The Pretense of Inclusion:

Contextualizing Sexual and Reproductive Health Policies in the Lived Realities of Indigenous Youth

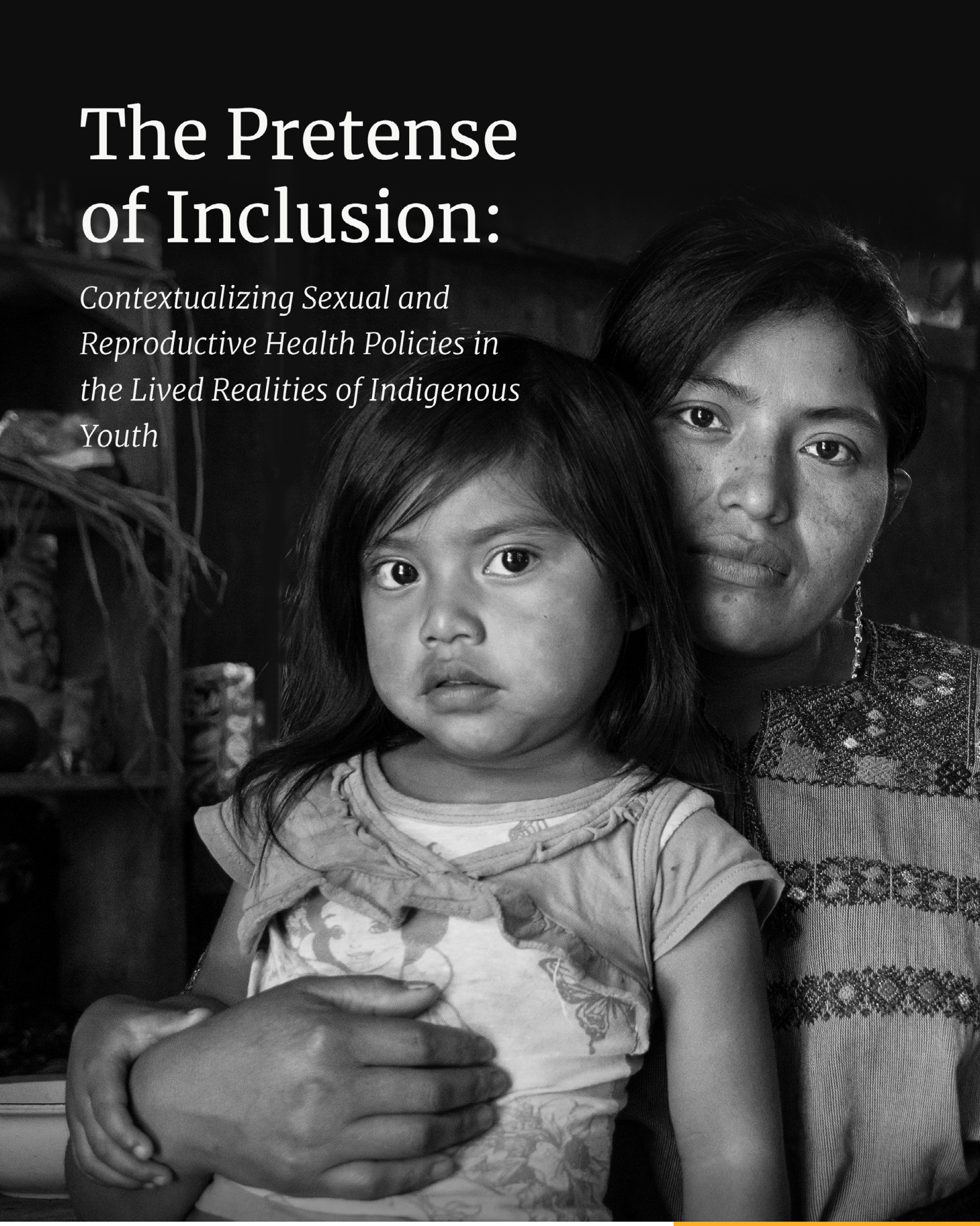

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Table of Contents

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Acronyms and Abbreviations

- **CONAPO** — Consejo Nacional de Población (National Population Council)
- **DIGEPO** — Dirección General de Población de Oaxaca (General Directorate of Population of Oaxaca)
- **ENAPEA** — Estrategia Nacional para la Prevención del Embarazo en Adolescentes (National Strategy for the Prevention of Adolescent Pregnancy)
- **GEPEA** — Grupo Estatal para la Prevención del Embarazo en Adolescentes (State Group for Adolescent Pregnancy Prevention)
- **GIPEA** — Grupo Interinstitucional para la Prevención del Embarazo en Adolescentes (Interinstitutional Group for Adolescent Pregnancy Prevention)
- **IMSS** — Instituto Mexicano del Seguro Social (Mexican Social Security Institute)
- **INMUJERES** — Instituto Nacional de las Mujeres (National Institute for Women)
- **NOM** — Norma Oficial Mexicana (Official Mexican Standard)
- **OMM** — Observatorio de Mortalidad Materna en México (Observatory for Maternal Mortality in Mexico)
- **SMO** — Secretaría de las Mujeres de Oaxaca (Secretariat of Oaxacan Women)
- **SRH** — sexual and reproductive health
- **SRHR** — sexual and reproductive health and rights
- **UyC** — "usos y costumbres" (traditions and customs)

Background

Adolescents and youth compose over a quarter of Mexico's total population; and while the overall fertility rate among 15- to 19-year-olds has declined, there remains severe inequality across the country in fertility trends, contraceptive needs and health care access.[1,2] Within this age group, Indigenous youth have a higher fertility rate than their non-Indigenous peers, at approximately 97 births per 1,000 women compared to 68 births per 1,000 in 2015.[3] The sociocultural contexts of Mexico's Indigenous populations are fundamental to explaining such disparities between these groups. Access to quality reproductive health care among Indigenous youth is influenced and affected by community and cultural contexts as well as cultural incompetence in health programs, as exemplified by health care actors and policymakers.

