

EQUITY IN ACCESS





Equity in Access:

Enabling culturally relevant sexual and reproductive health care for indigenous youth in Mexico — a preliminary report brief

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 great variation across the country in fertility trends, contraceptive needs and health care access.^{1,2} Fundamental to the explanations for such disparities are the sociocultural contexts of Mexico's indigenous populations. Access to quality reproductive health care among indigenous youth is influenced and affected by community and cultural contexts as well as cultural incompetence, as exemplified by health care providers and policymakers.



These issues are of pressing concern given the lack of clarity on how the current administration of President López Obrador 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 Prevention of Adolescent Pregnancy, ENAPEA). Introduced in January 2015, the ENAPEA, which seeks to halve fertility among 15- to 19-year-old adolescents and to eliminate pregnancy among girls ages 10 to 14 by 2030, is a focused blueprint aligned with the broader *Programa Sectorial de Salud* (Health Sector Program, PROSESA) 2013-2018. Like PROSESA, the ENAPEA in part aims to reduce health inequities among various populations and improve the social conditions of the most vulnerable.^{3,4} Of relevance, it 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.⁵

While the needs for improved sexual and reproductive health (SRH) services among indigenous populations are widely known, there is scarce information about the relationship among institutional barriers, societal norms and limited health care access for indigenous youth and adolescents. Moreover, the country's

indigenous populations continue to be overlooked or altogether forgotten in the development and execution of national plans.^{6,7,8} As such, while civil society representatives participated in the development of the interdisciplinary and multisectoral ENAPEA, and all 32 Mexican states are represented in local implementations of the plan through *Grupo Estatal para la Prevención del Embarazo en Adolescentes* (State Groups for the Prevention of Adolescent Pregnancy, GEPEA), it remains unclear whether and, if so, how the ENAPEA will respond to the different needs of indigenous youth across the country.

Since 2018, Chiapas-based civil society organization (CSO) *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 Tzeltal 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 for indigenous youth. These include deficiencies in cultural competence among health care providers and facility staff, as well as in the health facilities managed by Mexico's Ministry of Health and Social Security Institute.^{9,10} Building on OMM's findings and responding to 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 sexual and reproductive health services; and
5. Guarantee the right of girls, boys, and the adolescent population to receive comprehensive sexual education at all public and private levels.

concern that President López Obrador's campaign promise of a "fourth transformation" to enhance the country's democracy and economic prosperity while uprooting corruption will not reach the largely indigenous southern states, this brief shares emerging themes from focus group discussions with indigenous youth from Chiapas and Oaxaca, civil society and government representatives conducted by PAI and OMM in 2019.

Participants were engaged in conversations around

how the interplay of institutional barriers and social norms affect access to SRH care and realization of sexual and reproductive rights among indigenous youth. Answers to this and related questions will expand the recorded knowledge base of indigenous youth's specific SRH concerns, needs and desires, and will strengthen understanding of whether and how their sexual and reproductive health and rights (SRHR) are being realized, in order for CSOs to better hold federal and state administrations accountable to their constituents.

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

Methods

Data were obtained between July and August 2019 from eight semi-structured key informant interviews and focus group discussions with representatives of civil society from Chiapas, Mexico City and Oaxaca; and representatives of 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), all of whom are involved in ENAPEA implementation. As well, seven semi-structured focus group discussions were conducted with 45 indigenous youth and young adults ages 11 to 27 across Chiapas and Oaxaca, including perspectives from Tsotsil, Tzeltal and Mixtec communities. 30 girls and young women and 15 boys and young men were included, and discussions were conducted in both gender-segregated and mixed-gender groups. Informed consent and assent were verbally and physically obtained from all participants prior to data collection, and signed copies were retained by participants and PAI staff.

Changing identities

It is important to consider the various dimensions of identity among the adolescent and youth focus group participants. Most of the youth respondents in Chiapas spoke Spanish, but some had limited Spanish comprehension despite having had formal education. In part for this reason, responses from some Chiapanecan youth were brief. In contrast, all youth focus group participants in Oaxaca spoke and understood Spanish comfortably. In Chiapas, many youth participants did not wear traditional dress but instead wore more contemporary fashions. Those who did wear traditional garments were the youngest female participants. Traditional dress has become more of a ceremonial garment; it is also more expensive than commercially available modern clothing.¹¹ In Oaxaca, none of the youth participants wore traditional clothing.

