, and among the adult population it is among the top causes of death.¹⁵⁸ Chiapas, in turn, is the state with the highest mortality rate associated with PTB, but it is also one of the states most lacking in health resources for adequately dealing with the spread of this disease.¹⁵⁹

¹⁵⁸ Sánchez-Pérez HJ. *Tuberculosis pulmonar en zonas de alta marginación socioeconómica de Chiapas, México: Problemas y retos a superar: El caso de la Región Fronteriza*. Doctoral thesis. Barcelona: Universidad Autónoma de Barcelona, 1999.

¹⁵⁹ Sánchez-Pérez HJ, Hernán M, Hernández-Díaz S, Jansá JM, Halperin D, and Ascherio A. "Detection of pulmonary tuberculosis in Chiapas, Mexico." *Annals of Epidemiology* 12, no 3:2002: 166–172. Available at: <http://www.sciencedirect.com/web-editions/journal/10472797>. Accessed November 7, 2005; Sánchez-Pérez HJ, Flores-Hernández JA, Jansá JM, Caylá JM, and Martín-Mateo M. 2001. "Pulmonary tuberculosis in areas of high levels of poverty in Chiapas, Mexico." *International Journal of Epidemiology*;30 (2): 386–93.

TABLE 6. Rates of Pulmonary Tuberculosis (PTB) Overall and Among Persons aged 15 and older, by Political Affiliation of Communities.

	COMMUNITY TYPE			Total
	Pro-Govt.	Opposition	Divided	
Estimated total population for the studied communities ¹	17,258	3,154	13,592	34,004
Estimated population age fifteen and older estimated for the studied communities ²	9,129	1,680	8,985	17,994
Number of PTB positives ³	14	1	14	29
Unadjusted PTB Rate per 100,000 persons in the estimated total overall Population ³	81.1 IC _{95%} [44.40-271.10]	31.7 IC _{95%} [0.00-176.50]	103.0 IC _{95%} [56.30-172.80]	85.3 IC _{95%} [57.10-122.50]
Unadjusted PTB Rate per 100,000 persons 15 years and over (in the estimated total population 15 and over) ³	153.4 IC _{95%} [83.90-257.20]	59.5 IC _{95%} [0.00-331.20]	155.8 IC _{95%} [85.20-261.30]	161.2 IC _{95%} [108.00-231.40]

¹ From the number of recorded inhabitants and the proportion of households studied in each community.

² From the proportion of the population age fifteen and older found in each type of community.

³ According to the results of acid-fast smears and cultures made from sputum samples obtained from patients age fifteen and older with productive cough of fifteen or more days of duration (n = 22 cases, ten pro-government communities and twelve divided communities) and seven cases of patients with less than four months in treatment at the time of the study (five with negative acid fast smears, and two cases in which it was not possible to collect samples; four from pro-government communities, two from divided communities, and one from an opposition community).

This investigation identified serious deficiencies in both the detection and treatment of PTB, as well as alarming conditions that expose people to risk of PTB. In forty-six communities surveyed, twenty-nine cases of smear-positive PTB were found, only thirteen of them (fewer than half, 45%) had been previously detected by health services. The overall unadjusted prevalence of smear-positive PTB calculated for the total population of the communities studied, was 85.3 per 100,000 inhabitants, and 161.2 per 100,000 for those age fifteen and older (Table 7).¹⁶⁰

Of the twenty-nine PTB-positive cases identified, four had not received any medical care. Of the twenty-five who had received medical care, twenty-two had done so in government health services and three in private services. Of these twenty-five cases, ten had not received any diagnosis, thirteen had been diagnosed with PTB, and two received diagnosis other than PTB (asthma and throat infections). Of the thirteen cases, which had been

¹⁶⁰ It is possible that these rates are underestimated. They were calculated by estimating the number of all inhabitants in the studied communities. However, it is probable that there were cases of PTB that were not detected by the study due to the stigma associated with PTB in the communities. Additionally, it is possible that cases of coughing may not have been identified either by the field team or by health services. In fact, considering only the PTB rates in the interviewed households, unadjusted rates of PTB would be 161.8 per 100,000 for the general population and 306.5 per 100,000 population for persons fifteen and older.

diagnosed by health services, one had not received any treatment, six were receiving anti-tuberculosis treatment, and six had failed to comply due to several irregularities and deficiencies in their treatment.¹⁶¹

The rate of official detection (thirteen out of twenty-nine identified by the survey) is far below the WHO recommendation (which stands at a minimum of 75%) for effective management and control of PTB cases. In addition, it is highly probable that the official rates of PTB incidence in Chiapas are underestimated, in part due to under-diagnosis. There is evidence that under-diagnosis is very high, because of the presence of for-

¹⁶¹ Examples include one patient who only received three months of treatment, and another whose treatment ended after four days because of political reasons (e.g. in the Altos region, a 29-year-old Tsotsil woman was diagnosed with PTB in San Cristóbal de Las Casas. However, the conflicts between her community and the community where the health clinic was situated made it impossible for the patient to follow her anti-tb treatment (File 18)). Another patient, a 30-year-old man from a divided community had a bacilloscopies performed in his nearest clinic, located in another community, three weeks before the study. The clinic already had his PTB positive results but had not yet told the patient because the nurse was afraid to go to his house owing to the political conflicts between the community where the clinic was located and where the patient resided. In other words, under-diagnosis, poor quality care, inadequate case monitoring, and problems associated with the conflict, led to the non-compliance with anti-tuberculosis treatment in six of the thirteen cases previously diagnosed by health services and kept one known PTB positive patient from initiating treatment.

midable problems in obtaining sputum samples in order to effectively detect bacillus through bacilloscopy, the laboratory method upon which the system for epidemiological surveillance of PTB in the Mexico depends.¹⁶² Despite carrying out the anti-tuberculosis program in accordance with DOTS, in practice there are many deficiencies in its application in Chiapas.

In 2000, while Chiapas ranked ninth highest in the country for the incidence of PTB cases, it ranked highest in the mortality associated with this disease.¹⁶³ Nearly one out of every ten patients diagnosed with PTB in Mexico lives in the state of Chiapas and more than half of them are indigenous.¹⁶⁴ Although it was not possible to accurately establish deaths caused by tuberculosis because the majority of deaths occurred without medical care, the team found twelve deaths whose case stories seemed highly compatible with PTB.

Interventions by national and international health organizations, which were intended to address the PTB problem, too often generated fragmentation and diminished coordination in the activities of PTB control and treatment. Anti-tuberculosis treatment schedules were provided under differing criteria and without strict monitoring, as set out by currently recommended international norms.¹⁶⁵

In sum, severe deficiencies were found in the diagnosis and treatment of PTB patients. During the field work, the team observed the use of expired anti-tuberculosis drugs, shortages of medicines, and a lack of flexibility in assisting patients by bringing medicines to their homes (when they were physically unable to get to the clinic or lacked the economic resources to do so). Further, political tensions led to the under-diagnosis of cases, services could not provide bacilloscopy results

and anti-tuberculosis treatment, and some patients failed to comply due to irregularities and inadequate monitoring.

Availability, Accessibility, Acceptability, Quality and Use of Health Services for Self-reported Illness in the Month Prior to the Study

Chiapas has the greatest degree of poverty and the fewest health resources in Mexico, both of which combine to restrict access to health services. There is strong evidence that high levels of poverty help cause the low utilization of health services and delays in seeking care.¹⁶⁶ Chiapas state has the lowest proportion of inhabitants that have insurance through social security. In 2000, only 17.6 % of inhabitants were enrolled in any institutional or private medical service.¹⁶⁷ Chiapas has the worst indices of any Mexican state for health resources, manifested in an evident lack of supplies and resources in the state health services responsible for treating the majority of the people (who lacking social security have little or no access to other types of health services). Chiapas also lacks resources to properly train health personnel and supervise and evaluate services, all of which comprise key aspects for increasing the quality, accessibility, and use of services by the population.¹⁶⁸ Chiapas has the poorest outcome indicators in Mexico with respect to many health conditions including maternal mortality and mortality due to infectious diseases (e.g. tuberculosis, gastrointestinal diseases, cervical cancer).

Governmental programs have failed to successfully expand access to health care. For example, the Seguro

¹⁶² Sánchez-Pérez HJ, Hernán M, Hernández-Díaz S, Jansá JM, Halperin D, and Ascherio A. "Detection of Pulmonary Tuberculosis in Chiapas, Mexico." *Annals of Epidemiology* 2002;(12)3:166-172; Sánchez-Pérez HJ, Hernández-Flores JA, Jansá JM, Caylá JA, and Mateo M. Pulmonary Tuberculosis in Areas of High Poverty in Chiapas, Mexico. *International Journal of Epidemiology*. 2001;30:386-393.

¹⁶³ SSA. *La situación de salud en los estados, 1999*. México: SSA, 2001; SSA, Dirección General de Estadística e Informática (DGEI). *Coordinación de Planeación Estratégica: Mortalidad, 2001*. México, D.F.: SSA, DGEI, 2001; SSA. Sistema Nacional de Vigilancia Epidemiológica. *Epidemiología*. Sistema Único de Información 2001;51(18) Semana 51, 16-22 de diciembre de 2001.

¹⁶⁴ SSA. *Mortalidad, 2001*. México: SSA, 2001; SSA, DGEI, 2001; SSA. Sistema Nacional de Vigilancia Epidemiológica. *Epidemiología*. Sistema Único de Información 2001;51(18) Semana 51, 16-22 de diciembre de 2001.

¹⁶⁵ Lee JW, Loevinsohn E, Kumaresan JA. *Response to a Major Disease of Poverty: the Global Partnership to Stop TB*. *Bull World Health Organ*. 2002;80(6):428; Mitra M. "A TB Scientist Reflects on the Continuing Struggle Against a Global Threat." *JAMA* 2005; 293 (22): 2708-17.

¹⁶⁶ Bindman AB, Grumbach K, Osmond D, Komaromy M, Vranizan K, Lurie N et al. "Preventable Hospitalizations and Access to Health Care." *JAMA* 1995;274:305-11; Ochoa-Díaz López H, Sánchez-Pérez HJ, Martínez-Guzmán LA. "Uso de un índice de bienestar social para la planificación de la salud a nivel municipal." *Salud Pública de México*;1996;38(4):257-67. Available at: <http://www.insp.mx/salud/38/384-5.html>; Andrulis, D. P. 1998. "Access to Care is the Centerpiece in the Elimination of Socioeconomic Disparities in Health." *Annals of Internal Medicine*. 1998;129(5):412-16.

¹⁶⁷ Including Instituto Mexicano del Seguro Social (IMSS), Instituto de Servicios y Seguridad Social para los Trabajadores del Estado (ISSSTE), public and semi-public health institutions, private institutions with company agreements, and other types of institutions. Instituto Nacional de Estadística, Geografía e Informática (INEGI). *Perspectiva Estadística: Chiapas*. Aguascalientes, México: INEGI, Septiembre 2005: 22.

¹⁶⁸ SSA, Organización Panamericana de la Salud (OPS) *Situación de salud en México: Indicadores básicos, 1995*. México, D.F.: SSA, OPS, 1995; SSA, Dirección General de Estadística e Informática (DGEI). *Boletín de información estadística. Recursos y Servicios, 1997*. México D.F.: SSA, DGEI, 1998.

Popular is a federal program that has emerged from national health reform, and seeks to reduce out-of-pocket payment for health insurance. The program expands health coverage for unemployed citizens and families and citizens that do not qualify for insurance through social security. Seventy thousand Chiapas families have been enrolled in this program. Participation is voluntary but not entirely free; annual fees for participants range between 600 and 1000 pesos (\$55 and \$92 US dollars). However, the program only covers a limited number of conditions, treatments, and medications. This has created disparities for those who qualify for the program and can be treated within public health services, and those whose conditions or needs do not.

The second principal health program, called Oportunidades, is a federal program that affects 549,567 families in Chiapas, or approximately half of the state's population.

In many communities there were allegations that doctors, instead of prioritizing care for patients based on clinical needs, determined whether they were enrolled in the Oportunidades program or not, treating first those who were, and deferring care and medications for those who were not. Further the study found evidence that participation in Oportunidades is at times conditional. For example, in a pro-government community in the Norte region, a 21-year-old woman reported that she had gone to the clinic in her community because she had an infection of the uterus. The doctor there told her that she would treat her but that "she had to use contraception" (*tenía que planificarse*), that is, to use family planning methods. In addition, she was told that if she did not accept family planning, she would be removed from the Progres/Oportunidades program. According to the same woman, her husband complained to the area supervisor; the doctor found out about the complaint and subsequently scolded her, saying that she would not give her a consultation because she had complained.¹⁶⁹ (File 4039-02).

Availability of care is also adversely affected in the studied communities because medical personnel routinely are forced to leave their health facility in order to attend meetings, courses, deliver information, or to take vacations. The tremendous burden of administrative work forces doctors to devote more time to administrative matters than to clinical work. The team discovered that it is not uncommon to see health centers without a doctor for ten days or more out of every month. Further, interviewees asserted that clinics often close at 6 p.m., after which time there is no available care.

Additionally, the study confirmed that many clinics in the rural areas of Chiapas are staffed by social service

doctors who only stay in a facility for about nine to twelve months, or doctors who have annual contracts. This constant turn-over leads to problems in continuity of care, monitoring of patients (especially the chronically ill), and tracking down contacts for diseases, such as PTB.