These issues are of pressing concern considering President López Obrador's current administration has not clearly stated how it will respond to the unique needs of Indigenous youth across Mexico, particularly in the ongoing implementation of the Estrategia Nacional para la Prevención del Embarazo en Adolescentes (National Strategy for Adolescent Pregnancy Prevention, ENAPEA). Introduced in January 2015, the ENAPEA seeks to halve fertility among 15- to 19-year-old adolescents and to eliminate pregnancy among girls ages 10 to 14 by 2030. It also aims to reduce health inequities among various populations and to improve the social conditions of the most marginalized people in Mexico.[4,5]

Giving specific attention to the country's Indigenous citizens, the ENAPEA categorically prioritizes municipalities with Indigenous populations of 20% or larger and of more than 1,000 persons aged three years or older who speak an Indigenous language. The strategy to address early pregnancies among Mexico's Indigenous groups is based on the following:

- Unequal social power between men and women in Indigenous communities is a significant contributing factor to adolescent pregnancies;
- Indigenous youth leave school earlier than young non-Indigenous people on average, with over one-third of 10- to 19-year-olds and approximately half of 15- to 17-year-olds out of school; and
- Poor, out-of-school girls and adolescents in rural communities, highly marginalized urban settings and early unions are the most vulnerable to early pregnancy and constitute the group with the highest fertility rates.[6]

Although the need for improved sexual and reproductive health (SRH) services among Indigenous populations is widely known, information about the relationships among institutional barriers, cultural and societal norms and health care access for young Indigenous people is scarce. Moreover, Mexico's Indigenous populations continue to be overlooked and excluded in the development and execution of national government plans.[7,8,9] As such, while civil society representatives participated in the interdisciplinary and multisectoral development of the ENAPEA, and all 32 Mexican states are represented in local implementations of the strategy through their Grupo Estatal para la Prevención del Embarazo en Adolescentes (State Group for Adolescent Pregnancy Prevention, GEPEA), it remains unclear whether — and if so, how — the ENAPEA will respond to the different needs of Indigenous youth across the country.

The ENAPEA and Relevant Policies

The ENAPEA asserts that its plan of action is rights-based, expressly driven by the rights of youth to SRH and to a life without violence, as well as the right for young people to participate in the development, implementation, monitoring and evaluation of public policies relevant to their lives. The strategy's construction was guided by reviews of long-term, multisectoral strategies and of international experiences with the reduction of adolescent pregnancies. These studies — alongside the knowledge acquired by multiple federal agencies, the Instituto Mexicano del Seguro Social (Mexican Social Security Institute, IMSS) Prospera program and civil society organizations — led the Grupo Interinstitucional para la Prevención del Embarazo en Adolescentes (Interinstitutional Group for Adolescent Pregnancy Prevention, GIPEA) to determine five of the most effective strategies for decreasing adolescent pregnancies:

1. Comprehensive sexuality education in schools or in collaboration with schools;
2. Adolescent-friendly health services and clinics;
3. Adequate supplies and effective contraceptives for adolescents;
4. Use of media for mass communication of interventions and social marketing; and
5. Social policies for school retention and job placement.

These strategies guided the ENAPEA's conceptual framework, which begins with "less impactful" individual-level interventions perceived by the GIPEA as less complex to implement, and progresses to social, cultural and political interventions with broader effects and more multifaceted implementation requirements. Achieving the interventions outlined in the ENAPEA will require reforms in health, education and development.[10]

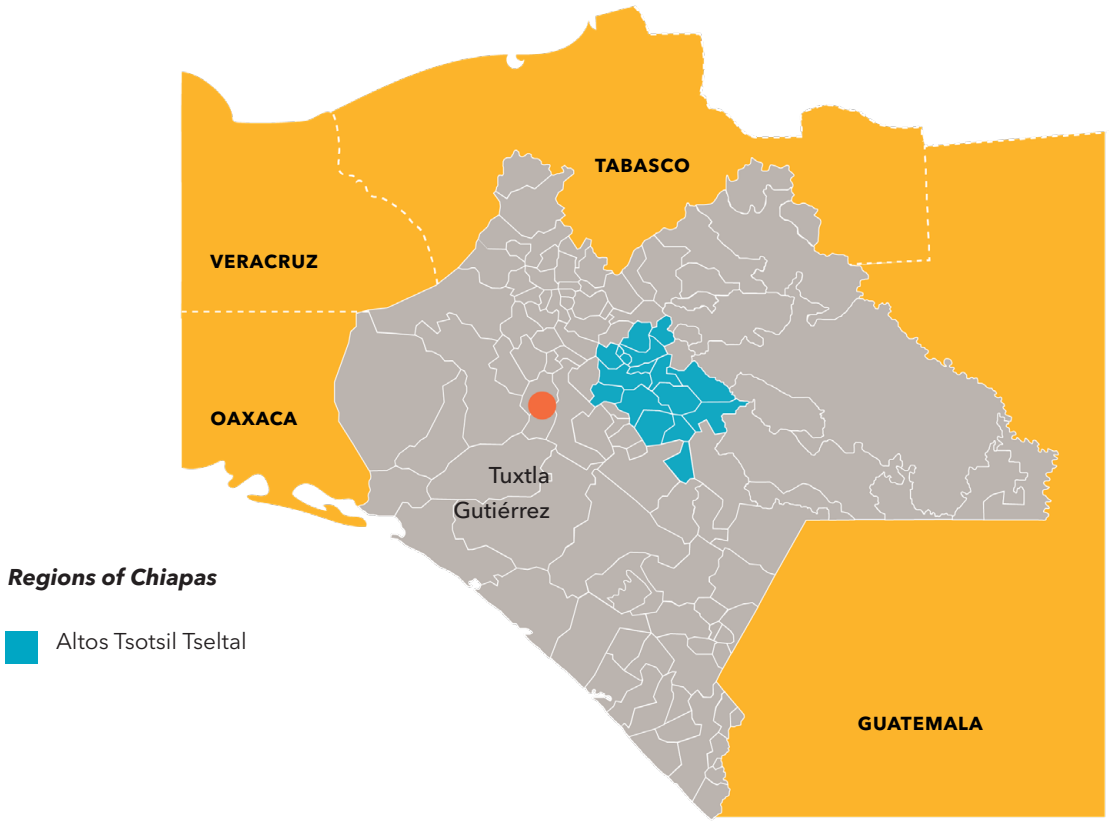
The conceptual framework and key interventions align with the Norma Oficial Mexicana (Official Mexican Standard, NOM) 046-SSA2-2005 (hereafter referred to as NOM 046), which regulates detection, prevention and response to domestic and sexual violence, and 047-SSA2-2015 (NOM 047), which ensures health care for 10- to 19-year-olds.[11] NOM 046 safeguards access to emergency contraception and voluntary termination of pregnancy in cases of sexual violence and rape for women and girls over 12 years old. For girls under age 12, it requires the consent of a legal guardian. NOM 047 stipulates that adolescents and youth ages 10 to 19 have the right to request and receive family planning and SRH counseling and services without adult supervision, and that these services should be inclusive, nondiscriminatory and provided with respect, confidentiality and informed consent. Additionally, NOM 047 requires health care providers to identify possible signs of violence or sexual abuse in pregnant youth under age 15 and adhere to the guidelines established by NOM 046 where appropriate. Both standards require adherence by all public and private health care personnel and institutions, and align with national and international human rights standards.

The ENAPEA establishes five objectives to reduce the number of adolescent pregnancies in Mexico:

1. Contribute to the human development of and expand economic and educational opportunities for adolescents in Mexico;
2. Foster a supportive environment that facilitates free, responsible and informed decision-making by adolescents about their sexuality and pregnancy prevention;
3. Ensure effective access to a complete range of contraception, including long-acting reversible contraception, to guarantee free and informed choice and male co-responsibility in the exercise of sexuality;
4. Increase demand and the quality of adolescent SRH services; and
5. Guarantee the right of girls, boys, and the adolescent population to receive comprehensive sexual education at all public and private levels.