Indigenous youth are undergoing many changes, with migration within Mexico or to the United States transforming ways of life, such as the breakdown of family units, influence of ideals and images from other places and the assumption of new social roles. Recently, modern socialization through engagement on social networks and other internet avenues have exposed indigenous youth to information that was inconceivable even a decade ago. However, in their communities, they still live by conservative gender constructs.¹² This creates a social dissonance in their development. Despite the increased inclusion of indigenous girls in schools, education in the home prepares them solely for domestic responsibilities. Indigenous boys are prepared for work in the fields. Another example is the new ownership of SRHR among indigenous youth. OMM's youth health promoters have taken on roles to share information among peers, both at random and when their peers request it unprompted. These changes are notable because previous generations seldom received and much less accepted this type of information.

Emerging themes and preliminary analysis

A. INDIGENOUS YOUTH HAVE LIMITED HUMAN RIGHTS, SRHR AND SRH KNOWLEDGE

While many of the young people have had some introduction to human and reproductive rights, knowledge of the subjects was disconnected from the other and primers or introductory conversations were taking place in isolation. Dialogues about biological aspects of reproductive health were occurring in the classroom and sometimes between mothers and daughters, or between female relatives; social aspects of SRH were largely discussed among friends and peers; and human rights conversations mostly took place in the home, where children either overheard their parents talking about the concept or were sometimes spoken to directly about it. Human rights are also sometimes discussed in school civics classes. Additionally, a couple of boys shared that their fathers spoke with them about sex and pregnancy prevention. The separation of conversations among the spheres of school, family and peers is notable for deciphering from whom, what and how these young people are learning about and interpreting SRHR.

Most of the young indigenous girls and boys were able to speak briefly about definitions of SRHR, albeit along singular lines of pregnancy and/or childbirth, having sex, contraception, male and female reproductive organs or protection against infectious diseases. When asked about human rights, the youth mostly spoke broadly of freedom and free expression. Pointedly, a young girl from

Santiago el Pinar, Chiapas stated that human rights are the equality of women and men, and another from the same group shared “freedom from violence” as a right. Each of the accounts on their own are incomplete, but elemental concepts were presented across most of the respondents. This demonstrates some learning and comprehension within these communities. However, one group of adolescent boys in Santiago el Pinar had never heard of reproductive rights or human rights, which may indicate variation in experiences, in human rights and SRHR knowledge and in customs and norms across the indigenous populations and communities represented in the sample at a minimum.

A specific objective of the ENAPEA is the provision of comprehensive sexuality education at all levels of education — public and private — and with connection to community and familial environments to further promote knowledge.¹³ While the focus group discussions with indigenous youth suggest that some basic reproductive health instruction may be taking place, sexuality and reproductive education is far from comprehensive, and ultimately incomplete, in their homes, schools and communities. Although the young people have rudimentary familiarity with sex, reproduction and health, their fundamentals do not assist their participation in and receipt of positive, youth-friendly and responsive reproductive health care.



B. COMMUNICATION, LANGUAGE AND RESPECT ARE BARRIERS TO SEEKING AND ACCESSING CARE

Indigenous youth also have unfavorable reproductive health care experiences because of culturally insensitive health care actors. Communication barriers and the reality that many indigenous languages do not have terminology or concepts for SRHR and human rights further complicate the patient-provider relationship. Though not required by law, younger adolescents in the focus group — those up to age 16 — who seek health care at public facilities are often accompanied by parents. Providers will often speak directly and sometimes exclusively to parents. This creates both communication and language challenges and is disrespectful to patients. Firstly, it requires the parents to adequately explain their child's malady, questions or needs, and to possibly convey their child's physical or emotional experience. Given that many young people are not discussing their sexual and reproductive experiences and needs with parents, parent-provider interactions that limit or ignore youth may cause additional discomfort and challenge the provision of responsive reproductive health care. Additionally, in order for conversations to be productive, providers and parents must speak the same language. Although there is movement toward bilingual education for children and adolescents, in many of the indigenous communities of Mexico, parents do not speak Spanish — the

predominant language of the country, and in which the overwhelming majority of providers conduct their services. Alongside inconsistent availability of trained translators and a common aversion among attending staff to interacting with young clients, these failures expose a widespread atmosphere of disrespect towards young indigenous health care seekers and ultimately create a health system of cultural injustice. Notably, the boys generally feel comfortable during their consultations, though they also speak of language as a barrier. Some of the older adolescents and young adults, especially males, tend to feel more comfortable engaging with health providers.