Even services that are available are often not used. The study found a non-utilization rate of 30% of government health services for a variety of different conditions, ranging from vaccinations, to obstetric care to PTB treatment. Of the 2,947 persons that reported illness in the month prior to the household survey, 675 (23%) did not seek any medical attention. Of the 2,272 who did seek care, 168 (7.4%) reported that they had been denied access to care. The reasons for denial of services were: administrative constraints (schedule, living outside of catchment area –e.g., "you don't belong to this clinic"), 44%; alleged lack of medications, 33%; conditioning (political, participating in the Progres/Oportunidades program, or having to perform work in the clinic) 6%; and being charged more than they could pay for services, 5%.

The study could not determine the degree to which the conflict may have helped discourage or obstruct the use of health services. But it does show that political factors, including distrust and outright refusals of care, have played a role in such a high non-utilization rate. Qualitative information, obtained in addition to the household surveys, helps shed some light on the conflict-related and non-conflict related factors affecting utilization of government health services in the studied communities. For example:

- One of the factions in a divided community in the Altos region would not let members of a nearby community use their clinic, because of problems related to the December 1997 massacre in Acteal and the ensuing political divisions.
- A sick child in an Altos region community that did not have a health clinic was taken by his parents to the nearest clinic. However the doctor there would not treat the boy unless his parents, who belonged to the EZLN, changed their political affiliation and "joined us." The boy was sick for two days and was taken to a traditional healer, but later died.
- A pro-government community in the Selva region, which had a government clinic, did not allow members of a "nearby" community (two hours away on foot) to use the clinic's services. The pro-government community said that if they treated people from the other community, they would not have enough medications to take care of their own people. As there was a clinic (without a doctor) in the other community, medical personnel were warned by local authorities not to treat patients coming from others communities (Files 379-04, 1690-01, 1704-01).

¹⁶⁹ Kirsch J, Arana-Cedeño M." Informed consent for family planning for poor women in Chiapas, Mexico. *Lancet* 1999;354(9176):419-20.

- Interviewees alleged that the presence of military personnel in communities where health clinics are located affects access to these clinics. This is particularly the case for women, as often their husbands will not let them go, or they do not dare going alone (as occasionally the soldiers allegedly molest them) and their husbands cannot always accompany them to the doctor.¹⁷⁰
- Residents of several divided and opposition communities in the Selva and Altos regions, complained that in order to receive treatment in their assigned clinic, located in another community, they were asked to wash sheets or cut the grass, etc. They also complained that if they stopped going to the clinic, they were “erased” from the list of the Progres/Oportunidades program, thereby losing all possibilities of receiving treatment. (Files 1876-02, 3223-01, 1116-03).¹⁷¹ Others forms of conditionality included: recipients must be a beneficiary of the Progres/Oportunidades program (File 181-01); and female recipients must accept family planning methods.

There are even greater barriers to secondary care than to primary care clinics.¹⁷² Poverty among the population makes hospital stays problematic, not only because of the costs but also the loss of earnings while away – earnings that provide families’ daily sustenance. Apart from the financial barriers, physical access also is difficult. For example, the field team was informed that problems in getting to hospitals are due to: 1) the possibility of being “assaulted” (ranging from simple robbery to murder) after 6 or 7 PM on the roads, and 2) during the rainy season (at least five months out of the year), the dirt roads running in and out of remote communities become impassable. Mudslides, washouts, and swollen rivers often make access to certain communities difficult.¹⁷³ Additionally, the field team learned that, especially in divided communities, inhabitants fear being robbed of their household belongings when

¹⁷⁰ Female members of the field work team were verbally harassed by soldiers when undertaking the survey in the conflict zone.

¹⁷¹ These types of complaints occurred in rural medical units of the IMSS-Oportunidades program, which do not charge for treatment but instead ask people to support the clinic through such activities.

¹⁷² One reason for not seeking secondary care is the fear of dying outside the community. This is a significant determinant of behavior, not only because of what it implies in juridical and administrative terms (filling out certificates, transferring the remains, etc.), but also because of the importance for inhabitants to die on their land. For example, the field team encountered a very sick woman, whose children, despite the severity of her condition, did not allow her to go to the nearest hospital for fear that she might die outside her community.

¹⁷³ In order to gain access to some communities, it is necessary to cross rivers in four-wheel-drive vehicles. In the rainy season, these rivers are practically impossible to cross and in some cases require heavy vehicles (three-ton trucks) to cross them.

they have to be away for several days.¹⁷⁴

In addition to lack of accessibility, community members reported low quality care, including outright discrimination to cultural insensitivity. For instance, a perception exists among the study population that they will not be fed or treated well in hospital. Hospital food offered to patients and their relatives is often completely different to the food that they are familiar with in their communities.¹⁷⁵ Allegations of poor treatment were also common. For example, a 35-year-old Tojolabal woman from a divided community in the Selva region reported that her nine-year-old daughter who had already suffered two years of stomach pain and headache, became much worse and was taken to the nearest health clinic for treatment. She was referred from there to a hospital where she was admitted. The woman complained that if she slept with her daughter, the nurses came and scolded her, saying that she could not sleep because she had to take care of her daughter. She was repeatedly reprimanded by the staff, who did not treat or examine her daughter adequately. During the time of the study, her daughter remained in ill health, but she said that “we don’t know where to take her for lack of economic resources, transportation, and road conditions,” and “in the nearest health clinic they constantly say there is no medicine” (File 1173).

The objective facts of lack of medications (or assertions to that effect) are often mixed with perceptions of inadequate quality of care and mistreatment. For example, a 62-year-old Chol man from the EZLN, stated that after having been denied medicine and medical attention at a clinic, three of his sons became ill, but he had not brought two of them for care because he knew that they would tell them “that there is no medicine or to come back later” and when they would

¹⁷⁴ This occurs more often in smaller households that cannot depend on relatives or social networks to take care of the children or even the home.

¹⁷⁵ For example, during the field work, the study team encountered the case of a male infant less than a year old, who was found in a severe state of malnutrition with an acute case of diarrhea. The field team transported him from his community to the general hospital in San Cristóbal de Las Casas (more than four hours away). Due to his health condition and age, it was necessary to bring along the infant’s mother (who could not speak Spanish), father, and his four-year-old sister. The infant needed to be kept in the hospital at least ten days to stabilize his condition, increase his weight, and treat his gastrointestinal infection. On the third day, the parents no longer wanted to stay in the hospital, because only the sick child and the mother were being fed (the father and the daughter did not receive anything), the food given to the mother was different from what she was accustomed, there was nobody to take care of things at their home, and the infant’s father had no income while away from his community. The child was discharged from the hospital at the request of the parents and was brought home, where a short time later he died. The death of this child was not included in the results of the study as it occurred about a month after the survey had been conducted.

return the doctor would not be there or the clinic would be closed. He also alleged that health workers scold indigenous people saying that “they do not know how to care for or clean themselves” (File 181). Similarly, a 37-year-old displaced man alleged that, in addition to being required to buy his medicines which he could not afford, he was discriminated against in the hospital due to his indigenous identity and displaced status, and claimed that non indigenous patients were treated better than indigenous patients with better quality of care, more medicines, and a shorter wait time to be treated (File 502-01).

In short, in addition to the lack of availability of health care in the conflict zone, the study found severe financial and physical barriers to care. There was reported discrimination in access, based on political affiliation as well as conditioning care based on participation in the Progreso/Oportunidades Program. The study documented acute problems with the quality of care, ranging from outright mistreatment of patients to lack of cultural considerations on the part of health services.

Limitations and Implications for Interpretation of Findings

Biases may have been introduced at various points in the collection of data, which present limitations to the conclusions that can be drawn from these findings. First, the classification of communities does not lend itself to replication or independent validation. This difficulty in replication is exacerbated by the high misclassification rate (approximately 25%) and subsequent replacement of communities.

Second, the sample size of opposition communities is not comparable to the number of pro-government or divided communities: 256 households versus 1,477 and 1,264, respectively. Third, in reaction to the high non-response rate among opposition communities in particular, four purposively selected opposition communities were added to those that had been randomly selected, which severely limits how the results can be generalized. Fourth, and perhaps most serious, it was primarily the “hard-line” resistance communities that declined to participate in the study. Therefore, this report cannot determine what health impacts have been associated with the rejection of all government health care and other social services.

Further, the political affiliation or status of a community is dynamic and fluid. As evidenced to some degree by the difficulty in taking a snapshot to classify the communities studied, these affiliations may shift rapidly and continually. For example, when a family or group of families in an opposition community begins to accept or seek certain government services, they may be ostracized and the community then becomes “divided.” As many of the health conditions reported on in this study are the result of long-term exposures (e.g. stunting) or are calculated over a long period in order to obtain statistically significant numbers (e.g. maternal deaths), the fluid nature of these communities does not permit a definitive correlation between one community type and any specific results obtained in any given snapshot.

Conclusions, however, can be drawn with respect to the health conditions in the conflict zone in general, and comparisons can be drawn between the conflict zone and the overall populations of Chiapas and Mexico.

V. THE FRAMEWORK OF THE RIGHT TO HEALTH UNDER INTERNATIONAL AND DOMESTIC LAW

When understood through the lens of international human rights law, it becomes clear that by providing woefully substandard health services to an overwhelmingly indigenous population, permitting political divisions to discourage or prevent a significant portion of the population from taking advantage of existing services, and failing to assure prevention of disease through appropriate public health measures, the government of Mexico has consistently violated its obligations.

In a previous report on Chiapas, *Health Care Held Hostage*, PHR analyzed a wide spectrum of violations of international human rights and humanitarian law by the Mexican government, including freedom of movement and the right to health care and violations of medical neutrality, as well as failures to respect medical neutrality in Zapatista communities. Seven years later, that analysis is still relevant to the situation in Chiapas. That report also noted that problems surrounding access to, quality of and discrimination in health care are perhaps best understood as systematic violations of the social right to health. Enjoyment of the right to health is dependent upon ending discrimination and securing a wide variety of human rights for the indigenous people in Chiapas, and also requires an inclusive and effective citizenship without loss of identity or dignity.

Introduction to International Norms and Status of Mexico's Obligations

The right to the highest attainable standard of physical and mental health (referred to here as the right to health), which is inextricably related to the right to life as well as other human rights, is set forth in a number of international treaties to which Mexico is a party, including: the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Rights of the Child (the Children's Convention); the Convention on the Elimination of All Forms of Discrimination Against Women (the Women's Convention); the Convention on the Elimination of All Forms of Racial Discrimination (Race Convention); the Additional Protocol to the American Convention on Human Rights Protocol of San Salvador; and Convention 169 of the International Labor Organization Concerning Indigenous and Tribal Peoples in Independent Countries (ILO Convention 169).

The core provision regarding the right to health is found in Article 12 of the ICESCR. Article 12(1) sets out the general statement that there is a right to the "highest attainable standard of physical and mental health." Paragraph 2 then announces four steps states should take in fulfilling the highest attainable standard of health: (a) the provision for the reduction of the still-birth-rate and of infant mortality and for the healthy development of the child; (b) the improvement of all aspects of environmental and industrial hygiene; (c) the prevention, treatment and control of epidemic, endemic, occupational and other diseases; and (d) the creation of conditions which would assure to all medical service and medical attention in the event of sickness.

A review of international instruments shows that the right to health as it is enshrined in international law extends well beyond health care services to include basic preconditions for health, such as clean water and sanitation, adequate housing and nutrition.¹⁷⁶ This understanding of the right to health is also consistent with Mexican law. Article 4 of Mexico's Constitution establishes that "every person has the right to health protection."¹⁷⁷

Numerous legal scholars have clarified the nature and purpose of the right to health protection. González Fernández writes that its purpose is "to guarantee the human right to health, to medical care, to protection of the means of subsistence, and to social services necessary for individual and collective well-being. As a result, the right to the protection of health for Mexicans consists of comprehensive health care of equal quality, efficiency, and timeliness made available through the appropriate institutions."¹⁷⁸ According to Diego Valadés,

¹⁷⁶ In addition to the right to health, there is a separate right to a healthy environment. For example, the UN Working Group on Indigenous Populations has highlighted the importance of a healthy environment to indigenous peoples. In the Inter-American System, the Protocol of San Salvador distinguishes between the right to health and the separate right to a healthy environment.

¹⁷⁷ Title 1, ch. 1, art. 4. *Constitución Política de los Estados Unidos Mexicanos* (Political Constitution of the United Mexican States). 13th ed. Mexico: Trillas; 1997.

¹⁷⁸ González-Fernández JA. "El derecho a la salud y las garantías sociales." *Revista de investigaciones Jurídicas, Escuela Libre de Derecho* 6(6): 1982; 425. In: Ruiz Massieu JF, "Mexico," in *The Right to Health in The Americas: A Comparative Constitutional Study*. Pan American Health Organization; 1989:372-389, 379.

“the statement of the right to health protection includes personal health services (preventive, curative, and rehabilitative medical care), and general or public health services (including environmental protection).¹⁷⁹

The meaning of the right to health under international law has been further explained by the General Comment issued by the ESC Rights Committee, which monitors implementation of and compliance of the ICESCR. (“ESC Rights Committee General Comment No. 14” or “General Comment”). The General Comment recognizes that “the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel” have to be available in sufficient quantity within the State party.¹⁸⁰ It specifies that health facilities, goods and services must be available, accessible, acceptable and of adequate quality.