In addition to the five core objectives, the ENAPEA has the following eight guiding principles that permeate both the objectives and courses of action:

1. Intersectorality
2. Citizenship and sexual and reproductive rights
3. Gender perspective
4. Life course and life plan
5. Co-responsibility
6. Youth participation
7. Research and scientific evidence
8. Evaluation and accountability



Catalysts for Exploration

Following former President Enrique Peña Nieto's administration, under which Mexico saw increased crime and corruption and weakened economic growth, the inauguration of President López Obrador in December 2018 inspired hope for challenging the establishment in order to meet the needs of all citizens. In his 2018 presidential campaign, López Obrador claimed he would lead Mexico through a "fourth transformation" that would enhance the country's democracy and prosperity by uprooting corruption, eliminating income disparities and securing the country's self-sufficiency.

Since 2018, Chiapas-based civil society organization Observatorio de Mortalidad Materna en México (Observatory for Maternal Mortality in Mexico, OMM) has engaged Indigenous youth in citizen monitoring of state-run health facilities in six Tsotsil and Tseltal municipalities in the Chiapas Highlands. In the time since then, the young citizen monitors have corroborated OMM's prior documentation of administrative barriers to contraceptive access faced by Indigenous youth. These include deficiencies in cultural competence among health care providers and facility staff, including those managed by Mexican Secretariat of Health and IMSS.[12,13]

These barriers, alongside cultural norms and economic hardships that influence early marriage and childbearing in Indigenous communities, contribute to the high unmet need for contraception of nearly 23% in Chiapas relative to the national average of 10%; within Chiapas, Indigenous adolescents and young adults ages 15 to 24 have the highest unmet need.[14,15] Thus, there is a strategic advocacy focus on reducing administrative and cultural barriers to contraceptive uptake among Indigenous youth in order to increase access, uptake and method mix, and to improve service provision.

Study Objectives

Building on OMM's findings and responding to an expressed concern among civil society that President López Obrador's campaign promise will not reach the large Indigenous populations in the southern states, this report shares an exploration into the reproductive realities of young Indigenous people from Chiapas and Oaxaca and details how government and civil society representatives are working to ensure the SRH needs of Indigenous youth are being met through the ENAPEA's implementation.

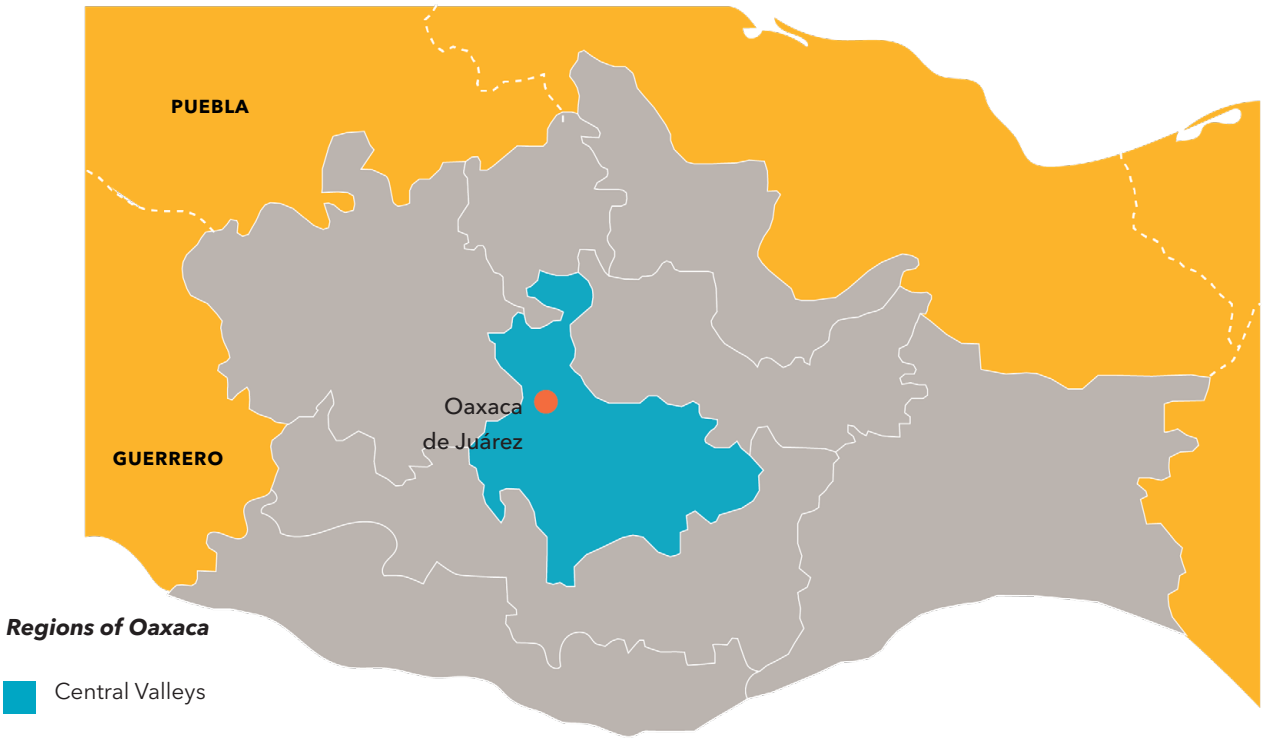
Participants were engaged in conversations about how the interplay of institutional barriers and social norms affect access to SRH care and the realization of sexual and reproductive rights among Indigenous youth. Their responses will strengthen the collective understanding of whether and how their sexual and reproductive health and rights (SRHR) are being realized in order for civil society to better hold federal and state administrators accountable to their young Indigenous constituents. This inquiry will expand the knowledge base of specific SRH concerns, needs and desires of Indigenous youth in these communities.

Methods

Data were obtained between July and August 2019. Seven focus group discussions were conducted with 45 Indigenous adolescents and young adults ages 11 to 27 across Chiapas and Oaxaca, with perspectives from Tsotsil, Tseltal and Mixtec communities. Thirty girls and young women and 15 boys and young men were included, and discussions were held in both gender-segregated and mixed-gender groups of varied sizes. In addition, four key informant interviews were conducted with representatives from the following federal and state administrative agencies: Consejo Nacional de Población (National Population Council, CONAPO), Dirección General de Población de Oaxaca (General Directorate of Population of Oaxaca, DIGEPO), Instituto Nacional de las Mujeres (National Institute for Women, INMUJERES) and Secretaría de las Mujeres de Oaxaca (Secretariat of Oaxacan Women, SMO). Similarly, four focus group discussions were held with representatives of civil society from Chiapas, Mexico City and Oaxaca, some of whom are members of their respective GEPEA. Informed consent and assent were verbally and physically obtained from all participants prior to data collection.