Several young people also addressed feeling more comfortable when health care providers speak in their native language. Girls and boys disclosed feeling “ashamed” when they have difficulty either understanding what the providers are saying or expressing themselves. A young citizen monitor declared, “There are Tsotsil words that do not have a Spanish translation ... sometimes they use unknown words and we feel ashamed and just respond yes or no.” The shame experienced from their inability to convey themselves in the predominant language of the health system is amplified by provider reactions. Anecdotes of doctors deriding or becoming frustrated and angry with clients who do not speak Spanish, and one of a nurse speaking in Spanish rather than Tsotsil as to feel superior, were shared by girls across

communities. Moreover, it ultimately impacts the quality of care they receive from geographically accessible providers.

Indigenous young people generally do not trust providers or the public health system as they are frequently not treated well by health care providers. Many of the respondents described searches for alternative health care services or options. These include visiting community clinics run by Zapatista organizations¹ or inquiring at pharmacies or private facilities, where they were more likely to receive medications if necessary but still not guaranteed to have needs met or be treated with respect and dignity. A representative from a state government agency validated these experiences when she said, “From an urban perspective, sometimes we think that indigenous communities are stagnant, but they are changing, and we have not found the best way to communicate with them. I feel like we are not speaking the same language.” This expressed both figurative and literal sentiments around language and communication with indigenous populations.

¹ Full name: Zapatista National Liberation Army (EZLN).

C. GIRLS AND YOUNG WOMEN FEAR VIOLENCE AND HARASSMENT

Alongside the anxiety of being examined by intimidating health care providers, girls and young women fear physical and emotional violence and harassment, including physical abuse, intimate partner violence, rape and other sexual assault, street harassment and medical abuse. When asked about fears of sexual harassment and violence in the community, a young girl in Tenejapa, Chiapas responded, “Yes, always, of everything in all places.” Many girls feared drunkards in their communities. A consistent theme across focus groups with girls was the influence of alcohol and machismo, with fears being most pronounced at night. A couple of boys expressed 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 for this study, proposing pregnancy as protection from violence for women and girls was soundly discredited in almost every youth focus group, with declarations that, “It doesn’t matter if you are pregnant or not, you are going to experience violence,” and “No, it doesn’t



Regions of Chiapas

■ Altos Tsotsil
Tseltal

"From an urban perspective, sometimes we think that indigenous communities are stagnant, but they are changing, and we have not found the best way to communicate with them. I feel like we are not speaking the same language."

— State government agency representative

matter if they are pregnant ... there is a lot of violence in the communities."

One girl heard of "a girl who was pregnant whose mother started to kick her in the stomach," and another said, "If the family does not like her, the woman can face psychological or physical problems." Furthermore, girls and women are afraid to respond 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 — it sometimes exacerbates forms of violence.

That said, of significance are the words of two health promoters, boy and girl, who spoke about how fear of violence and acts of violence depend on the girl against whom violence may be perpetrated. Where the young man said, "Girls allowed it to happen. It depends a lot on how one acts," the young woman said, "I'm not afraid because it depends on one's character." While the young man spoke directly to the influence of women's actions on sexual violence, the young woman's response is less overt and it is possible she was speaking to bravery as a character trait. These statements 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.

Embedded 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 are several action points. These include strengthening the prevention of and responses to violence and sexual abuse of children and adolescents and the promotion of state-level legislation to standardize criminal codes with national and international regulations against violence and sexual abuse of minors.¹⁴ 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, discussions with adolescents and youth both within and out of schools around ideas of consent and bodily autonomy and creation of safe spaces that facilitate confidential reporting and therapeutic recovery could mitigate the daily unease experienced by girls and women.

D. CONFUSION BETWEEN CIVIL SOCIETY ORGANIZATIONS AND GOVERNMENT AGENCIES AROUND EXISTENCE OF THE IMSS PROSPERA PROGRAM

Although unmentioned by the youth in their focus group discussions and not specifically asked by the interview protocols, the *Instituto Mexicano del Seguro Social* (Mexican Social Security Institute, IMSS) *Prospera* program was deliberated in conversations with civil society and government representatives. In 2017, *Prospera* reportedly served approximately 12.4 million people across 28 Mexican federal entities, over 77% of whom are "highly marginalized" and nearly one-third of whom are from predominantly indigenous communities.¹⁵ These data were not further disaggregated, so the proportion of adolescent and young adult indigenous persons who were served by the program is unknown. Separate interviews with representatives of civil society and government called attention to ambiguity on whether and how the program would operate under the new federal administration. While federal government representatives thought that *Prospera* was still operating at a lower scale than originally designed, CSOs believed the program to have been shut



