PRESENT AND ACCOUNTED FOR


EDUARDO
RAMIREZ

ABOUT PAI

PAI is a global organization advancing the right to affordable, quality contraception and reproductive health care for every woman, everywhere. PAI works to improve reproductive health services by building political will in the U.S. and internationally for these programs.

ACCESO

Acceso is a PAI initiative that provides technical support to sub-regional and national organizations in Latin America and the Caribbean to address gaps in sexual and reproductive health services. Through high-impact advocacy for health sector reform, PAI's regional partners engage governments, regional networks and community leaders to improve access to quality services and strengthen contraceptive security.

ABOUT OMM

Observatorio de Mortalidad Materna (The Observatory for Maternal Mortality, 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.

INTRODUCTION

The overall success of the family planning program in Mexico hides steep disparities for two key groups—young people and indigenous populations. In Chiapas, these disparities are heightened, given the large proportion of indigenous adolescents and youth. Inequality undermines universal access to sexual and reproductive health and rights, and progress requires a multipronged, sustained advocacy approach.

With one of the highest teenage pregnancy rates among the Organization for Economic Cooperation and Development (OECD) countries, Mexico established the National Strategy for Adolescent Pregnancy Prevention in 2015. Specifically related to quality and access, the strategy contains several key provisions, including updating counseling protocols to ensure adolescent and youth-friendly family planning services, training for providers to guarantee technical competence and securing sufficient budget allocation for contraceptive supplies for adolescents and youth.

THE STATE OF CHIAPAS

Chiapas is the poorest state in Mexico, home to the nation's third largest indigenous population. Indigenous people in Chiapas are disproportionately impacted by poverty.

12 indigenous languages are spoken in Chiapas

28.1% live on less than USD 1.90 a day

77.1% of the population live in poverty

91.5% of the population is deprived of at least one basic need
(adequate housing, education, health care, nutrition, social security, or water and draining)

Source: The National Council for the Evaluation of Social Development Policy (CONEVAL)

To address the unique challenges indigenous youth face, including cultural and language barriers as well as social stigma around youth and sexuality, the *Observatorio de Mortalidad Materna* (OMM), supported by PAI, engaged with the government and civil society stakeholder group implementing the national strategy to advocate for the inclusion of culturally relevant policies for indigenous adolescents and youth. For example, in Chiapas, culturally competent staff are needed to provide counseling in local indigenous languages.

CULTURALLY RELEVANT PRACTICES

- Information and educational material about adolescent sexual and reproductive health and family planning provided in indigenous languages
- Bilingual education, including sexual education
- Services available in indigenous languages
- Ability to wear traditional dress in medical facilities
- Ability to receive the same quality of services in medical facilities, despite wearing traditional dress (women and girls have been denied services, including for obstetric emergencies)
- No requirement of parental consent for contraceptive use
- Discreet counseling (i.e. not disclosing private information to a male accompanier, partner or parent)
- Informed choice and voluntary decision-making for contraceptive use (as there is a pervasive problem of forced sterilization)

To track the implementation of the strategy—including cultural considerations for indigenous youth—at the public health facility level, OMM introduced its own campaign of social accountability.

The organization's staff trained indigenous Tzotzil and Tzeltal youth to conduct citizen monitoring of Ministry of Health and Mexican Social Security Institute-run clinics to ensure they were operationalizing the strategy. While social accountability has become an increasingly popular tool throughout the world to hold governments accountable to their commtiments, OMM was unique in empowering indigenous youth to lead these efforts in Chiapas where discrimination is widespread against indigenous populations—and especially youth.

The following stories provide a window into adolescent, indigenous and low-income populations' needs and the ongoing barriers to quality sexual and reproductive health care within communities in Chiapas. They encapsulate the yet-unfulfilled responsibility to honor indigenous viewpoints, culture and customs. They also illustrate the potential of innovative youth-led advocacy strategies to ensure rights for the most vulnerable.

Amalia Sánchez Gómez

AMALIA

Frequently, when Amalia Sánchez Gómez is in the company of doctors, they joke that *parteras*, or traditional birth attendants, have no idea what they are doing. She laughs, thinking to herself, *even though doctors are specialists with professional studies, they don't have experience and knowledge about how people live here, and what their needs are*.