This exploration employed inductive coding and content analysis. All key informant interviews and focus group discussions were conducted in Spanish and guided by semi-structured interview protocols. Three of the youth focus group discussions also included translators for Tsotsil and Tseltal. Each conversation was recorded and subsequently transcribed in Spanish. All transcripts were imported into MAXQDA software for in vivo and simultaneous coding and analysis.

Following the analysis, youth health promoters who participated in the youth focus groups were convened to discuss the findings and provide recommendations related to the ongoing implementation of the ENAPEA and achievement of its objectives.



Reproductive Realities of Tsotsil, Tseltal and Mixtec Youth in Chiapas and Oaxaca

To better understand the respondents, it is important to consider various dimensions of identity among the adolescent and young adult participants. Firstly, differences in language are significant: Most of the youth respondents in Chiapas speak Spanish, but some had limited Spanish comprehension despite receiving a formal education. For this reason, in part, responses from some Chiapanecan youth were brief. In contrast, all youth focus group participants in Oaxaca spoke and understood Spanish comfortably during the discussions. Another element of identity that varied among participants was clothing: Many of the respondents wore more contemporary fashions instead of traditional clothing. Traditional dress has become more ceremonial over time and is more expensive than commercially available modern clothing.[16] The youngest girls in Chiapas were the only participants who wore traditional garments, while none of the youth participants in Oaxaca wore traditional clothing.

These differences in expression through dress and language are examples of the many changes Indigenous youth are experiencing. Migration across Mexico or to the United States and the influence of images, ideas and ideals from other places are also transforming ways of life in Indigenous communities. For instance, some communities are experiencing the breakdown of multigenerational family units and the assumption of new social roles by individuals. Recently, modern socialization through engagement on social networks and other online avenues has exposed Indigenous youth to information that was inconceivable even a decade ago. However, they often still live by conservative gender constructs in their communities.[17] Despite increased inclusion of Indigenous girls in schools, their education at home continues to focus solely on domestic responsibilities. Meanwhile, Indigenous boys are prepared for work in the fields. These divergent realities are creating a social dissonance in youth development. Another example of change is the ownership of SRHR among Indigenous youth. For example, OMM's youth health promoters have taken on roles to share information among peers, both at formal request and unprompted. Such differences are notable because previous generations seldom received, and much less accepted as true, this type of information. These issues and others were raised in conversations across the three respondent categories. The following sections are examinations of the major themes that emerged, stemming from topics raised in the youth focus group discussions and connecting to the conversations with civil society and government representatives.

Insufficient Familiarity with Human Rights and SRHR Among Indigenous Youth

Most of the young respondents had very limited to no knowledge of human rights or SRHR and related concepts. The exceptions included youth health promoters, who have extensive training and continuing education in the field, and the young adult participants ages 18 years and older. None of the participants below age 15 had heard of "human rights," "reproductive health" or "reproductive rights," and they were unable to express anything beyond vague, if any, understanding of related issues around sex and reproduction. The youngest respondents were from small communities in Emiliano Zapata, Oaxaca and the predominantly Tseltal-speaking municipality of Tenejapa, Chiapas.

Among the participants ages 15 years and older, there was considerable variation in knowledge and understanding of rights. Most had heard of or had some familiarity with the term "human rights," and while unable to define it, many could name at least one example. The most common responses were around freedom of expression, right to life, "the right to choose," right to education, right to health care and good service, the right to food and freedom in a general manner. Two respondents spoke of women's rights and the ability to participate and to attend school, as well as the establishment of equality between men and women and the right to freedom from violence. A youth health promoter provided the most comprehensive response: "… human rights are where all those things we can do as citizens, as individuals — and also what we cannot do — are articulated in detail, as I said at the national level." A young girl from Tenejapa also shared, "We all have rights. That no one can take that right away from us."

Among the younger contributors, familiarity with human rights began at home, either by overhearing or in direct conversation with their parents, who mostly spoke of the right to free speech. Many of the respondents who were in high school had been introduced to human rights in civics and ethics classes, with the concept of rights connected to the Constitution. This illuminates that the understanding of human rights for these respondents was in the context of their country. However, national rights are not always akin to international human rights, so it is important to note that their comprehension of rights was not also situated in their global citizenship. This may be a reflection of widespread estrangement and exclusion of many Indigenous communities from global dialogues, in addition to national discourses.

On the subject of SRHR, there was substantially more awareness among the youth participants, though varied in issues and depth of insight. There was a general conflation of reproductive health and reproductive rights across all participants, as well as sexual health and reproductive health, but as with the discussions of human rights, many of the core components of SRH were voiced across the groups. Most respondents were able to speak briefly about many facets of SRH, including: unspecific recognition of the "male or female [reproductive] organ, about sexuality;" sex; pregnancy — and more often than not, the avoidance of pregnancy; childbirth; menstruation; contraception; and/or protection against sexually transmitted infections. The contraceptive methods most cited were condoms, the pill, injections and emergency contraception. The SMO raised emergency contraception as a cause for concern because young women across Mexico consider it a standard form of birth control. A handful of respondents had heard of the term "safe sex," but they were uncertain how it could be practiced.

As for where the respondents were learning about SRH, some young people mentioned that the biological aspects of reproductive health were discussed in school, of which the earliest mention was a fourth grade biology class. These conversations were mostly led by teachers, but sometimes students were instructed by guests from civil society organizations or community clinics. A minority of youth had conversations with their parents or other adult relatives about sex, but most were reticent to do so with their much older family members. The less clinical and more social and cultural aspects of SRH were most often spoken about between friends and sometimes same gender siblings, if at all. A small number of respondents — all girls — shared that they did not yet have interest in sex, motherhood or marriage. While there is community-based education occurring and comprehension advancing, these dialogues do not seem to occur consistently or widely, and they are limited in topics of instruction. Notably, some of the younger participants from Tenejapa mentioned learning some of these terms from youth health promoters in their communities, signifying SRH education steered by civil society initiatives, beyond the scope of government leadership.

Relatedly, no respondents were able to speak to any laws — federal, state or local — that protect their SRH and sexual and reproductive freedoms. As well, an overwhelming majority of youth respondents shared that they do not feel their local leaders and authorities care about their SRH or SRH needs. Two youth health promoters summed up the sentiment shared by most of their peers across the youth focus groups:

> "... health is the last thing, and least of all, young people... for the majority, the only thing that matters is financial, money, it is the only thing that matters to them. If the hospital provides good service, if there are methods? No! This is the last thing, as if it is worthless, not of interest."