Availability refers to having sufficient quantity of health facilities, goods and services, including drinking water, sanitation, and other determinants of health. Accessibility has four overlapping dimensions: first, the principle of non-discrimination demands that “health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds;”¹⁸¹ second, physical accessibility means that “health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations...;”¹⁸² and accessibility also implies that “medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas.”¹⁸³

Third, economic accessibility requires that “health facilities, goods and services must be affordable for all...including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.”¹⁸⁴ *Campesinos* who depend upon subsistence farming and do not have

access to cash face particular difficulties, which need to be considered in governmental policy and practice. Accessibility also includes the “right to seek, receive and impart information and ideas concerning health issues,” which includes health information in indigenous languages.¹⁸⁵

With respect to acceptability, the ESC Rights Committee states that “[a]ll health facilities, goods and services must be respectful of medical ethics and culturally appropriate, *i.e.* respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements...”¹⁸⁶ Cultural acceptability requires respect for traditional medicines and practices which have not been shown to be harmful to human health.¹⁸⁷

Finally, “health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, *inter alia*, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.”¹⁸⁸

Through Mexico’s General Health Law, the National Health System theoretically guarantees both the availability and quality of health services, particularly to so-called vulnerable groups, such as indigenous persons.¹⁸⁹ The 1998 reform to the Law of Fiscal Coordination indicated a formula for distributing the health budget more equitably, with an emphasis on marginalized groups.¹⁹⁰

However, in practice, the findings of this study indicate that health care is not sufficiently available or accessible to many indigenous (as well as non-indigenous) persons in Chiapas, and in particular those communities that are in the conflict zone. Economic inaccessibility is a tremendous barrier to use, as patients of the health system are expected to cover costs of medications and ancillary expenses even when services are provided free of charge or at reduced fees. Cases of parents being asked to purchase or pay for

¹⁷⁹ Valadés D. “El derecho a la protección de la salud y el federalismo.” In: *Derecho constitucional a la protección de la salud*. (1994) cited in Jose Francisco Ruiz Massieu, “Mexico,” in *The Right to Health in The Americas: A Comparative Constitutional Study*, Pan American Health Organization; 1989:372-389, 379.

¹⁸⁰ UN CESCR. “General Comment 14.” August 2000; para 12 (a).

¹⁸¹ *Id.*, UN CESCR. 2000; para 12 (b).

¹⁸² *Id.*, UN CESCR. 2000; para 12(b).

¹⁸³ *Id.*, UN CESCR. 2000; para 12(b).

¹⁸⁴ *Id.*, UN CESCR. 2000; para 12(b).

¹⁸⁵ *Id.*, UN CESCR. 2000; para 12(b).

¹⁸⁶ *Id.*, UN CESCR. 2000; para 12(c).

¹⁸⁷ Traditional practices that have been shown to be harmful, such as female genital cutting, should be abolished in keeping with international human rights law. UN. *Women’s Convention*. 1981; Art. 5.

¹⁸⁸ UN CESCR. “General Comment 14.” August 2000; para 12(d).

¹⁸⁹ Title III, ch. 1, Art. 25. *Ley General de Salud*. (Mexico General Health Law). February 7, 1984.

¹⁹⁰ Ley de Coordinación Fiscal (Law of Fiscal Coordination) Gobierno Federal de la Nación. 1997 cited in Lozano R, Zurita B, Franco F, Ramírez T, Hernández P, Torres JL. “Mexico: Marginality, Need, and Resource Allocation at the Country Level.” In: Evans T, Whitehead M, Diderichsen F, Bhuiya A, Wirth M, eds. *Challenging Inequities in Health: From Ethics to Action*. New York: Oxford University Press; 2001:292.

syringes in order to have their children vaccinated were also documented. Further, the study findings suggest that geographic dispersion coupled with transportation expenses pose inordinate barriers to care for these rural populations, and that lack of security also makes transportation of patients extremely difficult. Although some of these obstacles are partially compensated for by kinship or other forms of culturally developed mechanisms of sharing and solidarity, in divided communities many of these traditional mechanisms of mutual support are lost. Across communities, the study found distrust of government services and instances of outright denials of care at public health facilities due to such factors as: political affiliation, bureaucratic arguments about not being on a particular clinic's patient "list", and non-participation in the Oportunidades Program. The lack of accessibility is reflected in the relatively high percentage of people who fail to utilize governmental health services, even for vaccinations and obstetrical care.

Furthermore, health services are often not acceptable to local populations for various reasons, and this fact affects the non-utilization of services across political affiliations. For example, the Special Rapporteur on the Right to the Highest Attainable Standard of Physical and Mental Health (Special Rapporteur on the Right to Health) has called on governments to: make "health facilities, programmes and projects, and health-related information [available] in languages spoken by indigenous peoples"; institute "training of indigenous health workers to conduct outreach services to and health care in indigenous communities;" and institute "training of health professionals to ensure that they are aware of, sensitive to, issues of ethnicity and indigenous culture."¹⁹¹ Not only are these conditions not being met in Chiapas today, as the report documents, indigenous persons complain of rampant mistreatment on the basis of their ethnicity and of health personnel making disparaging remarks about their habits and demeanor.

Finally, many of the programs administered by the public health system are of inadequate quality. For example, the General Health Law prioritizes maternal-child health. According to the law, maternal-child health includes: "(1) the care of women during pregnancy, childbirth, and the post-partum period; (ii) the care of the child and regard for his/her growth and development, including the promotion of timely vaccinations; and (iii) the promotion of the integration and well-being of the family. However, in practice, the study found

that health care for children and emergency obstetric services have not been effectively provided to mothers in indigenous and economically marginalized areas.¹⁹²

Inadequate quality is reflected, too, in the absence of diagnosis and appropriate treatment for pulmonary tuberculosis. Indeed, in relation to PTB, the normative requirements of availability, accessibility, acceptability and quality of care should translate into a concerted plan with deliberate steps aimed at providing people with: a reliable and timely diagnosis; adequate medical treatment and monitoring, independent of their political or religious affiliation, their having social security or not, and their economic ability to pay; clear and adequate information and counseling concerning their diagnosis, the illness, its treatment, its evolution, its possible complications, and the possibility of infecting others; and comprehensive treatment. The study found that reasonable steps, including the establishment of a comprehensive DOTS program, were not being taken toward the fulfillment of the government's obligations.¹⁹³

In addition to the ICESCR, Mexico is a party to other treaties that are relevant for understanding its health-related obligations. Article 24 of the Children's Convention, which Mexico has ratified, adopts a similar definitional approach to the right to health as the ICESCR.¹⁹⁴ Article 12 of the Women's Convention, which Mexico has also ratified, puts the right differently because it speaks to the obligation of States parties to eliminate discrimination against women in the field of health care.¹⁹⁵ However, read in conjunction with Articles 14 and 16 of the Women's Convention, it is clear

¹⁹² See: Brentlinger P, Sánchez-Pérez HJ, Arana-Cedeño M, Vargas MG, Hernán MA, Micek M, Ford D. "Pregnancy outcomes, site of delivery, and community schisms in regions affected by the armed conflict in Chiapas, Mexico. A Community-based Survey." *Social Science and Medicine* 2005;61:1001-1014; Freyermuth G. *Las mujeres de humo. Morir en Chenalhó. Género, étnica y generación, factores constitutivos del riesgo durante la maternidad*. México: Centro de Investigaciones Estudios Superiores en Antropología Social (CIESAS); Comité por una Maternidad Volutaria y sin Riesgos, Instituto Nacional de las Mujeres, Miguel Ángel Porrúa, 2003.

¹⁹³ According to the WHO, the five elements of DOTS are: sustained political commitment; access to quality-assured TB sputum microscopy; standard short-course chemotherapy under proper case management conditions; uninterrupted supply of quality-assured drugs; and recording and reporting system enabling outcome assessment.

¹⁹⁴ Article 24 (2)(d). United Nations. *Convention on the Rights of the Child* (Children's Convention). G.A. Res. 44/25, 44 UN GAOR, Supp. No 49, UN Doc A/44/736 (1989). Mexico ratified the Convention on the Rights of the Child on September 21, 1990.

¹⁹⁵ Article 14 (2)(b), United Nations. *Convention on the Elimination of All Forms of Discrimination Against Women* (Women's Convention). Adopted December 18, 1979. GA Res 34/180, UN GAOR Supp (No 46). UN Doc/A/34/36 (1978). Reprinted in ILM 33 (1980). Entered into force September 3, 1981. Mexico ratified the Women's Convention on March 23, 1981.

¹⁹¹ Report by Paul Hunt, Special Rapporteur to the Commission on Human Rights, on "The Right of Everyone to the Highest Attainable Standard of Physical and Mental Health," submitted in accordance with Commission resolution 2004/27. UN Doc. A/59/422. October 8, 2004, para 58.

that access to health care services, including family planning, is part of women's right to full participation in decisions affecting their well-being.¹⁹⁶

Article 10(2) of the ICESCR specifically addresses pregnancy when it states that "[s]pecial protection should be accorded to mothers during a reasonable period before and after childbirth."¹⁹⁷ The Women's Convention provides that "States' parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services . . ."¹⁹⁸ It too specifically addresses the needs of pregnant women: "States parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary."¹⁹⁹ Both the ICESCR and the Women's Convention assert that States parties must take all appropriate steps or measures to "the maximum available extent of [their] resources" to assure the fulfillment of the right to health including medical attention for all in the event of sickness (such as obstetric complications) and to "eliminate discrimination in health care, including special measures for pregnant women," respectively.²⁰⁰

The reduction of maternal mortality is explicitly mentioned in both the 1999 CEDAW General Recommendation on "Women and Health," and in the 2000 ESC Rights Committee General Comment on "the Right to the Highest Attainable Standard of Health." The ESC Rights Committee General Comment states that, "A major goal should be reducing women's health risks, particularly lowering rates of maternal mortality."²⁰¹ For its part, CEDAW states in its General Recommendation that States' parties must report on the measures they have taken "to ensure women appropriate services in connection with pregnancy, confinement and the post-natal period" and in particular should include information on "the rates at which these measures

have reduced maternal mortality and morbidity in their countries."²⁰²

The Committees then go further by announcing that essential obstetric services must be provided and made accessible to women in fulfilling a State's obligations. The ESC Rights Committee has singled out essential obstetric services as an important component of States parties' obligations with respect to the right to health in its General Comment and has stated that the provision of maternal health care constitutes part of a State's essential or minimum core obligations.²⁰³ In its General Recommendation "Women and Health," CEDAW notes that "it is the duty of States parties to ensure women's right to safe motherhood and emergency obstetric services and they should allocate to these services the maximum extent of available resources."²⁰⁴ The alarmingly high maternal mortality ratio found in the study, although from a small sample, indicates that Mexico is not complying with its obligations under international law with respect to this aspect of the right to health and therefore with ending discrimination against women in the field of maternal health care.

Children's health is a special concern of international human rights law. Article 24 of the Children's Convention, to which Mexico is a party, recognizes the right that children have "to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health" and "to combat disease and malnutrition," among other things, "through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution".²⁰⁵

Article 12 of the ICESCR calls on States parties, such as Mexico, to take steps to ensure the "healthy development of the child." Further, among the minimum obligations set out by the ESC Rights Committee in its General Comment No. 14 is the duty of States parties "to ensure access to the minimum essential food which is, nutritionally adequate and safe, to ensure freedom from hunger to everyone [including children]".²⁰⁶ Further, the Human Rights Committee, which is the body that issues authoritative interpretations of the International Convention on Civil and Political Rights, to which Mexico is also

¹⁹⁶ United Nations Committee on the Elimination of Discrimination Against Women (UN CEDAW). "General Recommendation No. 24: Women and Health." 20th Session of the Committee on the Elimination of Discrimination against Women. New York: February 2, 1999; para 2.

¹⁹⁷ UN. *Cairo Programme*. Chapter IV: "Reproductive Rights and Health." 1994; Art. 10(2).

¹⁹⁸ UN. *Women's Convention*. 1981; art. 12(1).

¹⁹⁹ *Id.*, UN. 1981; art. 12(2).

²⁰⁰ UN. *Women's Convention*. 1981. arts 1, 12; United Nations. International Covenant on Economic, Social and Cultural Rights. Geneva: 3 January 1976; Arts. 1, 12.

²⁰¹ UN CESCR. "General Comment 14." August 2000; paras 14 and 21.

²⁰² UN CEDAW. "General Recommendation No. 24." 1999; para 26.

²⁰³ UN CESCR. "General Comment 14." August 2000; paras 14 and 44.

²⁰⁴ UN CEDAW. "General Recommendation No. 24." 1999; para 27.

²⁰⁵ Article 24. United Nations. *Convention on the Rights of the Child* (Children's Convention). G.A. Res. 44/25, 44 UN GAOR, Supp. No 49, UN Doc A/44/736 (1989).

²⁰⁶ UN CESCR. "General Comment 14." August 2000; para 43.

²⁰⁷ United Nations High Commission for Human Rights. "General Comment 6." April 1982; para 5.

a party, has defined the role of states in protecting human life to include obligations to “reduce infant mortality...and to eliminate malnutrition and epidemics.”²⁰⁷

The right to food should not be interpreted as the “right to food assistance”—*i.e.*, as a hand-out, as it has been interpreted in practice in Chiapas—but as the right of the population to food security through its own food production or remunerated work that permits access to sufficient quantities of appropriate food. However, the alarming rates of malnutrition found in the study (54.7% stunting) indicate that the Mexican government has failed to provide for food security for the population.