Here, in Oxchuc, a town about 30 miles outside of San Cristóbal de las Casas in Chiapas, Amalia has worked as a *partera* for 40 years. Community members often feel most comfortable turning to *parteras*, who know them personally, share their culture and practice traditional medicine, rather than going to public health facilities. She was just 17 years old the first time she delivered a baby, without any formal training. "There were three *parteras* at the time who were attending births, but it was never enough," she says, sitting in a newly constructed, two-room concrete structure behind her house that she plans to use for deliveries. "Of course I was nervous, but after the second, the third, the fourth time, I started finding my rhythm. No one was telling me how to do it. I learned from the women I was attending to."

Like many other women, Amalia lived far from the town's center, so she provided family planning counseling and general care for those living in the rural community. There were so many women in need of childbirth assistance that family members started to look for her when other *parteras* were not available. She had already completed seven or eight deliveries before the government held a three-week training program in Oxchuc for *parteras* in the region. The training sessions were nearly 12 hours long each day, focusing on traditional birthing methods and traditional medicines.

"It was difficult. I was young and had two children of my own already. Even though I fought with my husband… my priority was getting the formal recognition," Amalia says. "I got the second highest score. I still have my diploma to this day."

FAMILY PLANNING IN CHIAPAS

Unmet need for family planning in Chiapas is twice the national average, indicating acute barriers to sexual and reproductive health. This need is highest among youth (ages 15 to 19) and indigenous women. Maternal mortality remains high despite decreases in other states.

22.6% unmet need for family planning

deaths per 100,000 live births *(with significant underreporting in indigenous communities)* **72.9**

58.6% contraceptive prevalence *(below the national average of 72.3%)*

Source: Consejo Nacional de Población (CONAPO)

After completing the training program, she introduced herself to the staff at the closest health clinic to build a relationship, so when she had a complicated delivery needing specialized care she could facilitate a referral. Since then, she has also attended several follow-up trainings at the clinic. Despite her affiliation with the facility, she has many frustrations with the modern medical system and its treatment of *parteras*.

"One of the biggest issues is there's no recognition and respect for the work parteras are doing."

Even though doctors should be trained to treat complications, she finds they are overwhelmed or refuse to attend to women she refers, instead telling the women to wait or referring them to the hospital in San Cristóbal de las Casas. In one case, a patient's baby was in a dangerous position so she referred her to the local hospital. But, when Amalia accompanied the woman to the facility, the doctor wouldn't treat her, saying he was too busy with other patients. He told the woman to go outside and walk around, despite Amalia's warnings that this could induce labor without addressing the complication. The baby was born in a nearby park away from the clinic, and died three days later. Amalia notes that in cases like this, doctors place the blame on the *parteras* even though they made the referral to the facility.

"One of the biggest issues is there's no recognition and respect for the work *parteras* are doing. It's something I've talked to *parteras* in other states about. We've spoken candidly about the problems we're facing, but nothing comes of it. There is no change or recognition from the medical system, or support for the work," she says. "I refer patients because I don't have modern medical supplies—I don't have support. If doctors can't handle it, what good is it?"

Although there are challenges, Amalia takes pride not only in how many lives she has saved throughout her career, but also in knowing her patients appreciate and value her. When someone she has cared for in the past comes back with a chicken or some beans as a thank you, she remembers she is meeting the needs of the community in ways others never could.

Parteras like Amalia play a critical role in meeting the sexual and reproductive health needs of women, youth and girls in rural communities throughout Chiapas. Despite being historically ostracized by the formal health system, *parteras* continue to advocate for integration into the system in order to better tackle critical conditions, including high rates of adolescent pregnancy and maternal mortality.

Sebastián Girón at home in Tenejapa

SEBASTIÁN

Sebastián is very interested in politics. "It's a passion," he says. "Especially in this municipality, Tenejapa, where politics are—for lack of a better word—dirty."

"Indigenous people don't have [access to] the same right to quality services as the mestizo population."

He is not sure what form it will take, but his goal is to leave a footprint in Tenejapa, located in the Chiapanecan highlands, and create lasting change. His focus would be ensuring youth and indigenous people are informed of their rights, whereas most politicians are only concerned about money, he says. "Here, people buy a vote for 500 pesos and are upset when they do not win."