Another shared more succinctly, "There is no support for youth." The lack of consideration and support from their community leaders and government officials was questioned by an older teen boy, who candidly inquired, "Well, they should do more, right? ... I don't know, give more talks or provide more guidance to youth, right? For removing every doubt that everyone may have, right?" Most of the responses were given briefly and precisely, yet all expressed some sense of frustration and disappointment. Only one respondent, another youth health promoter, provided an appreciation for her community president's interest in youth education.

The discussions with civil society and key informants from government agencies provided connections to these exchanges with youth respondents on SRHR knowledge. Concerning human rights, members of the Oaxaca GEPEA shared the need to harmonize rights with local customs, such that rights could be enjoyed without ignorance or disrespect to community life and cultures. This would require contextualizing SRH and bolstering conversations and consistent engagement with Indigenous communities in a way that ensures human rights are understood and recognized so that they may not be violated, while also recognizing and respecting Indigenous traditions.

However, there are undeniable differences in the importance of and adherence to culture, which exist along generational, gender and community lines. "Usos y costumbres," loosely translated to traditions and customs, were brought up in many of the discussions, and there is a considerable foundation of patriarchy on which these practices rest. Religion also features significantly in the cultural considerations. One member of the Oaxaca GEPEA shared, "So there, there is a serious rights violation, because one should also consider, which I have always said, that you have to recognize the adolescent question, but you also have to empower them as subjects of rights, because a consequence of them not knowing all of this is that the same system also violates rights, the rights that the state is supposed to confer." The idea of situating youth as the "subject of rights" was also endorsed by Chiapas civil society representatives, INMUJERES and the SMO — the latter two conspicuously government agencies focused on women. However, these groups acknowledged that young people are not considered the subjects of rights and are still treated as wards of the state. Youth need to be empowered with the requisite information, tools and skills so that they can demand the fulfillment and protection of their own rights.

The ENAPEA's proposed interventions can directly impact the enfranchisement of youth as subjects of rights. In particular, integrating comprehensive sexuality education within schools, improving the enabling environment to encourage healthy choices among youth and increasing attention to the social determinants of health could have immediate bearing on supporting young people as the subject of rights within their respective communities and throughout the country. Additionally, the other two pillars of the ENAPEA framework — more effective clinical interventions and access to modern contraception, including long-acting reversible contraceptives — would also empower young people, and more quickly. However, the specific tactics for implementation of these points of action must be positioned within community contexts and respect the many, varied Indigenous populations. The inclusion of Indigenous youth and communities in operationalizing such systems and procedures is vital to ensuring dignity and achieving progress.

Importantly, while it is necessary to examine sexual and reproductive rights on their own, human rights are indivisible. A GEPEA member in Oaxaca reminded the group of this during the conversation, sharing:

> "We cannot think of one thing — access to rights — without thinking [about], and more so, in an Indigenous population. In other words, we cannot think about access to a road, for example, which is something that, if it exists, is linked to access to sexual health, to reproductive health, because there are communities where there is only one health center or clinic in which only one person works, once a week. And so if it is not possible [to receive services] in this community, [people] have to travel to a nearby community where this a health center which is on another level, meaning there is an attending nurse every day and accessible by road, this helps rights; so it is linked, but you are not working on strengthening the tools, skills, to directly defend our rights."

Issues of SRH are directly correlated with other health issues such as cancers, sexual and gender-based violence and psychological well-being, and they can also be related to morbidities like obesity. A civil society representative in Mexico City highlighted some studies that demonstrated systematically influenced higher rates of Type II diabetes among Indigenous populations. The enabling environment necessitates the existence of supportive policy and programs as well as the infrastructural developments necessary to connect communities to those advantageous services. There is certainly need for decision-makers to establish and maintain strong connections to Indigenous groups throughout the country to better understand and attend to their various — often interconnected — needs.

Language and Communication Barriers to Accessing Quality Health Care

Due to culturally insensitive health care providers, Indigenous youth have had many hostile and adverse health care experiences. From administrative staff to nurses and doctors, language and communication have been barriers to quality health care services. At times, Indigenous youth may not understand the terminology used by medical professionals, and most Indigenous languages do not have direct translations or terminology for — or even conceptions of — SRH and human rights. This is a major complicating factor in the relationships between health care providers and their Indigenous clients, effecting clear, continuous communication and comprehension in both directions.

Spanish is Mexico's predominant language and the language in which the overwhelming majority of health care providers conduct their services. While nurses occasionally serve as informal translators when doctors cannot adequately communicate with patients, they are not always available to provide this service nor are they necessarily formally trained as translators and interpreters. Despite a national movement toward bilingual education in order to completely nationalize Spanish, there remain hundreds of thousands of Indigenous language speakers who do not speak Spanish. This aggregate includes older generations especially, but also young Indigenous speakers who are either new learners or not yet confident in their bilingual language skills. Although Indigenous language comprehension is on the decline, Chiapas and Oaxaca are the states with the most Indigenous language speakers, and monolingualism is highest among Tsotsil and Tseltal speakers.[18] It is noteworthy that the bilingual education campaign does not necessarily apply to individuals who speak Spanish as their first language and are learning Indigenous languages, of which there are hundreds of dialects.

Many youth respondents revealed they often do not understand everything that their doctors, nurses or pharmacists convey to them, and responding is also difficult. This is especially true for those whose parents are not Spanish-speaking and for those who do not feel comfortable speaking or comprehending Spanish. Several young people addressed feeling more comfortable when health care providers speak in their first language. When communication proved challenging, either in understanding providers or expressing themselves, youth respondents disclosed feelings of shame and

embarrassment. A young citizen monitor shared, "There are times that they also use very unfamiliar words and since we are ashamed to answer them, we only say yes, no, yes, no, but we do not even understand what they are saying." The shame experienced from the inability to express themselves in the dominant language of the health system is amplified by provider reactions. Anecdotes of doctors deriding or becoming frustrated or angry with clients who do not speak Spanish — and one of a bilingual nurse choosing to speak in Spanish rather than Tsotsil, in a display of superiority — were shared by girls across communities. Remarkably, although some spoke of language as a barrier to health care, the boys generally felt comfortable during their health consultations. Regardless, these language limitations ultimately have negative consequences for the quality of care Indigenous youth are able to receive from accessible health care providers.

All respondents who shared these sentiments in Chiapas said they would prefer to have translators available in their first languages. This was endorsed by some civil society representatives in Chiapas and Mexico City who amplified that interpretations are often subjective and that translation is made more difficult if the words do not exist. The SMO further corroborated this by sharing its experiences with monolingual Mixtec and Mazatec speakers, for whom there were no words available in the Indigenous languages for translation from Spanish. A Mexico City civil society representative incisively stated the existing challenge of "reconceptualizing the entire health system" for the many Indigenous populations that are unable to participate in their health care due to the language barrier.