In paragraph 44 of General Comment No. 14, the ESC Rights Committee states that an obligation of *comparable priority* to those set out in the minimum core are “to ensure...child health care” and “to provide immunization against the community’s major infectious diseases.”²⁰⁸ Such immunization coverage is provided through a national immunization program. It further clarifies with respect to Article 12(2) (c) that “[t]he control of diseases refers to States’ individual and joint efforts to, *inter alia*,...implement] or [enhance] immunization programmes and other strategies of infectious disease control.”²⁰⁹ The study however found that almost a quarter of the children under the age of five had not received their full immunization schemes, as set out by the Mexican government, and that there were sociopolitical, economic and physical barriers to the accessibility of immunization services, as well as some direct refusals by health care practitioners to immunize.

The International Convention on the Elimination of All Forms of Racial Discrimination (Race Convention), to which Mexico is also a party, calls on States parties to eliminate racial discrimination and “guarantee the right of everyone, without distinction of race, colour, or national or ethnic origin” the enjoyment of, among other rights, “the right to public health, medical care, social security and social services.”

Article 25 of the ILO Convention 169, which Mexico has ratified, most specifically addresses the rights of indigenous persons to health: “Governments shall

²⁰⁸ *Id.*, UN CESCR. 2000; para 44(2).

²⁰⁹ *Id.*, UN CESCR. 2000; para 16

²¹⁰ Article 7(2). International Labor Organization. *International Labor Organization Convention Concerning Indigenous and Tribal Peoples in Independent Countries* (ILO Convention 169). Reprinted in *Twenty-five Human Rights Documents*. New York: Center for the Study of Human Rights, Columbia University; 1994. This article states: “The improvement of the ...levels of health...of the peoples concerned, with their participation and cooperation, shall be a matter of priority in plans for the overall economic development of areas they inhabit. Special projects for development of the areas in question shall also be designed as to promote such improvement.”

ensure that adequate health services are made available to the peoples concerned, or shall provide them with resources to allow them to design and deliver such services under their own responsibility and control, so that they may enjoy the highest attainable standard of physical and mental health.”²¹⁰

At the regional level, the American Declaration on the Rights and Duties of Man (American Declaration) mentions the right to health in Article XI.²¹¹ The Inter-American Commission and Inter-American Court on Human Rights have both broadly interpreted the protections of the right to life in the American Convention on Human Rights (American Convention), to which Mexico is a party to include dimensions of health and wellbeing necessary to human survival and flourishing.²¹² Further, the Protocol of San Salvador, to which Mexico is also a party, specifically includes the right to health in Article 10, as well as the right to a healthy environment in Article 11.²¹³

Mexican laws relating to health protection are found principally in the General Health Law, the Organic Federal Law on Public Administration, and the State Health Law provisions of Chiapas. The Mexican Constitution grants authority to the Mexican Congress to enact laws related to the “general health,” and establishes a General Health Council with authority to make general provisions, which are obligatory throughout the country.²¹⁴

Mexican national law is also consonant with international law’s recognition of different dimensions of the state’s obligations to guarantee the right to health: to respect, or avoid from direct infringement through, e.g., discrimination; to protect from interference by third parties, e.g., through such measures as environmental regulation; and to fulfill by adopting appropriate means to realize the right, including providing available, accessible (economically and physically), acceptable and quality health goods and services to all.²¹⁵ Nevertheless, as this report details, these obligations are not being honored in practice in the conflict zone.

²¹¹ Article XI. *American Declaration on the Rights and Duties of Man*. Bogotá: 1948. Approved in the IX Inter-American Conference of the Organization of American States (OAS).

²¹² Article 4, para 1. OAS. *American Convention on Human Rights: Pact of San José, Costa Rica*. Approved at San José, Costa Rica, November 22, 1969. Available at: <http://www.oas.org/juridico/english/Treaties/b-32.htm>. Accessed November 8, 2005. Ratified by Mexico March 2, 1981.

²¹³ OAS. *Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights: Protocol of San Salvador*. OAS Treaty Series No. 69: 1988. Entered into force 1998. Mexico ratified the Protocol of San Salvador in 1996.

²¹⁴ Title 1, ch. 1, art. 4. *Constitución Política de los Estados Unidos Mexicanos*. 13th ed. Mexico: Trillas; 1997.

²¹⁵ UN CESCR. “General Comment 14.” August 2000; para 12.

Principles Characterizing a Human Rights Approach to Health and How They Apply to the Conflict Zone in Chiapas

International human rights norms relating to the right to health are not abstract aspirations; on the contrary, they provide a concrete set of principles by which to evaluate the design and implementation of health policy-making and programming. It is widely recognized that a human rights-based approach to health includes, but is not limited to, the following principles: non-retrogression and adequate progress; non-discrimination and equality; meaningful participation; accountability; and multi-sectoral strategies.

Non-retrogression and Adequate Progress

Violations of these legal obligations constitute injustices and not simply tragedies. In language that is echoed in economic and social rights provisions of other treaties, the ICESCR obligates States parties such as Mexico to take steps “toward the progressive realization” of all of the rights contained in the Covenant to the “maximum available extent of its resources.”²¹⁶ As a matter of law, as a party to the ICESCR, the Women’s Convention, the Children’s Convention and the Protocol of San Salvador, Mexico is by no means free to defer taking action with respect to such rights.²¹⁷ Ten years after the EZLN uprising, Chiapas continues to trail the country in many health and social indicators and the government’s response has been inadequate.

One of the principal governmental programs intended to address the health conditions of marginalized people in Chiapas and elsewhere is the Oportunidades program, which was initiated during the administration of President Salinas under the name of SOLIDARIDAD. The program serves individuals who are not covered by formal health insurance, and Chiapas has received a high proportion (22%) of federal funds for this program. However the program has perverse incentives built into it which do not lend themselves toward creating self-sufficiency or improving communal conditions: in order to receive funding from this program, individual beneficiaries must continually demonstrate that they live in conditions of extreme poverty. As a result, women and families receiving benefits from the program often reject other programs aimed at the improvement of their standard of living, which may be community-oriented, so that they can continue benefiting from Oportunidades Program.

In its last review of Mexico’s compliance with the

ICESCR, in 1999, the ESC Rights Committee noted how concerned it was “that very little progress has been achieved by the State party [] to reduce poverty [and] by the increase in the number of persons living in poverty and extreme poverty. The Committee considers that unless the structural causes of poverty are properly addressed, a more equitable distribution of wealth between the various sectors of society, between states and between rural and urban areas will not be achieved.”²¹⁸ The ESC Rights Committee further specifically addressed: “the persisting plight of indigenous populations, particularly those of Chiapas, [] who have limited access to, *inter alia*, health services, education, work, adequate nutrition and housing”.²¹⁹

For its part, in its 1995 review of compliance with the Race Convention—shortly after the Zapatista uprising began—the Committee on the Elimination of Racial Discrimination (CERD) stated: “The situation of extreme poverty and marginalization of the majority of the indigenous population in Mexico is a matter of concern. Such a situation has complex causes, some of them stemming from the impact of the encounter of civilizations, as well as the consequences of the recent internationalization of the economy for social policies in Mexico. It has been, and still is, the responsibility of the Government to improve the economic and social situation of the indigenous population of Mexico.”²²⁰ Five years later, Daes, the Chairperson-Rapporteur of the Working Group on Indigenous Populations reported with concern after her visit that “while economic, social and cultural rights are a matter of progressive implementation...it is clear that the Government of Mexico, like every government, is responsible for undertaking sustained and systematic efforts for the enjoyment of these rights, using both its means and if those are not adequate, through international assistance of the international community...Serious challenges still exist...in the area of economic, social and cultural rights, especially in terms of malnutrition, and, in general, more resources appear to be needed in the health area.”²²¹ This study found that not only are more resources needed, but those resources must be spent in such a way as to foster self-sufficiency and reduce inequities. As noted here and confirmed by other studies in Mexico, health care expenditures (especially those made on a discriminatory basis) do not necessarily reduce mar-

International Covenant on Economic, Social and Cultural Rights, UN Doc. E/CN.4/1987/17. Annex reprinted in *Human Rights Quarterly*. 1987;9:122,125.

²¹⁸ UN CESCR. “Concluding Observations.” 1999: para 16.

²¹⁹ *Id.*, UN CESCR. 1999: para 18.

²²⁰ UN CERD. “Concluding Observations: Mexico.” 1995.

²²¹ Daes: paras 10, 13.

²¹⁶ *Id.*, UN CESCR. August 2000; Art. 1. See also “Children’s Convention.” Art. 4; “Protocol of San Salvador.” Art 10.

²¹⁷ See e.g. UN. *Limburg Principles on the Implementation of the*

ginality or observed inequalities.²²²

The ESC Rights Committee has forcefully stated that violations of the ICESCR occur when a state fails to satisfy a “minimum core obligation to ensure the satisfaction of, at the very least, *minimum essential levels* of each of the rights”.²²³ These minimum obligations should be viewed as priorities for states to measure whether they are making adequate progress and include steps to ensure minimal nutrition levels and prevent epidemic diseases. The truly alarming levels of malnutrition and lack of complete vaccination schemes among children in the study, as well as gross inadequacies in access to care ranging from obstetric services to anti-tuberculosis treatment, as well as in the basic pre-conditions of health, suggest that Mexico is not complying with even its basic obligations regarding the right to health. This includes providing reproductive and maternal health care and conditions for the healthy development of the child, and ensuring the prevention and treatment of epidemic diseases such as PTB, as well as non-discrimination in all health care facilities, goods and services.

Furthermore, courts have found that, regardless of limited resources, states can be obligated to adopt and implement public health strategies and plans of action.²²⁴ Such plans, according to the ESC Rights Committee on the basis of epidemiological evidence, should address the health concerns of the whole population; “the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action is devised, as well as their content.”²²⁵ In the case of Chiapas, not only has the absence of such a participatory plan of action for health been starkly apparent, the government has used health policy in a politicized and manipulative fashion to undermine support for the EZLN.

²²² Lozano R, Zurita B, Franco F, Ramírez T, Hernández P, Torres JL. “Mexico: Marginality, Need, and Resource Allocation at the Country Level.” In: Evans T, Whitehead M, Diderichsen F, Bhuiya A, Wirth M, eds. *Challenging Inequities in Health: From Ethics to Action*. New York: Oxford University Press; 2001:271-295, 291.

²²³ See UN CESCR. “General Comment 3: The Nature of States Parties Obligations.” UN doc. E/1991/23. Geneva: 14 December 1990; Annex III, para 10.

²²⁴ “Minister of Health v Treatment Action Campaign.” CCT 8/02. Constitutional Court of South Africa, July 2002. Available at: <http://www.tac.org.za/Documents>. Accessed November 7, 2005. The decision of this case resulted in court-ordered extension of Nevirapine treatment to prevent mother-to-child transmission of HIV and development of HIV/AIDS policy meeting specific criteria to be monitored by court.

²²⁵ UN CESCR. “General Comment 14.” August 2000; para 18.

Non-discrimination and Equality

Non-discrimination is a core principle for the full realization of the right to health, as for all human rights. The ESC Rights Committee has stated that: “By virtue of article 2.2 and article 3, the Covenant proscribes any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health.”²²⁶

In Chiapas there are discrimination and patterns of inequity on multiple levels. First, the conflict zone is pervaded by constant tensions, which have been systematically exacerbated by politicized social policies, including health programs. In the face of the EZLN uprising and resistance, the government’s social policy has for years been one of attempting to obtain and maintain the loyalty of communities through a combination of targeting social services, land distribution, and development programs to some while cutting off services, such as water and electricity, to others. As described in earlier sections of this report, the effects of these discriminatory policies have been to create a cycle of fragmentation and polarization among and within communities. Over the years, some communities and some families within communities chose to receive services and participate in governmental programs while others resisted. All of the findings in this report must be understood in light of a health system functioning within an extremely politicized context of chronic conflict.

Although the study found no evidence that pro-government communities had fared better than those in resistance, it did find that the pervasive tensions and divisions produced by these policies affected utilization of, and access to, health care services across community types, as when the nearest clinic belonged to a community of a different political affiliation, for example. Further qualitative information suggests that divided communities face extreme difficulties in responding collectively to their health needs, ranging from addressing sanitation issues to transporting women in obstetric emergencies.

At the micro-level, international human rights, as well as Mexican law, dictates that individual members of opposition communities cannot be discriminated against by individual providers. As health personnel are

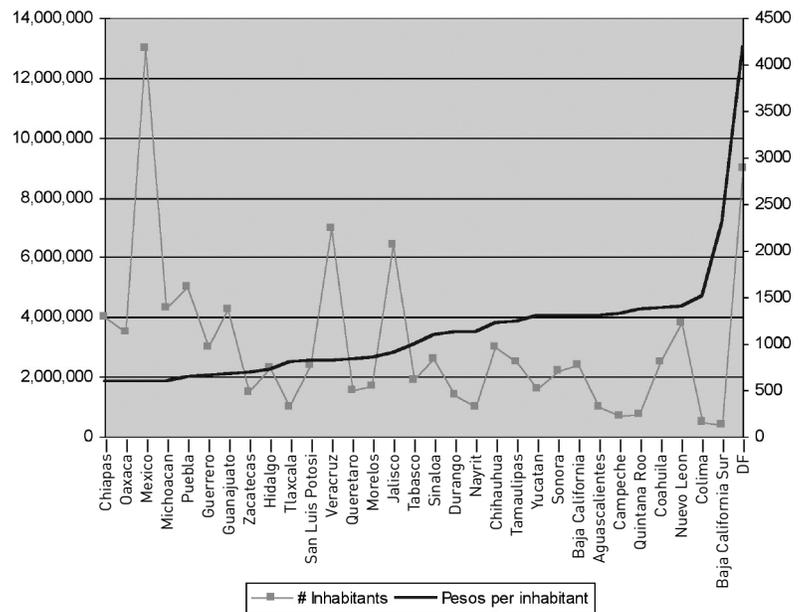
²²⁶ UN CESCR. “General Comment 14.” August 2000; para 18.

state agents acting on behalf of state institutions, deliberate acts of discrimination or conditioning of care, violates international law. Dozens of instances of discrimination by health practitioners were alleged by respondents, both due to political affiliation and, more frequently, due to a patient's indigenous ethnicity. Remedies should be provided to the victims of individual acts of discrimination, when these acts result in harm.