down or defunct due to poor resource allocation. This confusion around the program's existence is significant, as *Prospera* provided health coverage and services to many indigenous people across Chiapas and Oaxaca who had no alternative for health care. It also administered care to many indigenous persons in rural areas who were covered by the national health insurance scheme *Seguro Popular* but did not have geographical access

to clinics under management of the *Secretaría de Salud* (Secretary of Health). In October 2019, following data collection for this study, approval for *Instituto de Salud para el Bienestar* (Institute of Health for Well-being, INSABI) was granted, creating a new Institute of Health for Well-being that will replace *Seguro Popular*. It will absorb *Prospera* and guarantee free health services and medication for the uninsured. Nevertheless, even with INSABI entering into force January 2020, many questions remain about the agency's financing and operations.

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Conclusion

As the outcomes of these focus groups demonstrate, there is an urgent need to address the following situations:

1. MULTICULTURALISM IN HEALTH CARE PROVISION.

There is a pressing need to create or strengthen strategies that intergrate an intercultural focus in healthcare to meet the needs of indigenous youth, and marginalize and vulnerable populations throughout the country.

2. INSTITUTIONAL BARRIERS, SOCIOCULTUTRAL NORMS AND EXISTING GOVERNMENT POLICIES.

Institutional barriers, sociocultural norms, and existing government policies — most specifically the ENAPEA — are failing to adequately address the experiences, needs and concerns of indigenous young people, least of all to use culturally relevant and acceptable approaches that may improve SRH care for this key group.

These findings demonstrate that while the health policy is a critical factor in meeting the SRH needs of indigenous peoples and ultimately succeeding in the goal of reducing adolescent fertility, design and local implementation must attend to the realities of sexual and reproductive life, and confounding variables, in addition to ensuring health care access. Focus group findings suggest that ENAPEA implementation has been narrow, inadequately addressing the intricacies of SRH and well-being in predominantly indigenous areas.



3. LACK OF INDIGENOUS YOUTH PARTICIPATION IN PUBLIC POLICY DEVELOPMENT.

To effectively respond to the complex SRH needs of indigenous young people and to ensure that the government's plans and policies for an inclusive "fourth transformation" will actually reach indigenous youth in Chiapas and Oaxaca, the voices of youth, such as those represented in the focus groups, should be elevated and heard more often within policymaking processes. The inclusion of their points of view in policymaking dialogues, including around the ENAPEA as recommended by the strategy's guiding principles, will help to ensure policies and programs are developed and implemented in ways that speak to the many diverse realities of indigenous adolescents and youth in Mexico.

4. LIMITED EVIDENCE FOR POLICYMAKERS.

Quantitative data on adolescent pregnancy drove the development of the national health strategy, but qualitative information as presented from probable health care recipients is sparse and should also inform policy making, serving the purpose of understanding and addressing root causes of the issue. The collection and dissemination of quantitative and qualitative evidence would broaden the scope of attention and support for, as well as further emphasize the support needed by, these populations. Further ENAPEA development and implementation should be aware of and include benefits to all of Mexico's peoples, and the administration should make efforts to equitably benefit the health of the country's marginalized indigenous populations through the policy.



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ABOUT US

At PAI, we are motivated by one powerful truth: A woman who is in charge of her reproductive health can change her life and transform her community.

Our mission is to promote universal access to sexual and reproductive health and rights through research, advocacy and innovative partnerships. Achieving this will dramatically improve the health and autonomy of women, reduce poverty and strengthen civil society.

ACCESO

Acceso is a PAI initiative that provides technical support to subregional and national organizations in Latin America and the Caribbean to address gaps in sexual and reproductive health services. Although the region has made important strides over the past two decades, high levels of inequality undermine universal access to sexual and reproductive health.

Through high-impact advocacy for health sector reform, PAI's local partners engage governments, regional networks and community leaders to improve access to high-quality services and strengthen contraceptive security.

ABOUT OMM

OMM is an autonomous and intersectorial network based in Chiapas, Mexico, composed of civil society, academia and health institutions. Founded in 2010, its main objective is to contribute to the reduction of maternal mortality. Through the production of strategic information and evidence, OMM aims to influence the design and implementation of public policies that favor maternal health from a rights-based approach.

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