Four years ago, he founded a youth collective that works to build awareness about gender equality, sexual and reproductive health and other issues that affect local youth by creating videos and reports, as well as engaging in community events and projects.

"The goal is really to inform and create consciousness in the youth who will be the future leaders," says Sebastián, now 24. He hopes to show young people that there are other paths besides early pregnancy and the unequal relationships he and his peers saw growing up in low-income communities.

"We have this idea that men are working hard, that they're the ones who have to physically work. They leave at six in the morning and come back at four in the afternoon and get ready to rest. Actually, the women are the hardest workers. They're up at four in the morning and their work doesn't end until 10 or 11 at night. It's easy for men to say they're done, but the critical part is putting in the effort and support in order to advance gender equality."

YOUTH OF CHIAPAS

Despite a significant decrease since 1990, adolescent fertility rates in Chiapas are among the highest in the region at 89.1 births per 1,000 women ages 15 to 19.

1/3 of Chiapanecans are under age 15[i]

of women and girls of reproductive age are between ages 15 and 19[i] **20.7%**

18.3% of births registered in Chiapas in 2015 were to a mother **under age 20**[ii]

[i] *CONAPO*
[ii] *Instituto Nacional de Estadística y Geografía (INEGI)*

His work with the collective connected him to OMM, where he became a youth promoter. While monitoring facilities, Sebastián has noticed that the quality of health services varies widely throughout the municipality. This is especially true when comparing more urban localities where populations are largely *mestizo* (people of mixed European and indigenous descent) to areas with higher indigenous populations. “The difference is marked,” Sebastián says. “Indigenous people don’t have [access to] the same right to quality services as the *mestizo* population.”

He remembers during one visit, a woman from a rural community came to one of the facilities with massive bleeding from a deep cut. Though it was an emergency, the doctor refused to attend to her, seeing other patients instead while she waited for her turn. Desperate, she begged Sebastián if there were anything he could do to bring a doctor to her community. “That shouldn’t be happening,” says Sebastián.

Progress from monitoring and evaluation has been a slow build. While contraception is now on display so women can see what it looks like, and they have brochures, there are still contraceptive stockouts. They may not have supply from one month to another. “It’s particularly harmful because when people from low-income communities come for an implant, they are told by the doctor, ‘[you can have it] only if you buy it.’ How can they buy it?”

He has joked with his best friend that in order to create change, one of them must become the president of the community and the other the congressional representative. That is a long-term aspiration, but, for now, Sebastián is concentrating on finishing university.

Above: Maruch Hernández
Maruch Hernández prepares breakfast for her mother

MARUCH AND JUANA

“These things were so taboo—talking about rights, talking about being able to decide,” Maruch Hernández says, remembering the early days of providing trainings on sexual and reproductive health. “Especially in San Juan Cancuc, where girls marry young and a lot of times it’s forced. I myself lived it,” she says quietly, wiping away tears.

At 28 years old, Maruch has been working as a health promoter for several months and has years of experience teaching workshops about sexual and reproductive health and rights. She started this work when she was in university, but financial difficulties meant she had to take a break from her studies to support herself. A local organization hired her to provide trainings at high schools in the municipal capital. At the time, she didn’t enjoy the work much, recalling how nervous she was standing in front of classrooms full of students to talk about condoms and other forms of contraception.

Now, with a university degree in languages and cultures under her belt, Maruch has resolved to use her experiences to help youth in her community access the information they need to choose their own futures.

“I left home at 14 because my father didn’t want me to study,” Maruch says, adding that her low-income family didn’t have the means to support her education. “He said women are only here to have children and get married. For me, leaving and then having these opportunities to learn and share this information was important.”

This is one of the reasons Maruch enjoys being paired with Juana so much.

Juana Jiménez Guzman, a self-possessed 17-year-old high school student, also became a health promoter with OMM a few months ago after learning about the work from one of her classmates. “He asked me, “Are you just going on vacation when school is out for summer, or do you actually want to do something? Most of my classmates weren’t interested, but I was.”

EMPOWERING YOUTH TO LEAD SOCIAL ACCOUNTABILITY

In Mexico, local PAI partner OMM has trained 10 indigenous Tzotzil and Tzeltal youth to conduct citizen monitoring of public health facilities to evaluate implementation of the culturally relevant policies aligned with the National Strategy for Adolescent Pregnancy Prevention.