The investigation further reveals that the health status and conditions of all of the communities in the conflict zone are far worse than national averages, which is in part attributable to patterns of discrimination based on race and ethnicity.²²⁷ It is not necessary under international law to have the purpose or intent of discriminating against a certain group; rather, the effect of nullifying the enjoyment of a right is enough to indicate a violation of international law. In Mexico, a conspiracy of inequities produces discriminatory effects on the enjoyment of the right to health of the largely indigenous population in the conflict zone.

For example, it has previously been documented that the allocation of health resources in Mexico is inversely related to marginality and that per capita expenditures are an astounding twelve times higher for the insured population than the uninsured population.²²⁸ Chiapas is the Mexican state that gets the lowest amount of health resources per capita.²²⁹ Apart from Mexico City, where tertiary care hospitals dramatically increase health care per capita spending, there are stark differences between Chiapas (581 pesos per capita) and other states, such as for example, Baja California Sur (2255 pesos per capita).²³⁰ Chiapas also has the lowest number of inhabitants covered by some form of social security (i.e., employment related health insurance): barely

FIGURE 4. Budget Inequality. Health Budget per Inhabitant per State, 1999



Source: Secretaría de Salud. Own estimation with data of "La Situación de la Salud 1999", www.ssa.gob.mx cited in Lavielle B, Gabriel L, Díaz D. *Curitas para la Salud: El Mapa de la Inequidad*. Mexico: Fundar Centro de Análisis e Investigación; 2004.

17.6% versus 40.1% for the entire country.²³¹ In this study, the proportion of inhabitants without any insurance was over 92% for all types of communities studied.

Indigenous people in Mexico are not only disproportionately represented among the poor and uninsured; studies have shown that the availability of health care resources increases when the proportion of indigenous persons in a county is very low.²³² The study found that between 80% and 99% of the population in the conflict zone are indigenous,²³³ and nearly half do not speak Spanish.

CERD noted in its last review of Mexico the failure of the Mexican government to address persistent discrimination against indigenous people and economic and

²²⁷ See also Lozano R, Zurita B, Franco F, Ramírez T, Hernández P, Torres JL. "Mexico: Marginality, Need, and Resource Allocation at the Country Level." In: Evans T, Whitehead M, Diderichsen F, Bhuiya A, Wirth M, eds. *Challenging Inequities in Health: From Ethics to Action*. New York: Oxford University Press; 2001:271-295.

²²⁸ E.g., Lozano R, Zurita B, Franco F, Ramírez T, Hernández P, Torres JL. "Mexico: Marginality, Need, and Resource Allocation at the Country Level." In: Evans T, Whitehead M, Diderichsen F, Bhuiya A, Wirth M, eds. *Challenging Inequities in Health: From Ethics to Action*. New York: Oxford University Press; 2001; Hernandez-Peña P, Zapata O, Leyva R, Lozano R. "Equidad y salud: necesidades de investigación para la formulación de una política social." *Salud Pública de México*. 1991.

²²⁹ Lavielle B, Lara G, Diaz D, Curitas para la Salud: El mapa de la inequidad, Fundar. 2001: 48-62.

²³⁰ Numbers reflect entire health "Función 08" federal spending. The "Ramo 33" federal spending within Función 08 is also highly inequitable. Lavielle B, Lara G, Diaz D, Curitas para la Salud: El mapa de la inequidad, Fundar. 2001: 48-62, at 49, 52.

²³¹ Sánchez-Pérez HJ. *Tuberculosis pulmonar en zonas de alta marginalidad socioeconómica de Chiapas, México: Problemas y retos a superar: El caso de la Región Fronteriza*. Doctoral thesis. Barcelona: Universidad Autónoma de Barcelona; 1999; Consejo Nacional de Población (CONAPO). 2001. Available at: <http://www.conapo.gob.mx>. Accessed November 7, 2005.

²³² Hernandez-Peña P, Zapata O, Leyva R, Lozano R. "Equidad y salud: necesidades de investigación para la formulación de una política social." *Salud Pública de México*. 1991.

social exclusion of entire populations, which has not contributed to the restoration of peace in Chiapas.²³⁴ CERD noted that, “Particular concern is expressed that the State party does not seem to perceive that pervasive discrimination being suffered by the 56 indigenous groups living in Mexico falls under the definition given to racial discrimination in Article 1 of the Convention. The description of their plight merely as an unequal participation in social and economic development is inadequate.”²³⁵

The study documented how the discrimination faced by women in the conflict zone manifests itself in, among other ways, the inattention to their health priorities, such as the need for accessible obstetric services. Both the ESC Rights Committee and CEDAW have called on States parties to eliminate “discrimination against women when it comes to access to health services during the life cycle, particularly regarding family planning, pregnancy, delivery and the post-partum period.”²³⁶ In the conflict zone in Chiapas, the alarmingly high indices of maternal mortality found in this study, coupled with the lack of effective access to obstetric services, clearly reflect the marginalization of women’s health concerns as well as structural problems in the health system.

The Women’s Convention relates the right to health services to combating discrimination against women in general. More particularly, it focuses on the need to ensure that rural women “participate in and benefit from rural development and, in particular, shall ensure to such women the right . . . [t]o have access to adequate health care facilities, including information, counseling and services in family planning.”²³⁷ CEDAW has specifically stated in a general recommendation that it is discriminatory *effect* as well as *purpose*, which triggers a violation of the treaty. In its most recent review of Mexico’s compliance with the Women’s Convention, CEDAW stated that “poverty constitutes a serious obstacle to enjoyment of rights by women, who

make up the majority of the most vulnerable sectors, especially in rural and indigenous areas,” and called on Mexico “to give priority to women in its poverty eradication strategy, with special attention to women in rural and indigenous areas; in this context, measures and specific programs should be adopted to ensure that women fully enjoy their rights on an equal footing [including] in the area of [] health, with special emphasis on joint work with non-governmental organizations and on women’s participation not only as beneficiaries, but also as agents of change in the development process.”²³⁸

According to its own law, the Mexican government is required to ensure that its health policies and programs are designed and implemented in a non-discriminatory manner. Mexico’s Constitution prohibits discrimination in the enjoyment of all rights, including the rights to health protection. The Constitution recognizes that “[e]very person in the United Mexican States shall enjoy the guarantees granted by this Constitution,” and that “men and women are equal before the law.” Further, the Constitution explicitly acknowledges Mexico’s indigenous populations, and protects and promotes the development of their cultures and resources.²³⁹

Yet, in practice, this is not occurring. On the contrary, this investigation found that the dysfunctional and abusive health system in Chiapas is intensifying exclusion, voicelessness, and inequity while simultaneously defaulting on its potential—and obligation—to fulfill individuals’ rights and contribute to the building of an equitable, democratic society.²⁴⁰

Meaningful Popular Participation

Participation

The right to health requires states to provide more than a package of services—even a package extending beyond medical care. Realization of the right to health also entails providing individuals and communities with an authentic voice in decisions defining, determining or affecting their well-being. Demands for social participation and control over the decisions affecting their health and well-being are at the core of the conflict in Chiapas and underlie Zapatista resistance. The San Andrés Accords set out a conception of pluri-cultural citizenship—i.e., a framework of respect for the funda-

²³³ In order to make this study comparable with others conducted in Mexico, those individuals age five and older whose first language was not Spanish were considered indigenous. Government population studies and analyses have considered municipalities or communities eminently indigenous if 40% or more of their population age five and older speak an indigenous language. With 80% of those speaking an indigenous language, one can say that all the communities have a predominantly indigenous population

²³⁴ United Nations Committee on the Elimination of Racial Discrimination (CERD). *Concluding Observations of the Committee on the Elimination of Racial Discrimination: Mexico*. CERD/C/304/Add.30. August 6, 1995.

²³⁵ *Id.*, CERD 1995, para 381.

²³⁶ UN CEDAW. “General Recommendation No. 24.” 1999.

²³⁷ Women’s Convention: 1981; Art. 14.

²³⁸ CEDAW Concluding Observations 2002, UN Doc A/57/38, CEDAW/C/MEX/5. August 6, 2002. part 3, paras 432-433.

²³⁹ Title 1, ch. 1, Art. 1. *Constitución Política de los Estados Unidos Mexicanos*. 13th ed. Mexico: Trillas; 1997.

²⁴⁰ See “Who’s Got the Power: Transforming Health Systems for Women and Children,” *Millennium Project Task Force Report on Child Health and Maternal Health*; 2005:12.

mental cultural diversity of the Mexican nation and for indigenous rights—as well as “free determination” for indigenous peoples within “national unity.” Although the San Andrés Accords were never implemented, these principles are also part of international human rights law. That is, a recognition of autonomy for indigenous communities, including the opposition communities, with respect to the organization of their health services among other things, is consistent with ILO Convention 169 and other international instruments to which Mexico has voluntarily bound itself. Mexico however, in contrast to other states in the region, has never adopted national legislation to incorporate its international obligations into domestic law or to recognize some genuine degree of autonomy of indigenous communities, including those in opposition, in relation to the organization and delivery of social services.²⁴¹

It is clear that participation under international human rights law requires more than using local health promoters to register pregnant women or assist in locating children to be vaccinated. On the contrary, states should provide resources for indigenous peoples to design, deliver and control their health services so that they may enjoy the highest attainable standard of physical and mental health.²⁴² Local communities should be able to define their own health priorities, assist in the development and implementation of programs and play a pivotal role in the evaluation of health programs. True rights-based participation requires programs that enable people to be active, informed and critical agents and citizens, rather than objects of charity.²⁴³

According to the ESC Rights Committee that monitors the ICESCR, an “important aspect is the improvement and furtherance of participation of the population in the provision of preventive and curative health services, such as the organization of the health sector, the insurance system and, in particular, participation in political decisions relating to the right to health taken at both the community and national levels.”²⁴⁴ The Special Rapporteur on the Right to Health has called for governments and other actors to make every effort to ensure “the active and informed participation in the

formulation, implementation and monitoring of health policies and programs.”²⁴⁵

Article 25 of ILO Convention 169 specifically stresses the need for community participation in the organization of indigenous peoples’ health services: “Health services shall, to the extent possible, be community-based. These services shall be planned and administered in co-operation with the peoples concerned and take into account their economic, geographic, social and cultural conditions as well as their traditional preventive care healing practices and medicines.”²⁴⁶ This cooperation with the communities has not been present in Chiapas.

In another statement, the Special Rapporteur calls specifically for “the active and informed participation of indigenous people in the formulation, implementation and monitoring of health policies and programs.”²⁴⁷ Additionally, although not a binding treaty, Article 31 of the Draft Declaration on Indigenous Peoples explicitly connects health to self-determination: “Indigenous peoples, as a specific form of exercising their right to self-determination, have the right to autonomy or self-government in matters relating to their internal and local affairs, including...health.”²⁴⁸

However, genuine participation of indigenous populations in health decisions is starkly absent in Mexico. In her 2000 report, Daes, the Chairperson-Rapporteur of the UN Working Group on Indigenous Populations lamented that, “the genuine and full participation of indigenous communities in the development process [including access to basic resources, education and health services] is still a challenge for the Government of Mexico. It is recommended that the competent authorities review the process of decision-making and fully involve indigenous communities in the planning, implementation and evaluation of development projects

²⁴¹ In the 1990s, Colombia, Bolivia and Paraguay reformed their constitutions to incorporate the rights of indigenous peoples, in keeping with ILO Conventions 107 and 169 and as a part of the standards included in the International Convention on the Elimination of All Forms of Racial Discrimination. The movements for constitutional reforms later inspired similar efforts in Ecuador, Peru and Venezuela.

²⁴² UN CESCR. “General Comment 14.” August 2000; para 21.

²⁴³ See e.g. Veneklasen L, Millar V, Clark C, and Reilly M. “Rights-Based Participation and Beyond: Challenges of Linking Rights and Participation,” IDS Working Paper 235 (December 2004):14.

²⁴⁴ UN CESCR. “General Comment 14.” August 2000; para 17.

²⁴⁵ Hunt P. “The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health.” Special Rapporteur of the Commission on Human Rights on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Submitted in accordance with CHR resolution 2004/27, UN Doc. A/59/27: September 2004 (advance edited version); para. 58 (c-e).

²⁴⁶ ILO Convention 169, art 25.

²⁴⁷ Hunt P. “The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health.” Special Rapporteur of the Commission on Human Rights on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Submitted in accordance with CHR resolution 2004/27, UN Doc. A/59/27: September 2004 (advance edited version); para. 58(b)

²⁴⁸ United Nations Sub-Commission on Prevention of Discrimination and Protection of Minorities. “Draft Declaration on the Rights of Indigenous Peoples.” UN Doc. E.CN.4.SUB.2.RES.1994.45. 1993; art. 31.

affecting their lives. Special measures need to be taken for the participation of women in the development processes.”²⁴⁹

Demands for social participation and control over the decisions affecting their health and well-being are at the core of the conflict in Chiapas and underlie Zapatista resistance. The implementation of the San Andrés Accords would have been a significant step toward clarifying Mexico’s internal law. Implementing its obligations pursuant to ILO Convention 169 would go far towards establishing a framework to promote indigenous people’s rights to health, including those in opposition communities. Mexico’s current law uses the rhetoric of participation without truly implementing the principles of autonomy called for under ILO Convention 169 and the 1986 Declaration on the Right to Development. For example, the General Health Law promotes education aimed at “public participation” in prevention of illness, public awareness of cases of illness and environmental hazards to health, and public orientation in the areas of nutrition, family planning, occupational health, and adequate use of health services.²⁵⁰ Participation is thus a strategy or tool used by the government to achieve health goals, and is not linked to the devolution of control to indigenous communities, as called for under international human rights law.