Relevant to language inaccessibility is the communication barrier to quality health care between young people and health care providers. Though not required by law, most adolescents in the focus groups who seek health care at public facilities are often accompanied by a parent — particularly those up to age 16, but including some 17- and 18-year-olds. Providers tend to speak directly, and sometimes exclusively, to the parent. This requires parents to adequately explain their child's issues and needs, and to suitably convey their child's physical and/or emotional experience. Given that many young people are not discussing their sexual and reproductive experiences and needs with parents, the parent-provider dynamic that limits communication from or ignores the young person may cause additional discomfort and challenges the provision of responsive SRH care. Additionally, it demonstrates a disrespect for the personhood of the young patient, who has a right to responsive health care.

Regardless of health care provider intent, the minimal and inconsistent availability of skilled translators and the common aversion among attending staff to interact with young clients expose widespread disrespect toward young Indigenous health care seekers and perpetuate an unjust, inequitable and discriminatory health system. Considering their frequent mistreatment while accessing care, young Indigenous people expressed a general distrust of health care providers and the public health system altogether. Some respondents described searching for alternative health care services or options from the Secretariat of Health or IMSS-managed facilities. This includes seeking remedies at pharmacies, where their health histories and status do not wholly guide the resultant care, and visiting autonomous community clinics run by the Zapatista National Liberation Army, where they are more likely to receive necessary medications but still not guaranteed to have all needs met or to be treated with respect and dignity. The latter is consequential because of the historical Zapatista response to the civil and economic exclusions of Indigenous people, and the demarcation of Zapatista and state communes adds a layer of difficulty to seeking their available services. A representative from the SMO shared:

> "... I think the world is moving so quickly and the changes happen so fast that it seems from the city, from an urban perspective, that Indigenous communities are stagnant — but they are also changing ... very quickly, and I feel like we have not found the best way to communicate with them. I feel like we are not speaking the same language of the boys and the girls and that this limits us. I do not know what would be necessary to modernize or be more innovative in our communication. But I feel that we are ... still steps behind in being able to communicate with them in the same vein."

This insight expresses both figurative and literal sentiments around language and communication with Indigenous youth. The centralized, urban perspective that drives the development of official SRH strategies assumes a regressive or static nature of Indigenous life and thereby fails to account for the development and transformation occurring within those communities, their connections to the national and international communities and their evolving needs and desires. Government ignorance of these facts is preventing young Indigenous people from realizing their sexual and reproductive rights, among other human rights.

Fear of Harassment and Violence Among Indigenous Adolescents and Young Women

In addition to experiencing anxiety about examinations from intimidating health care providers, girls and young women fear physical and emotional violence and harassment — including physical abuse, intimate partner and domestic violence, rape and other sexual assault, street harassment and medical abuse. While some of the girls in smaller communities like Emiliano Zapata, Oaxaca first said they were rarely afraid of sexual harassment or street harassment because of community ties and an established trust, all the girls shared that they feel differently at night. One young girl offered her thoughts on this fear:

> "Well, for me, not at night because let's say yes, you know the neighborhood but only to a certain extent — because with the highway, anyone can enter. Then it is not like they were saying that it was someone from the neighborhood who did something bad, then it could have been someone who came in."

Another agreed that the risks are greater at night, and added "... I say that it happens anywhere, there is always that ..." Most girls were quick to express these fears in an array of situations: on the street, at the market, with older boyfriends or in their neighborhoods. A consistent theme among girls across the focus groups was that of "machismo" and the influence of alcohol. Most boys and young men acknowledged that violence against women and girls is a significant threat. Two boys began to express fears as well, though they concluded that the fear was for their sisters and wanting to protect them.

A talking point among government officials, including a key informant from CONAPO, proposing that pregnancy is used as protection for women and girls from intrafamilial violence was soundly discredited in almost every youth focus group. Almost all groups that included girls and young women shared that there is no reduced risk of violence when one is pregnant. One teenage girl shared:

> "... if you get pregnant, it doesn't matter, they'll hit you. One time I saw a Facebook post — not just here — where a girl was pregnant and her husband didn't care and he beat her — he beat her and she miscarried. She had a miscarriage because of how much he beat her. Or even if we still live with our parents, a girl says that she told her mother she was pregnant and her mother started to kick her belly, [her mother] beat her until [the girl] fell down and started to kick her belly."

Furthermore, girls and women are afraid to respond to this violence for fear of "something worse." It is clear that in these Indigenous communities, pregnancy does not lower the risk of violence against women and girls — in fact, it sometimes exacerbates forms of violence by men and various family members.

Of note, one young health promoter shared that she does not have these fears, and while she has never been in such a situation of fear, her opinion is that "... I think it depends on one's character." One of her male peers similarly suggested that it depends on the woman's character, and that "... maybe they hit you or maybe they pay attention to you, too." The young woman's response was less conclusive, as it is possible she was speaking to bravery as a character trait for her lack of fear. The young man's take, however, was explicit, speaking to women's and girls' contribution to or influence on sexual violence or unwanted attention. These statements generally deviated from the responses of other youth in the sample, but they reflect common global sentiments around how girls and women are to blame for their experiences of violence.

In a review of data on early unions and adolescent pregnancy in Oaxaca, the SMO found that "the vast majority" of these pregnancies were due to sexual violence. In conversation with parents of adolescents, the SMO learned that many of the women themselves had been adolescent mothers and that several of their pregnancies resulted from sexual violence and forced marriages or the "sale of women." The SMO also found many cases of depression and suicide among Mazateca adolescents, with several of the cases caused by sexual violence. Surprisingly, GEPEA members only made very brief mention of violence and femicide, embedded within comments about other themes.

Representatives of both CONAPO and INMUJERES affirmed that their agencies were clear that pregnancies among girls below age 15 are the consequence of sexual violence. INMUJERES shared:

> "I think that the Institute has taken a clear and categorical stance in saying that any pregnancy in a girl 14 years of age must presume that there was sexual violence or at least coercion, so we are focusing on the application of NOM 046. So, I think that is a very clear position and one that the Institute will continue pushing."

NOM 046, along with NOM 047 and NOM 005-SSA2-1993 (NOM 005) on family planning, including adolescent services, are the three most-cited policy documents regarding issues of adolescent SRHR.[19] They were often discussed separately and distinctly from the ENAPEA.

There are several action points within the ENAPEA's objective to cultivate an enabling environment that allows adolescents to make fully informed and responsible decisions regarding their SRH and pregnancy prevention. These include strengthening the prevention of and responses to violence and sexual abuse of children and adolescents as well as the promotion of state-level legislation to standardize criminal codes in alignment with national and international regulations against violence and sexual abuse of minors.[20] The need for stronger laws and policies that protect and respect girls and women is undeniable, but preventative measures such as early education on violence prevention and community-level responses, such as case registries, are also critical to protecting these groups. Other ENAPEA objectives, like comprehensive sexuality education, can also make powerful sociocultural impacts on violence prevention. For example, hosting discussions with adolescents and youth both in and outside of schools around consent and bodily autonomy and creating safe spaces that facilitate private and confidential reporting and therapeutic recovery could mitigate the daily unease experienced by girls and women.