Social accountability—specifically citizen monitoring—is needed to provide oversight to the relatively decentralized public health system. Citizen monitoring is leveraged as a tool to follow up on Ministry commitments, ensure appropriate policies and programs and bring historically absent voices to the forefront of policymaking.

Just a few months shy of graduation, Juana aspires to be a nurse and sees this experience as a leg up in her studies and future career.

"A big part of the fear is that youth are afraid the community will talk about them, that word will get around."

Despite their age difference, the two have had many experiences in common growing up in San Juan Cancuc, and both have prioritized education above all.

Together, Maruch and Juana regularly visit public health clinics in 11 communities, surveying nurses and other staff about the availability of contraceptive supplies and medicines to treat sexually transmitted infections, as well as youth-friendly services, recording the data on the tablets designated for the job.

Juana relishes the many opportunities to learn in the health promoter position. Before she started, she knew a little bit about contraceptive methods and sexually transmitted infections from information sessions given at her high school. However, she's never used family planning because she's not interested in starting a relationship. She likes spending time with Maruch, who is very supportive.

With her friends, Juana has talked about the work she's doing, advising them to use contraception if they start having sexual relationships. Unfortunately, a lot of them are timid about going to a health center so they are not using contraceptives. "A big part of the fear is that youth are afraid the community will talk about them, that word will get around," she says, "Especially because a lot of the medical units have volunteers from the community for cultural reasons, and here the tradition is you don't start having sex until you're married, so it can create issues for young people."

Previously, Juana had only visited health facilities for vaccinations, and had no problems with medical staff. Once she started monitoring, she noticed that many doctors did not treat clients well. "They were just there for the job and don't care for the patients," Juana says.

Maruch agrees, "It really makes me sad to see how a rude doctor or nurse is treating a woman—women above all, because they are the ones who come for services. They're being yelled at because they didn't come early enough. I walk away from these visits and go home feeling really down." On their visits they also document that clinics often don't have medicines or contraceptives in stock. Or, in others, they have all the supplies, but the facilities are packed with people waiting hours for services.

Maruch Hernández, 28, and Juana Jiménez Guzman, 17, Tzeltal youth promoters visit a health center in San Juan Cancuc

It can be difficult for the pair to find transportation between medical units, many of which are spread out. They also found that several facilities are not open on a daily basis, with some open just once a week. This can make it tricky to coordinate monitoring visits—not to mention harder for patients to receive care.

Despite the challenges, the monitoring work has reaffirmed to Maruch how vital it is for communities to have access to information. In addition to teaching sexual and reproductive health workshops, she's also currently enrolled in two training institutes—one about land conservation and another on leadership for indigenous women. After she completes the courses, she will replicate the trainings in her own workshops for young men and women in San Juan Cancuc.

Reflecting on her time spent training and visiting clinics, Juana has no doubt she made the right decision about how to spend her summer. She notes that many of her female classmates have gotten pregnant and were forced to leave school and get married. Like Maruch, Juana views her hands-on engagement in the health and rights of young people in Chiapas as a conduit to a better future for herself, and a way to help peers along the way.

"It's important for youth to participate," says Juana. "It's how you learn. It's how one day, if something happens to me or happens to someone I know, and I need to go to to a clinic, I'll be able to know what I need. If I hadn't done this work, I wouldn't know anything."

Juana Jiménez Guzman on the grounds of her high school in San Juan Cancuc

Dr. Hilda Eugenia Argüello Avendaño, technical secretariat of Observatorio de Mortalidad Materna

HILDA

Dr. Hilda Eugenia Argüello Avendaño has quite a bit of perspective, having seen the health system in Chiapas from multiple angles. She's been a physician, a researcher and an advocate. She is the technical secretariat of the OMM, overseeing the organization's work to reduce maternal mortality and advance sexual and reproductive rights in Mexico. This includes the youth-led monitoring of 48 Ministry of Health and Mexican Social Security Institute facilities.

This monitoring is critical to OMM's advocacy for implementation of youth-friendly policies in public health facilities. Through this initiative, indigenous and rural youth—who are traditionally marginalized from policy decisions despite bearing the brunt of the ramifications—have a role in holding the health system accountable.