In its last review of the performance of the Mexican government in 1999, the ESC Rights Committee stated that its prior review and recommendations had not been heeded with respect to incorporating participation from civil society into social programs, including health: “The Committee specifically exhorts the Mexican government to include civil society in general and the assisted groups in particular in the planning, application and evaluation of the structural causes of poverty and programs to alleviate it.”²⁵¹

However, the most important federal government anti-poverty programs in effect in Chiapas, Oportunidades, does not incorporate real participation of the affected populations into the analysis of the structural causes of poverty and the design and the implementation of programs to address it. Oportunidades is a vertical program that treats individual beneficiaries as objects of aid. Moreover, the program contains incentives whereby beneficiaries have to demonstrate their poverty to stay in the program, thereby fostering continued dependency rather than addressing the “structural causes of poverty.”

In short, to be in compliance with international obli-

gations, at a minimum, the Mexican government must initiate long-term, coherent strategies for local planning of health programs. These long-term strategies must include input from both opposition and non-opposition communities and members, NGOs and local providers, and must include some devolution of decision-making power rather than tokenistic consultation.

Access to Information

Social participation and monitoring are impossible without access to information. In Mexico, access to information on health, and transparency in handling such information, are inadequate. Access to health information is part of the right to health and is fundamental for the ability of the public to monitor its implementation. To comply with its obligations under international law, a government should collect data on a disaggregated basis and this information, together with the methodologies used by the government, should be readily available to the public.²⁵² The Special Rapporteur on the Right to Health has explicitly called for “the disaggregation of health data by ethnicity, gender, socio-economic status, cultural or tribal affiliation and language.”²⁵³ However, census data in Mexico is not collected or broken down in such a way as to be able to analyze the health of indigenous people, even though there is an acknowledgement that language is insufficient to capture the dimensions of ethnic identity.²⁵⁴ Indeed, although under both the ICESCR and Women’s Convention, States parties are supposed to report disaggregated data to respond to the issue of misleading national averages that may mask discriminatory policies or effects, in its most recent review of Mexico, CEDAW noted “the lack of sufficient data disaggregated by sex in many of the areas covered by [its] report.”²⁵⁵

This investigation also found a consistent pattern of under-reporting, ranging from pulmonary tuberculosis prevalence to maternal deaths. For example, maternal mortality was detected at seven times the levels officially reported by the government; pulmonary tuberculosis was detected at three times the official state level. Although some discrepancies may be due to explainable factors, these numbers do show the need for the

²⁵² UN CESCR. “General Comment 14.” August 2000; para 20.

²⁵³ Report by Paul Hunt, Special Rapporteur to the Commission on Human rights, on The Right of Everyone to the Highest attainable standard of Physical and Mental Health, submitted in accordance with Commission resolution 2004/27. UN Doc. A/59/422. 8 October 2004, para 58(a).

²⁵⁴ Bronfman M. “La salud de los pueblos indígenas: una conquista impostergable.” *Cuadernos de Salud*. Mexico City: Secretaría de Salud, 1994.

²⁵⁵ CEDAW Concluding Observations 2002, UN Doc A/57/38, CEDAW/C/MEX/5 (part 3, paras 447. 6 August, 2002.

²⁴⁹ Daes: para 11

²⁵⁰ Title II, Ch. 1, Art. 6(1-8) *Ley General de Salud*. (Mexico General Health Law). 7 February 1984.

²⁵¹ ESC Rights Committee. Concluding Observations 1999; paras 27, 31.

Mexican government to improve the methodology with which it reports on these critical public health indicators.²⁵⁶ There is no reason, for example, that all death certificates cannot include questions about whether the woman was pregnant at the time or that reporting of maternal deaths include process indicators that reveal the availability of, and access to, obstetric services.²⁵⁷

Furthermore, there is a lack of accessibility of health information. Despite highly touted programs of “transparency,” this investigation found that government data is not easily accessible by the public, nor are the methodologies used shared with the public or interested NGOs. Communities do not even have access to local health center and hospital records to be able to evaluate care and review health priorities. During the field study, the team observed that many health workers do not keep any medical records of their patients, especially in those cases when patients come from other villages. In qualitative interviews, patients complained of not being made aware of their most basic rights, such as their right to their medical records or to informed consent in all procedures, including sterilizations.

Multi-sectoral Strategies

As noted above, the right to health goes beyond the provision of medical care and indeed beyond the health sector. Not only are adequate water and sanitation, as well as education regarding health problems, components of the minimum core obligations set out in the ICESCR, but addressing health in a rights framework calls for looking at broader development, improving adequate dwelling conditions, food security, environmental protection, access to arable land, and their impacts on health.²⁵⁸

Mexico’s General Health Law sets out an integrated, multi-sectoral approach to health, calling on ministries of health, education, and labor to work jointly to, *inter alia*, promote maternal-child health, strengthen the health of families, encourage occupational safety for minors and pregnant women, and take actions related to education, as well as access to potable water and sewage. In addition, the goals of the National Health System, set forth in the General Health Law, integrate the biological and socioeconomic factors essential to good health. Specifically, the National Health System objectives are to supply quality health services to all, pay special attention to preventative actions, contribute

to harmonious demographic development, collaborate through social assistance services toward equitable economic and social well-being, and give impetus to family and community development, including the physical and mental growth of children.²⁵⁹

However, in practice this is not the case. Indeed, the high rates of malnutrition and other childhood diseases of poverty found across community types in this study, are the result of a failure of the Mexican government to institute a coherent rural development policy, which incorporates health concerns. The investigation found inadequate living conditions, lack of access to sufficient, safe drinking water, lack of access to basic sanitation for disposal of excreta, lack of access to educational opportunities (especially for women) across all communities in the study. The process of fragmentation and dispersion only makes it more difficult to establish basic preconditions of health, such as adequate water, sewage and housing, a point which was noted by the ESC Rights Committee in its last review of Mexico’s compliance with the ICESCR.²⁶⁰

One program run by the state of Chiapas, Vida Mejor para las mujeres, las niñas y los niños de Chiapas (Better Life for the Women, Boys and Girls of Chiapas), does have a multi-sectoral focus, and unlike the Oportunidades Program, is directed towards the community as opposed to the individual. It has a far smaller scope than Oportunidades, and is currently only covering 164 small regions. Developed in the aftermath of 26 new-

²⁵⁸ For example, the importance of land tenure, and consequently agrarian reform policies, to the wellbeing and survival of indigenous peoples cannot be overstated. In its August 31, 2001 ruling in the case of the Mayagna (Sumo) Awas Tingni Community v. Nicaragua, the Inter-American Court of Human Rights explained that land has to be understood in an integral fashion for indigenous peoples:

Para 149. ...Among indigenous peoples, there is a communitarian tradition regarding a communal form of collective property of the land, in the sense that ownership of the land is not centered on an individual but rather on the group and its community. Indigenous groups, by the fact of their very existence, have the right to live freely in their own territory; the close ties of indigenous people with the land must be recognized and understood as the fundamental basis of their cultures, their spiritual life, their integrity and their economic survival.

In the conflict zone in Chiapas, in addition to the health conditions associated with unchecked displacement and paramilitary violence coupled with governmental policies of land distribution, which this report recounts, these have also affirmatively broken the affected indigenous peoples’ relationship to the land. Inter-American Court of Human Rights, the Mayagna (Sumo) Awas Tingni Community v. Nicaragua ruling of August 31, 2001, Available at: http://www.wcl.american.edu/humright/hracademy/corteidh/seriec_ing/index.html.

²⁵⁹ Title III, Ch 4, Art 60. *Ley General de Salud*. (Mexico General Health Law). February 7, 1984.

²⁶⁰ CESCR Concluding Observations, 1999, para 27.

²⁵⁶ See e.g. Wardlaw T, Maine DP. “Process Indicators for Maternal Mortality Programmes.” In Berer M, Sundari Ravindram TK, eds. *Safe Motherhood Initiatives: Critical Issues*. Blackwell Science: Reproductive Health Matters: 1999; 24-30.

²⁵⁷ See Maine D, Wardlaw TW, Ward V, McCarthy J, Birnbaum A, Akalin MZ, Brown JE. *Guidelines for Monitoring the Availability and Use of Obstetric Services*. UNCIEF/WHO/UNFPA: 1997.

born deaths in December of 2001 at the General Hospital of Comitán, the program was developed to provide better attention to women during their pregnancies within their rural communities. With greater prenatal care and the prevention of malnutrition, the program has succeeded in combating prenatal morbidity and has reduced malnutrition of children under five years of age by 40% in its catchment areas. The program, which is intended to create a sense of community responsibility for health and diminish fragmentation within communities, was designed on the basis of successful experiences by NGOs. However, the impact of this laudable program has been limited because it competes with the Oportunidades Program, which provides incentives for individuals and individual families to opt out in order to retain their benefits from the federal government. The lack of coordination between these programs undermines potential progress in advancing the affected populations' right to health.

Coordination among sectors, such as among the health sector and the agricultural and social development sectors, is crucial to combat the food insecurity and deplorable conditions of housing and sanitation found in the study. Coordination between the federal and state governments, and with local governments, is also essential in providing programs that meet communities' health needs and adopt approaches that encourage cooperation and capacity-building.

Accountability

As the right to health is more than a set of basic services, it also requires aspects of a functioning legislative and judicial system. The ESC Rights Committee reiterates the importance of ratifying international instruments, which provide protection for the right to health, and of enacting and implementing legislation: "The incorporation in the domestic legal order of international instruments recognizing the right to health can significantly enhance the scope and effectiveness of remedial measures and should be encouraged in all cases. Incorporation enables courts to adjudicate violations of the right to health, or at least its core obligations, by direct reference to the ICESCR."²⁶¹

CEDAW's General Recommendation on Women and Health mentions specifically the enactment and enforcement of laws to provide sanctions for gender-based violence or sexual abuse of women patients by health care professionals, as well as laws prohibiting, *inter alia*, marriage of girl children, defined as being under the age of eighteen.²⁶² In its latest review of Mexico's compliance, CEDAW expressed its concern "at the

fact that no instances are mentioned [in Mexico's report] in which the Convention has been invoked before the courts and the lack of a compilation of judicial decisions in this regard."²⁶³ For her part, the Chairperson-Rapporteur of the UN Working Group on Indigenous Populations stated in her 2000 report that "the system of administration of justice faces great challenges in Mexico, where indigenous people are affected by its problems and view it with mistrust."²⁶⁴

Accountability need not be purely judicial. In addition to providing remedies, the ESC Rights Committee encourages the adoption of a framework law to operationalize their right to health national strategy. The framework law should not only incorporate international norms into domestic law but should also establish national mechanisms for monitoring the implementation of national health strategies and plans of action.²⁶⁵ Imbuing human rights ombuds offices with the authority to investigate and sanction perpetrators in cases of abuse is one example.

Mexico has taken some, but not all the steps, needed to provide accountability for violations. Mexico's General Health Law ensures health protection, and contains programmatic provisions, which commit the State to action on health matters. "The law identifies the objectives of health protection to include physical and mental well-being, improved length and quality of life, social development, health services and social assistance, health education and research. Provisions of the General Health Law address medical care particularly for the benefit of vulnerable groups, maternal child health, education for health promotion, nutrition, occupational health, and basic sanitation."²⁶⁶ However, the implementation of the right to health protection acknowledged in the General Health Law requires Mexico to provide effective monitoring and oversight, as well as remedies for the victims of violations.²⁶⁷

However, Mexico's domestic law does not provide adequate enforcement mechanisms for the right to health protection. Article 60 of the General Health Law does include a provision regarding malpractice and medical negligence claims. Medical malpractice cases are generally brought to the National Commission on Human Rights (CNDH), state human rights commissions, and the National Medical Arbitration Commission (CONAMED). Although they can review negligence claims brought against individual providers, these insti-

²⁶³ CEDAW Concluding Observations, para 419.

²⁶⁴ Daes: para 19.

²⁶⁵ UN CESCR. "General Comment 14." August 2000; para 56.

²⁶⁶ *Ley General de Salud*. Art 60. [Mexico General Health Law]. 7 February 1984.

²⁶⁷ UN CESCR. "General Comment 14." August 2000; para. 59.

²⁶¹ UN CESCR. "General Comment 14." August 2000; para. 60.

²⁶² UN CEDAW. "General Recommendation No. 24." 1999; para 15.

tutions only provide mechanisms to enforce the patient rights against malpractice set out under Mexican law. Patients or their representatives can also sue in court for damages under Mexican law in malpractice cases involving “strict liability.”

More fundamentally, Article 60 fails to provide for claims regarding the accessibility or adequacy of health services as an institutional or systemic issue. In order to be truly effective, mechanisms such as the *amparo*, which is commonly used in civil and political rights violations cases, would need to be reformed in order to: (1) provide people and groups with a collective remedy; and (2) establish precedent for other related cases.