'Usos y Costumbres'

"Usos y costumbres" (UyC) were discussed repeatedly among all respondent categories and across ages in the youth focus groups. Most responses that mentioned these local cultural norms were provided during topics of conversation dealing with ideas of gender norms, such as separate spheres of domesticity and field work, cultural barriers to SRH care and violence perpetrated against women and girls. Among the youth respondents, boys were quick to bring up a machismo Mexican culture that allows boys and men to impregnate girls and women and then generally go about their daily lives socially unscathed, while the latter are criticized for not taking care of themselves. A young man shared that machismo allows for men to leave the responsibilities of childrearing to the women, "but in reality, it is the responsibility of both." A health promoter spoke to the generational aspect of UyC, sharing that the traditions of their grandparents, parents and the church have not been "eradicated" and outmoded mindsets still prevail. A few girls and boys talked about the religious taboos of discussing body parts, health and contraception. An older civil society representative offered the following digest:

> "These issues [derive] from the patriarchal structures that are called 'usos y costumbres'... it is the men who make the decisions, the men who decide on community [matters], about women's bodies, and adding to this, we see that this structure is made for perpetual subsistence. In other words, this structure is very obstinate structure, and it is made in such a way that obviously the moment in which a girl, because she is really a girl, begins to menstruate, she is ready to be married to an adolescent who by now can have an erection. So in this system, it is indeed important that this early union occurs because that would mean there is one more family that will support, collaborate, contribute to the system. So this system is perpetual, this system continues to grow stronger [because] with more families or unions, there are more defenders of these ideas that are the "traditions and customs." That yes, what you were saying is complex, how to eliminate these entrenched traditions and customs that even come from an ancestral culture ... this model is designed for subsistence. In other words, at the time you have 10 children, you know five will die, you need those five to marry so that they can survive, so this ethnic group survives, so that this language survives. So the faster she gets pregnant, the greater the chance is that the girl grows up, that the parents will be stronger, etc. Apart from all of this, the patriarchal traditions and customs structure is a hierarchal structure, meaning there are hierarchies."

As with many self-subsisting rural communities around the world, men continue to perpetuate and direct the reliance on family and small communities to not only survive, but also to sustain a sense of ethnicity and belonging. Men control all decisions, from community structure to marriage for reproduction, which often occurs before the national age of majority. The discussions of UyC in the youth focus groups as well as the key informant interviews validate the ENAPEA's guiding data around gender inequality as a contributing factor to adolescent pregnancies.

It could be argued that much of the foundation for subsistence reproduction is no longer relevant. With modern medicine, health care and ever-evolving lifestyles, there is no longer a need to bear more children solely to counter high mortality rates. Life expectancy has also increased for these reasons and more, so early pregnancy is unnecessary. Early marriages and pregnancies are prohibitive and abusive, exposing girls to a higher risk of intimate partner violence and more often than not, restricting their agency as subjects of rights.[21,22] However, while true, such straightforward statements and rationales would account for neither cultural integrity and sovereignty, nor the limited availability, accessibility (geographic and financial) acceptability and adequacy of the health care system for Indigenous communities. The desire for various communities to retain kinship and identity, and the fears of forced state changes, remain strong. Respect for Indigenous communities would allow populations to exert self-determination while simultaneously allowing and ensuring the systematic participation of Indigenous populations in the development and execution of health policies and programs — and all other matters relevant to their lives.

That said, the ENAPEA and its guiding GIPEA have been quick and brief in condemnation of "Indigenous culture" for causing the widely disparate fertility rates between Indigenous and non-Indigenous adolescents. This is a key point on which federal government diverges from both civil society and state agencies. A representative from the federal INMUJERES willingly spoke to how "the states are autonomous, so out of respect for autonomy" from the decentralized government, the states are responsible for ensuring that their ENAPEA implementation plans take interculturality into account. It is as if Indigenous populations are not compatriots, but instead, second-class citizens — or altogether inconsequential — for their cultures not to be considered in national plan designs.

Comparatively, civil society and state agency representatives shared their curiosities about the root causes of behavior and how government programs can connect with local cultures. A civil society representative in Oaxaca spoke forcefully about the need for people to "understand or situate our own stereotypes and prejudices towards communities" and that the existing debate on traditions versus rights is misleading and erroneous. Some of these issues have little if anything to do with traditions so much as economic welfare, for example. A representative from the SMO advised that "if we do not focus on these diversities within the same state, within the same regions, within the same municipality … again, we fall back to hegemonic thinking." This acknowledgement of predominance, both historical and contemporary, is an opportunity for affirmation and collaboration. Such an approach is much closer to recognizing the prerequisite of multiculturalism and contextualizing health in order to improve the sexual and reproductive lives of young Indigenous people: making an effort at true inclusion of Indigenous populations by inquiring about their everyday lives and life plans.

Myriad traditions and customs collude to prevent many young people from seeking professional SRH care and receiving SRH information, even through schools. The systemic disregard of Indigenous lives and cultural ineptitude of the federal government and health care actors — further complicated by gender, economic and developmental vulnerabilities — have greatly impacted the sexual and reproductive lives and freedoms of Indigenous youth across Chiapas and Oaxaca. These youth want and require socially and culturally relevant support that is respectful and protective of their human rights. They are anxious and eager to be recognized, heard and included.

Recommendations from Youth Health Promoters

The current generation of young people is the largest in human record: One-quarter of the global population is under 15 years of age and approximately 24% is between the ages of 10 and 24 years old — a population structure that is reflected in Mexico.[23] Yet, the distinct SRH needs of young people are often overlooked. It is a common refrain that "youth are the future," but this well-meaning sentiment fails to acknowledge their existence in the present and the undeniable truth that they know the lives they are leading best. Many adults currently in leadership and decision-making positions are unfamiliar with the novel and diverse ways that adolescents and young adults are living in and experiencing the world. It follows, then, that they should engage directly with young people, who may also have robust ideas about their own needs and how those might be attained.

Young people have been leading the way in putting long-neglected issues onto the global agenda — their active, meaningful engagement is critical to achieving better health outcomes for themselves, and ultimately for all. As such, the young Indigenous health promoters who participated in the youth focus groups discussed the findings and proposed initiatives they believe will improve their sexual and reproductive lives, consequently improving ongoing ENAPEA implementation and supporting the achievement of the strategy's objectives.

1 Ensure that comprehensive SRHR education is informed by youth experiences

The youth focus group participants expressed and demonstrated limited knowledge of SRHR. The youth health promoters, who demonstrated a more advanced SRHR understanding, addressed how this was predominantly the result of their training and continuing work as youth health promoters and citizen health monitors. All identified that knowing their rights and having basic information about human development, adolescence and supportive resources would have facilitated their understanding of self, instilled confidence and helped them to better protect themselves. Therefore, comprehensive SRHR education that begins early, evolves progressively, aligns with their development and lived experiences and connects young people to out-of-school resources is essential to enhancing youth agency and decision-making.