"In the medical practice, we are not very aware of the context—how people deal with health issues and the obstacles that they face," Hilda says, recalling the moment that eventually led her to switch professions.

After finishing medical school in Mexico City, she headed to Chiapas, where she would complete the required year of free medical practice as a social service. "That had a major impact on me," she says. "Because I was a physician, I was very clinical. I had no knowledge of social anthropology or sociological tools." She recounts the story of a man coming for an appointment with his five- or six-year-old son, who had a painful skin condition on his feet. Hilda deduced that the boy was allergic to his rubber boots, which he had worn during the long walk to the facility with his father. The answer left the boy's father at a loss. The family had to wear boots to protect themselves from the snakes near their home.

"It was a disease I easily diagnosed. I was very proud of myself. It was easy. This experience left me thinking that it's important to have a physician [understand] this context. For people who are very poor, they don't have a way to go from one place to another," Hilda says. "I'm not wrong; it's the correct diagnosis. But the presence of a doctor didn't solve the health problems. This was very important for me. Because I had the knowledge. I was there. But the problem, in the end, I realized I couldn't solve it—with my knowledge, with my presence."

"I had a breaking point in my career," she says. "I really had to think whether that clinical job was the most important, or to change the conditions in which people live so they can have access to health." Ultimately, Hilda chose the latter. She went back to school to study social and medical anthropology. From there, she worked as a researcher for Mexico's National Safe Motherhood Committee. She joined OMM a couple of years later, overseeing research on and monitoring of public policies before finally taking the reins as the technical secretariat. Given the critical

challenges of teenage pregnancy in the region, Hilda and her team took on sexual and reproductive health for youth as a new mandate.

"We are not going to speak for them. They have to speak for themselves."

"We discussed as a team this topic of pregnancy and contraceptive access for youth. It was important to see all these dimensions that people see as problems, to see them without any prejudgments. That was the spirit that inspired us to think of this project."

A social accountability undertaking helps to normalize the pursuit of information and evidence for a younger generation. "In Mexico, there isn't a culture of transparency. Few civil servants are accustomed to being asked for information, which is a right," Hilda continues. "Part of this process is solidifying that right to ask. Indigenous youth are now going to the health facility to ask, creating that change."

Underlying the monitoring visits, education on sexual and reproductive health and rights and exposure to the realities and limitations of medicine is the conceivable ripple effect of firsthand engagement. As Hilda did all those years ago, youth promoters are considering new and unexpected paths forward. "We think that as adults, we are in this project and can help them, but we are not young anymore. They have to do it by themselves. That's important," she says. "We are not going to speak for them. They have to speak for themselves."

Aracelly Maria Pereira Patron, Dr. Hilda Eugenia Argüello Avendaño, Ana María Gómez Serna and Marisela Sánchez Gómez; staff of Observatorio de Mortalidad Materna

WHAT'S NEXT?

Preliminary analysis from youth monitoring of 48 Ministry of Health and Mexican Social Security facilities in six priority municipalities found that persistent difficulties in access to contraception among indigenous youth could be traced to administrative barriers, including parental consent or an outright refusal by providers to offer contraception to nulliparous adolescents. Lack of culturally competent staff to provide counseling in a local language, coupled with the confluence of social norms and difficult economic conditions that drive early marriage and childbearing in the highlands are key barriers influencing user demand.

The monitoring also underscored recurring stockouts of injectables. This was primarily due to the burden that the central distribution system places on service providers at the facility level by requiring them to travel to the central jurisdiction to collect contraception and supplies assigned to that facility. Unsurprisingly, facilities located further away from the central jurisdiction were more likely to face stockouts. Injectables were cited as one of the most popular methods due the discreet nature and relative ease of use, compared to widely available pills or condoms.

OMM has utilized the preliminary analysis to engage in targeted advocacy at the municipal level, and in the coming year will advocate for systemic changes to supply chain management to facilitate distribution and improve the availability of popular methods, including injectables as well as implants.

PAI continues to work with OMM to ensure contraceptive stock meets user demand, including through monitoring the implementation of recommendations for improvements.

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pai.org

1300 19th Street NW, Suite 200
Washington, DC 20036-1624 USA
(202) 557 3400 • www.pai.org • info@pai.org

@paiwdc
@pai_org
@pai_org