Further, even in individual cases, Mexican judges have been inappropriately reluctant to use the *amparo* (protection writ) to enforce the right to health under the apparent misconception that “programmatic” rights are not actionable. Although aspects of the right to health entail programmatic obligations, violations of specific regulations relating to the government’s obligations with respect to health give rise to individual rights, and should be enforced according to the same criteria as other constitutionally protected rights.²⁶⁸

²⁶⁸ *Ley General de Salud*. Art 60. (Mexico General Health Law). February 7, 1984. In this vein, the Constitutional Court of Ecuador, e.g., has stated that “positive social rights ... are norms to be enforced immediately with full juridical effect and are binding on the authorities who have obligations in their capacity as obligors; [they are also rights that must] be implemented by courts such as this one for which the defense of human dignity is a fundamental mainstay of contemporary constitutional development.” “Jofre Mendoza et al v. Minister of Health,” Ecuador (Constitutional Court of Ecuador (2003) [failure to consistently provide full triple cocktail of ARVs in accordance with Ministry of Health regulations could produce viral resistance and lead to opportunistic infections and eventually death].

VI. RECOMMENDATIONS TO THE MEXICAN GOVERNMENT

1. The government should encourage a broad dialogue at the local, state, and national levels about the meaning of an inclusive democracy in Mexico, which fully recognizes its multiple constituent cultures. The dialogue should examine how health services should be designed and delivered and how the indigenous population's health needs could be addressed. Such a dialogue would need to be supported by and include non-governmental actors and civil society, as well as relevant governmental actors.
2. The Mexican government should take immediate steps to implement the San Andrés Accords, as well as its obligations under international law, including ILO Convention 169. This would confer some degree of autonomy on indigenous communities, including opposition communities, with respect to the organization of their affairs, including the organization of their health services.
3. The government should permit and promote the creation of local health care systems in the autonomous regions in Chiapas. These systems should be structurally independent and capable of responding to the specific health care needs of each community, but operationally coordinated with the state and national health system to provide vaccinations, medicines, and patient referrals. An autonomous technical support system, based at least in part on universities, could promote communication among all parties and facilitate better relations.
4. All federal, state, and municipal government activities related to health should be carried out without discrimination. All levels of government should display the highest degree of coordination and commitment to prevent programs and activities from provoking or aggravating internal conflicts. Programs that are functioning well in terms of reducing communal conflict and improving health status should be supported and expanded. As part of this commitment, all clinics should be required to attend to all members of a community, regardless of political affiliation or religion.
5. The government should improve its surveillance and detection systems, and should collect health data on a disaggregated basis, so that disparities based on gender and ethnicity may be detected and addressed. When the best available evidence indicates the importance of process indicators, such as the availability and use of essential obstetric care, the government should collect such indicators to be able to review its progress in addressing maternal health on an ongoing basis.
6. The government should establish an autonomous institution, made up of independent experts, to monitor governmental compliance with indigenous peoples' economic, social, and cultural rights, including their health rights, in Chiapas and beyond. This institution should be equipped to promote education and dialogue among groups and actors in society. It should also be authorized to receive and act upon individual and collective complaints and to hold the government accountable for violations.
7. The government should initiate amendments to Mexican law to allow the *amparo* mechanism (writ of protection) to provide for adequate remedies and accountability in the event of violations of the right to health, including providing for collective remedies and binding precedents. Lawyers and judges should be sensitized and trained in the enforcement and enforceability of the right to health.
8. Government social programs such as the *Oportunidades* program should actively foster and incorporate meaningful community participation in the design, implementation, and evaluation of activities, which includes providing communities with authority in allocating resources and auditing projects.
9. The government should increase and re-allocate health resources per capita to and within Chiapas based on the best evidence available of priority health needs for the populations affected.
10. The Program of Tuberculosis Prevention and Control should be re-structured to include investment in more resources, sensitizing, training, supervising, and evaluating a comprehensive DOTS program in Chiapas and beyond. The emphasis in this program should be placed on universality and free access without conditionality, as well as mechanisms to ensure follow-up of patients in accordance with international standards.

11. In keeping with the fulfillment of its obligations under the International Covenant on Economic, Social and Cultural Rights, the government should take the following steps to improve the availability, accessibility, acceptability and quality of health facilities, goods and services in Chiapas,:
 - a. train health personnel at all levels about human rights and the principles of medical neutrality with respect for cultural differences;
 - b. incorporate a basic working knowledge of the local indigenous language as part of the prerequisites for working in indigenous regions;
 - c. promote and reinforce community-based mechanisms for the management of health-related issues;
 - d. foster community-based mechanisms for monitoring and addressing health conditions, including rotating funds for obstetric emergencies;
 - e. develop intensive campaigns regarding the right to health in Spanish and the principal indigenous languages;
 - f. broaden and diversify options with respect to family planning methods for indigenous women and men, and ensure informed consent as well as their right to decide freely the number and spacing of their children;
 - g. revise and restructure the activities of food assistance and nutritional monitoring in accordance with local conditions and the consumption habits of the population;
 - h. provide available and accessible emergency obstetric care to the population in the conflict zone
 - i. improve the mechanisms of patient referral and transfer to hospitals, especially in obstetric emergencies;
 - j. promote greater structural and functional integration of services of the different government institutions (Ministry of Health and the IMSS-Oportunidades program), which provide medical care to the majority of the population in the study area;
 - k. improve the supply of medicines to health facilities; and
 - l. modify staffing policies to avoid frequent and long absences of health personnel, in particular physicians, from rural facilities and ensuing ruptures in relations with communities, due to rotations, attendance at meetings, participation in courses, paperwork, and the like.
12. Fragmented federal and state nutrition programs should be integrated to establish a stable policy oriented toward promoting the population's capacity for self-sufficiency in food production and food security. In the context of these three regions in the conflict zone, this includes the following:
 - a. providing secure conditions so that the population, independent of their political or religious affiliation, can move about freely and engage in their productive activities;
 - b. providing guarantees for an honorable and secure return of displaced people to their communities and agricultural lands;
 - c. promoting local production and regional exchange through a policy that stimulates the production and consumption of local products and avoids the "dumping" effect, which results in the widespread distribution of food acquired outside the region;
 - d. establishing regional supply centers to regulate the availability and price of food in less accessible regions; and
 - e. implementing a program of nutritional monitoring in the most vulnerable communities, with the participation of community members as well as civil society institutions to promote arrangements for the care of malnourished children, and foster local capacities.

APPENDIX

JOINT PROPOSALS WHICH THE FEDERAL GOVERNMENT AND THE EZLN COMMIT TO SEND TO THE DEBATE AND NATIONAL DECISION AUTHORITIES, IN ACCORD WITH POINT 1.4 OF THE RULES OF PROCEDURE¹

February 1996

The various parties commit themselves to sending to the Debate and National Decision Authorities the following joint proposals upon which they have agreed:

On the basis of the new relationship between the State and the indigenous peoples it is necessary to recognize, ensure and guarantee rights within an amended federalist framework. Such an objective implies the promotion of reforms and addenda to the Federal Constitution and the laws emerging from it, as well as to State Constitutions and local Judicial Dispositions, to further, on the one hand, the establishment of general foundations that may ensure unity and national objectives; and, at the same time, allow the federative entities the true power to legislate and act in accordance to the particularities of the indigenous issues coming before them.

I.

1. To urge a profound transformation of the State, as well as of the political, social, cultural, and economic relationships with the indigenous peoples, which satisfies their demands for justice.
2. To urge the emplacement of an all-inclusive new social agreement, based on the understanding of the fundamental plurality of Mexican society and on the contribution that the indigenous people can make to national unity, beginning with the constitutional acknowledgement of their rights, and in particular, to their right to self-determination and autonomy.
3. The legal reforms to be promoted must originate

from the principle of the equality of all Mexicans before the law and judicial organs, and not by the creation of special codes of law that privilege particular people; respecting the principle that the Mexican Nation is a pluricultural entity which is originally supported by its indigenous peoples.

4. The constitutional modifications represent one of the most important factors in the new relationship between the indigenous peoples and the State within the framework of reforming the State, so that their demands may find support within the State legal system.

II.

1. The creation of a judicial framework that establishes a new relationship between indigenous peoples and the State, based on the recognition of their right to self-determination and the judicial, political, social, economic and cultural rights that obtain from it. The new constitutional dispositions must include a framework of autonomy.
2. Such a judicial framework must be produced with the recognition of the self-determination of indigenous peoples, who, with previous societies, are the ones who have suffered a historical continuation of colonial oppression, maintain and recognize their own identities; and possess the will to preserve them, based on their own, distinct cultural, social, political and economic characteristics. Those attributes characterize them as indigenous peoples, and as such, they are constituted as subjects with a right to self-determination.

Autonomy is the concrete expression of the exercise of the right to self-determination, within the framework of membership in the National State. The indigenous peoples shall be able, consequently, to decide their own form of internal government as well as decide their way of organizing themselves politically, socially, economically and culturally. Within the new constitutional framework of autonomy, the exercise of self-determination of indigenous peoples shall be respected in each of the domains and levels in which they are asserted, being able to encompass one or more indigenous

¹ The Food for Chiapas Campaign. *The San Andrés Accords (Agreements and Joint Proposals)*. Available at: http://www.foodforchiapas.net/History/ezln/02_18_96implementation.html. Accessed March 22, 2006.

groups, according to particular and specific circumstances in each federal entity. The exercise of autonomy of indigenous people will contribute to the unity and democratization of national life and will strengthen national sovereignty.

It is appropriate to admit, as a fundamental demand of the indigenous peoples, their right to autonomy, insofar as they are communities with different cultures and they have the faculty to decide their own local issues within the framework of the National State. This acknowledgement is based on Agreement 169 of the OIT International Labor Organization, and ratified by the Senate of the Republic. Thus, the recognition of autonomy is based on the concept of indigenous group, which is founded on historical criteria and on cultural identity.

3. National legislation must acknowledge indigenous peoples as subjects with the right to self-determination and autonomy.
4. It is proposed to the Congress of the Union to recognize, in national legislation, these communities as entities with public rights, with the right to free association in municipalities with populations that are predominantly indigenous, as well as the right of a group of municipalities to associate, in order to coordinate their actions as indigenous peoples.

Competent authorities will execute the orderly and gradual transference of resources, so that the people themselves may administer the public funds assigned to them, and to strengthen the indigenous participation in government, negotiations and administration in the various domains and levels. It will be up to state legislatures to determine, in their case, the obligations and faculties that might be transferred.

State legislatures will be able to move forward on the remunicipalization in the territories in which the indigenous villages are established, said remunicipalization must be based on consultation with the towns involved.

In order to strengthen the federal contract, it is essential to revise in depth, not only the relationship between the Federation and the state governments, but also the relationship between the latter and the municipalities.

The union between townships and predominantly indigenous populations is proposed, not as a different type of municipality, but as one which, within the framework of the general concept of this political institution, may allow indigenous participation in its composition and unity, while, at the same time promoting and integrating indigenous communities into the municipal government. As to what

constitutes a municipality with a predominantly indigenous population, reaffirming the full meaning of a free municipality on which federalism is based, it is considered necessary that the organizations be constitutionally strengthened, in such a manner that:

- a. they may be endowed with duties that guarantee the exercise of autonomy of the indigenous peoples;
 - b. the structure foreseen in the Municipal Organic Law will guide and orient them toward facing the new challenges of development, and in particular to the needs and new forms of organization specifically for indigenous towns.
5. It is proposed that the Congress of the Union and to the State Legislatures acknowledge and establish the characteristics of self-determination and the levels and modes of autonomy, taking into consideration what "autonomy" means.
 - a. *Territory.* Every indigenous town is found in a territory that covers the entire habitat occupied or used by indigenous people in one form or another. The territory is the material base of their reproduction as a people and it expresses the inseparable unity people-land-nature.
 - b. *Demarcation of application.* Jurisdiction is the spatial, material and personal normative field of validity in which the indigenous people apply their rights. The Mexican State will acknowledge the existence of said fields.
 - c. *Responsibilities.* There must be compatibility with various federal, state and municipal authorities, as well as a distribution of political, administrative, economic, social, cultural, educational, judicial resources, for the management and protection of natural resources, with the purpose of responding opportunely to the requirements and demands of indigenous peoples. Furthermore, it will be required to specify the obligations, faculties and resources that are likely to be transferred to the indigenous communities and towns under the established criteria in Section 5.2 of the document entitled "Joint Pronouncements", as well as the various forms of participation by the communities and towns vis a vis the government authorities, so that they may interact and coordinate their actions with them, particularly at the municipal level.
 - d. *Self-development.* The indigenous communities and towns themselves must determine their development projects and programs. For this reason, it is considered appropriate to incorpo-

rate, in local and federal legislation, the ideal mechanisms that would promote the participation of indigenous peoples in the planning for development at all levels; so that the design of this participation may take into consideration their aspirations, needs and priorities.

- e. *Participation in the national and state channels of representation.* Local and national participation and political representation must be ensured, respecting the various socio-cultural characteristics, in order to create a new federalism.

It is proposed to the Congress of the Union, the recognition, in constitutional and political reforms that may derive, of the rights of the indigenous woman to participate as an equal with men in all levels of government and in the development of indigenous peoples.