- Start early, with age-appropriate material: Primary school was suggested as the starting point for this SRHR instruction, beginning as early as 8 years old — though consensus fell between ages 9 and 10 (or the equivalent of fifth grade). This was stated as especially important for girls, since they often experience biological maturation earlier than their male counterparts and they are more often pulled out of school early for domestic responsibilities. These initial discussions should speak to pubescence — forthcoming changes to their bodies and emotions and potential changes in personal relationships. Education in secondary school should continue the biological education and add on discussions of sexuality, gender, reproduction, rights, self-care and health management, as well as other related topics like bullying and violence.
- Use blended instruction: A varied group of professional, comforting instructors should be responsible for leading this education. Such teachers should include youth and young adult health promoters, who can talk to students more easily and freely, and with whom the students are likely to be most relaxed; schoolteachers; civil society members who can lead specific workshops; and psychologists who can better discuss the psycho-emotional aspects of gender, sexuality and reproduction.
- Link instruction to community-based resources: Students should be made aware of the various resources available to them within and around their communities, including appropriate health services and other social welfare institutions.
- Teach in first languages and with respect for their cultures: As discussed at length, the ability to comprehend and participate in communication around SRHR is vital to youth development and self-determination. First-language instruction and service provision, especially for monolingual learners or young people who are newly bilingual, promote deeper understanding.

2 Teach respectful and culturally attuned health care provision to health actors

The dearth of trust in and respect for health care actors among Indigenous youth is largely owed to the contemptuous service they and their families often receive. This is connected to the centrality of an urban perspective that conceives of Indigenous lives as other, rigid and regressive. Clinical education should be multicultural and teach cultural competencies, sensitivity and humility. It should also be attentive to adolescents, who deserve the same high-quality, courteous and considerate health care as everyone else.

3 Establish genuine youth-friendly health and social services

Health services for youth should be offered at accessible times, not only during school hours. Health care provision for youth should be dignified, delivered in ways that do not discriminate or shame; private and confidential; voluntary and informative; and able to meet all of their needs. Young people want accurate and up-to-date information on request and as necessary for them to make the best health decisions for themselves. This information should be provided through various media, such as print and radio, and in their local languages. Health and other social services should be clear and accessible to young people; account for their physical, social, emotional and psychological development and well-being; and be respectful of their personhood regardless of age, area of residence, language and any other characteristics. Such an inclusive system would also require accountability mechanisms for reporting abuses of authority and remedying issues.

4 Guarantee inclusion and respect for Indigenous youth in government programs, policies and decision-making processes

Young people want to be taken seriously. They want to be understood, accounted for and heard by their community leaders and their local, state and federal administrations. Their desire to be full participants in their communities and engaged by authorities in conversations that pertain to their lives speaks to a need for meaningful youth engagement in policy and program development, implementation, evaluation and reform. This type of engagement can also call for youth leadership on issues directly concerning their livelihoods on which they may have more expertise. Programs and policies must also include and respectfully account for Indigenous populations, with officials taking time to establish lasting connections with communities and respecting their knowledge and traditions.

5 Expand opportunities for youth in and outside of school

Almost all the young participants across focus groups expressed excitement about school and learning, especially those who were still in school or did not have an interrupted educational experience. The youth health promoters emphasized how their enhanced understanding of their rights and options have led them to reevaluate the life plans they had for themselves, many wanting to complete their secondary education before even considering marriage and childbearing. Several youth participants in the study spoke of postsecondary education as a desire. There is a shared longing for a full educational experience, including extracurricular learning in subjects like the arts. As well, a few participants, particularly the men, stated a need for more job prospects and more income to meet their basic needs.

Conclusion

The relationships among government policies, bureaucracy and institutional barriers and sociocultural norms have produced an environment that fails to adequately address the needs and concerns of Indigenous young people. Authorities have neglected to appreciate their lived experiences or use culturally relevant and acceptable approaches that may improve their SRH and the delivery of care. Findings demonstrate that while the ENAPEA is a critical factor in meeting the SRH needs of Indigenous populations and reducing adolescent fertility, its design and local implementation must address the realities of sexual and reproductive life and confounding variables, in addition to ensuring access to quality health care. Discussions across the focus groups suggested that the ENAPEA implementation has been narrow, inadequately addressing the intricacies of SRH and well-being in predominantly Indigenous municipalities.

Quantitative data on adolescent pregnancy largely steered the development of the ENAPEA, and although sparse, qualitative data is necessary to inform proactive and responsive policymaking that addresses the root causes of this issue. The collection and dissemination of mixed-methods evidence would broaden the scope of attention and support for — as well as emphasize the distinct needs of — Indigenous youth. To that end, it is imperative for federal and state strategies and programs to integrate a multicultural lens into health care in order to meet the needs of Indigenous youth and other marginalized groups throughout the country. Building robust intercultural frameworks requires the meaningful inclusion and continuous engagement of Indigenous youth in the ongoing implementation, monitoring and evaluation of the ENAPEA, in monitoring and evaluation of the strategy and its related programs across states and in the future development of government programs and policies. Connecting with Indigenous communities through their youth will also support trust-building and improve upon the currently limited qualitative evidence base from which policymakers create strategies and action plans. Policies and programs that have implications for young people's development and life plans will benefit from data that features more contextualized conversations around youth experiences with SRH.

The COVID-19 pandemic is certain to complicate, and perhaps impede, any progress that has been made on the ENAPEA's objectives. With Mexico experiencing the world's fourth-highest total COVID-19 deaths as of December 2020, and a show of federal government authorities who are denying its severity and flouting global public health guidelines, the global case surge will likely show strongly in the country.[24,25,26] Global trends have indicated that existing health and socioeconomic disparities exacerbate the effects of COVID-19 and the ability to cope, no different from the situation in Mexico.[27] As well, the gender divide is widening. The decentralized health care system's inadequate organization and facilities in states like Chiapas and Oaxaca that serve larger Indigenous populations, in addition to other system inequalities, put Mexico's Indigenous populations, especially the young people, at increased risk of morbidity, mortality or failing to have their essential needs met. The federal administration must make concerted efforts to equitably benefit the health of the country's most marginalized Indigenous populations.

To effectively respond to the complex SRH needs of Indigenous young people, especially during health crises like COVID-19, youth voices — such as those represented in the focus groups — should be consistently elevated and directly heard in decision-making spaces. Only then can there be assurance that the government's plans and policies for a "fourth transformation" are inclusive and will indeed reach Indigenous youth in Mexico's southern states. The inclusion of their points of view in such dialogues, including around the ENAPEA as recommended in the strategy's guiding principles, will help to better ensure programs and policies are developed and implemented in ways that challenge often-gendered sociocultural norms and speak to the diverse realities of Indigenous adolescents and young people in Mexico.

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