- 6. It is proposed to the Congress of the Union and to the State legislatures that, in acknowledging indigenous autonomy and for the determination of all its levels, they take into consideration the main rights that are the objects of said autonomy; establishing the characteristics required to insure its free exercise. Among said rights, the following may be emphasized:
 - a. to exercise the right to develop the specific forms of social, cultural, political and economic organization;
 - b. to obtain the recognition of their internal normative systems for regulation and sanctions, insofar as they are not contrary to constitutional guarantees and human rights, especially those of women;
 - c. to agree to State jurisdiction in a better way;
 - d. to agree collectively to the use and enjoyment of natural resources, except those which fall under national jurisdiction;
 - e. to promote the development of the various components of indigenous identity and cultural heritage;
 - f. to interact with the various levels of political representation in government and the administration of justice;
 - g. to cooperate with other communities of their ethnicity or different groups, in joining efforts and coordinating actions for optimal use of resources, and the initiation of regional and general development projects for the promotion and defense of common interests;
 - h. to design their community and their municipal government representation freely, as well as

selecting their authorities as indigenous peoples, in accordance with their own institutions and traditions;

- i. to promote and develop their languages and cultures, as well as their political, social, economic, religious and cultural customs and traditions.

III.

- 1. Increase in political participation and representation. Municipal strengthening. It is convenient to anticipate at the constitutional level the necessary mechanisms that:
 - a. Insure the adequate political participation of indigenous communities and peoples in the Congress of the Union and local congresses, incorporating new criteria in setting the boundaries of the electoral districts that correspond to the indigenous communities and towns;
 - b. Allow participation in the electoral processes without requiring participation of the political parties;
 - c. Guarantee the effective participation of the indigenous peoples in the publicity and supervision of those processes;
 - d. Guarantee the organization of internal election or nomination processes.
 - e. Recognize the system assignment of offices and other forms of organization, methods of designation of representatives, and the making of decisions in the assembly and of popular consultation.¹
 - f. Establish the election of municipal agents or allied figures or, when appropriate, be named by the corresponding towns and communities.
 - g. Foresee in the state legislation the mechanisms that may allow the revision, and, when appropriate, the modification of the names of the municipalities, proposed by the population located in the corresponding boundaries.
- 2. *The guarantee of full access to justice.* The State must guarantee the towns full access to the jurisdiction of the Mexican State, with recognition and respect for their own internal normative systems, guaranteeing full respect for human rights. It will promote the recognition that positive Mexican Law may acknowledge the authorities, norms and internal procedures for conflict resolution of towns and communities, will guarantee that local judgments and decisions are confirmed by the judicial authorities of the State.

The recognition of jurisdictional spaces to the designated authorities in the heart of the indigenous communities, towns and municipalities stems from a restructuring of the municipal charter, so that said authorities will be able to settle internal conflicts of coexistence; their knowledge and resolution may imply a better acquisition and distribution of justice.

The marginalization in which the indigenous people live and the conditions of disadvantage to which they consent in the system of granting and procuring justice, create the need for a serious revision of the federal and state judicial frameworks, so that effective access of the indigenous peoples be guaranteed, or in place of local action, access to its members to the State jurisdiction, and in this manner, avoiding partial distribution of justice to the detriment of the indigenous sector of the population.

In the legislative reforms that may enrich the internal normative systems it must be determined that, when sanctions are imposed upon members of the indigenous towns, the economic, social and cultural characteristics of those sanctioned must be taken into consideration, privileging sanctions other than incarceration. Preferably sentences may be carried out in places that are closer to home and also, that integration into the community be favored as an essential mechanism of social readaptation.

The insertion of the norms and judicial practices of the indigenous communities as a source of law applicable to procedures and resolutions of controversies under their authorities will be encouraged; also, in order to provide constitutional guarantees, it is strongly suggested that federal and local judgments in which the indigenous people are involved be taken into consideration.

3. *Knowledge and respect of indigenous culture.* It is considered necessary to elevate the constitutional rank of all Mexicans by means of a pluricultural education that acknowledges, disseminates and promotes the history, customs, traditions and, in general, the culture of the indigenous peoples, root of our national identity.

The Federal Government will promote the laws and necessary policies so that the indigenous languages in each state may have the same social value as Spanish, and it will promote the development of practices that deter discrimination against them in administrative and legal transactions.

The Federal Government commits itself to the promotion, development, preservation and practice of indigenous languages by providing education in the indigenous languages; moreover, it will favor the instruction of writing and reading in the lan-

guages themselves; and measures will be adopted to insure that these peoples have the opportunity to learn Spanish.

Knowledge of indigenous cultures is national enrichment and a necessary step to eliminate misunderstandings and discrimination toward indigenous peoples.

4. *Integral Indigenous Education.* The various governments commit themselves to respect the educational tasks of the indigenous peoples within their own cultural space. The allocation of financial, material and human resources must be brought about with fairness to plan and carry out educational and cultural activities determined by the indigenous towns and communities.

The State must bring about the indigenous peoples' right to a free and quality education, as well as to encourage the participation of the indigenous towns and communities in selecting, ratifying and removing teachers, taking into consideration criteria on academic and professional performance previously agreed on by the indigenous peoples and the corresponding authorities, and to form supervisory committees on the quality of education within the framework of local institutions.

The right to bilingual and intercultural education of the indigenous peoples is ratified. The definition and development of educational programs with regional content, where their cultural heritage is recognized, are established as the jurisdiction of federative entities in consultation with the indigenous towns. It will be possible, through educational action, to insure the use and development of indigenous languages, as well as the participation of towns and communities in conformance with the spirit of Agreement 169 of the OIT (International Labor Organization).

5. *The provision of basic needs.* The State must set up mechanisms to guarantee the indigenous towns the conditions that may allow them to satisfactorily tend to their nourishment, health, and housing at an adequate level of well-being. Social policy must set up priority programs for the improvement of the levels of health and nourishment of children, as well as support programs, in an egalitarian plane, for the training of women, increasing their participation in the organization and the development of the family and the community. Priority must be given to the intervention of the indigenous woman in the decisions regarding economic, political, social and cultural development projects.
6. *Production and employment.* Historically, development models have not taken into consideration the

productive systems of the indigenous peoples. Consequently, the utilization of their potentials must be encouraged.

The Mexican judicial system, both at federal and state levels must push for the recognition of the indigenous peoples' right to the sustainable use and the derived benefits of the use and development of the natural resources of the territories they occupy or utilize in any form, so that, in a framework of global development, the economic underdevelopment and isolation may be overcome. This action also implies an increase in and reorientation of social spending. The State must foster the development of the economic base of the indigenous towns and must guarantee their participation in designing the strategies directed toward the improvement of their living conditions and the provision of basic services.

7. *Protection of migrant indigenous peoples.* The State must set up specific social policies to protect migrant indigenous people, both in the national territory as well as beyond its borders, with inter institutional actions to support work and education of women, and health and education for children and youth, which, in rural regions, must be coordinated in the areas of contribution as well as those that attract agricultural workers.
8. *Means of communication.* With the purpose of creating an inter cultural dialogue from the community level up to the national level, that may allow a new and positive relationship between the various indigenous groups and between these groups and the rest of society, it is essential to endow these towns with their own means of communication, which are also key mechanisms for the development of their cultures. Therefore, it will be proposed to the respective national authorities, to elaborate a new communications law that may allow the indigenous towns to acquire, operate and administrate their own means of communication.

The Federal and State governments will promote that the means of communication currently in the hands of the Indigenists become indigenous means of communication, which is a demand made by the indigenous communities and towns.

The Federal Government will recommend to the respective authorities that the seventeen INI (National Indigenist Institute) radio stations be given to the indigenous communities in their respective regions, with the transference of permits, infrastructure and resources, when an expressed request by the indigenous communities has been issued to this effect.

In the same manner, it is necessary to create a new judicial framework in the area of communications that may consider the following aspects: national pluriculturalism; the right to use indigenous languages in the media; the right to rebuttal; guarantees to rights of expression, information and communication; and the democratic participation of the indigenous towns and communities before the authorities who decide on matters of communication. The participation of interested parties in establishing a civic responsibility process for the decision-making authorities in the area of communication, can be realized through the creation of a communications Ombudsman or a citizens' Council of communications.

IV. THE ADOPTION OF THE FOLLOWING PRINCIPLES, WHICH MUST GOVERN THE NEW RELATIONSHIP BETWEEN INDIGENOUS PEOPLE AND THE STATE AND THE REST OF SOCIETY:

1. *Pluralism.* The contact between the peoples and cultures that constitute Mexican society must be based on respect for their differences, and must assume their fundamental equality. Consequently, it must be the policy of the State to regulate its action, to promote a pluralist orientation in society, capable of actively combating every form of discrimination, and of correcting economic and social inequalities. Similarly, it will be necessary to move towards the creation of a judicial order nourished by plurality, reflecting intercultural dialogue with common standards for all Mexicans and respect for the internal systems of law of the indigenous peoples.
2. *Self-determination.* The State shall respect the exercise of self-determination by indigenous peoples, in all fields and levels where they will try to validate and practice their separate autonomy, without damaging national sovereignty and within the new normative framework for the indigenous towns. This implies respect for their cultural identities and their forms of social organization. It will also respect the abilities of the indigenous towns and communities to determine their own development, as long as national and public interest is respected. The various levels of government and State institutions will not intervene unilaterally in the affairs and decisions of the indigenous towns and communities, in their organization and forms of representation, and in their current strategies for the use of resources.

3. *Sustainability.* It is necessary and urgent to safeguard the natural areas and culture of the territories of indigenous peoples. Legislation will push for the recognition of the rights of the indigenous towns and communities to receive the corresponding indemnization, when the exploitation of natural resources carried out by the State causes damages to their habitat which may endanger their cultural survival. In the cases where damage has already occurred, and the towns are where damage has already occurred, and these towns are able to show that the given compensation does not allow their cultural survival, the establishment of review mechanisms will be promoted to allow the State and the affected to jointly analyze the specific case. In both cases the compensatory mechanisms will try to insure the sustainable development of the indigenous towns and communities.

In the same manner, there will be launched, in common accord with the indigenous towns, rehabilitation activities of those territories, and support of initiatives to create the conditions that may insure the sustainability of their practices of production and of life.

4. *Consultation and Accord.* The policies, laws, programs, and public actions that might relate to the indigenous towns will be consulted. The State must promote the integrity and agreement of all the institutions and levels of government that influence the life of the indigenous towns, avoiding partial practices influencing the life of the indigenous towns, avoiding partial practices that may split up public policy. To insure that their action corresponds to the distinct characteristics of the various indigenous towns, and to avoid the imposition of uniform policies and programs, their participation in all the phases of public action, including conception, planning and evaluation must be guaranteed.

Similarly, there must be a gradual and orderly transference of powers, obligations and resources to the municipalities and communities so that, with the participation of the latter, the public monies assigned to them may be distributed. As for resources, and for whatever purpose they may exist, they may be transferred to the forms of organization and association that are anticipated in point 5.2 of the document of Joint Pronouncements.

Since the policies in the indigenous areas should not only be conceived with the towns themselves, but implemented with them, the present indigenist and social development institutions that operate locally must be transformed into different entities that may be conceived and operated jointly and in concert with the State and the indigenous peoples

themselves.

5. *Strengthening of the Federal System and Democratic Decentralization.* The new relationship with the indigenous peoples encompasses a process of decentralization of the obligations, faculties and resources of the federal and state authorities to the municipal governments, in the spirit of point 5.2 of the document Joint Pronouncements, so that with the active participation of the indigenous communities and the population in general, they may assume the initiatives thereof.

V. CONSTITUTIONAL AND LEGAL REFORMS

1. The establishment of a new relationship between the indigenous peoples and the State has, as a necessary point of departure, the creation of a new judicial framework at the national level as well as in the federative entities. The constitutional reforms that recognize the rights of the indigenous towns must be achieved through a creative legislative spirit that may produce new policies and may give real solutions to social problems. To that effect, the research team proposes that these reforms must contain, among others, the following general aspects:
 - a. To legislate on the autonomy of the indigenous communities and towns, to include the recognition of the communities as entities with public law; their right to associate freely with municipalities that are of predominantly indigenous populations; and also the right of various municipalities to associate for the purpose of coordinating their actions as indigenous towns;
 - b. To legislate to "guarantee the protection of the integrity of the lands belonging to indigenous groups," taking into consideration the specifics of the indigenous towns and communities, in the concept of territorial integrity contained in Agreement 169 of the OIT (International Labor Organization), as well as establishing the procedures and mechanisms for the regularization of the various forms of indigenous property rights and for the promotion of cultural cohesion;
 - c. In issues related to natural resources, to install a preferential order that privileges the indigenous communities in the granting of concessions in order to reap the benefits of the exploitation and use of natural resources;
 - d. Legislate on the rights of the indigenous people, men and women, to have representatives in the

legislative entities, particularly in the Congress of the Union and in the local congresses; incorporating new criteria to delimit the electoral districts that may correspond to the indigenous communities and towns, and that they be allowed to have elections in accordance to the legislation on that matter;

- e. Legislate on the rights of the indigenous towns to elect their own authorities and to exercise authority according to their own internal norms in their autonomous localities, guaranteeing the participation of women on equal terms;
- f. In the content of the legislation, to take into consideration the pluricultural nature of the Mexican Nation that may be reflected in inter cultural dialogue, with common standards for all Mexicans and with respect for the internal normative systems of the indigenous towns;
- g. In the Constitution, to insure the obligation to not discriminate on the basis of racial or ethnic origin, language, gender, beliefs or social condition, thus, making possible the designation of discrimination as a crime. The rights of the indigenous towns to the protection of their sacred sites and ceremonial centers, and the use of plants and animals that are considered sacred for strictly ritual use must also be insured;
- h. Legislate so that no form of coercion may be exercised against the individual guarantees and the specific rights and freedoms of the indigenous towns;
- i. Legislate the rights of the indigenous towns to the free exercise and development of their cultures and their access to means of communication.

