Translated from Spanish

Health and Autonomy: the case of Chiapas

A case study commissioned by the Health Systems Knowledge Network

J.H. Cuevas

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Background to the Health Systems Knowledge Network

The Health Systems Knowledge Network was appointed by the WHO Commission on the Social Determinants of Health from September 2005 to March 2007. It was made up of 14 policy-makers, academics and members of civil society from all around the world, each with his or her own area of expertise. The network engaged with other components of the Commission (see http://www.who.int/social_determinants/map/en) and also commissioned a number of systematic reviews and case studies (see www.wits.ac.za/chp/).

The Centre for Health Policy led the consortium appointed as the organisational hub of the network. The other consortium partners were EQUINET, a Southern and Eastern African network devoted to promoting health equity (www.equinetafrica.org), and the Health Policy Unit of the London School of Hygiene in the United Kingdom (www.lshtm.ac.uk/hpu). The Commission itself is a global strategic mechanism to improve equity in health and health care through action on the social of determinants of health at global, regional and country level.

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General framework-

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- Mexico's indigenous peoples
- Chiapas, background information
- Health services structure in Chiapas.

The Zapatista Autonomous Health Care System

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- The EZLN Autonomy Project.
- Health policy .
- Structure of the SSAZ (Autonomous Zapatista Health Service).
- Interaction with the national health system
- Outcome indicators.

General framework-

Health system in Mexico

During the 1940s and 1950s, against the background of the period that followed the revolution of 1910, the Ministry of Health and the Mexican Social Security Institute were set up in response to the social demand for care for the thousands of peasants who took part in the revolutionary struggle against the chiefs and landowners who owned practically the whole territory.

However, it was not until 1984 that the Mexican health system was set up, on the basis of the right to health, and the assumption by the state of the responsibility to grant and supervise that right, on the basis of Article 4 of the 1917 Constitution.

It has a vertical structure, with three levels of care: the primary level, comprising general practitioners, nurses and health technicians; the secondary level, with highly specialized hospitals and institutes. In providing care, a distinction is made between the working population and the population at large. Care for the former is provided inter alia by the *Instituto de Seguridad y Servicio Social para los Trabajadores del Estado (ISSSTE)*[The Social Security and Service

Institute for State Employees] and Mexican Petroleum (PEMEX) to which workers contribute directly. The remainder of the population, most of whom are peasants and indigenous people directly depend on the network of services provided by the Secretary for Health (SSA). Over the years, the relatively affluent part of the population has come to meet its needs by using private medicine.

Mexico's indigenous peoples

These make up more than one tenth of the population of Mexico and number 12 million in all. They live on (and own) one fifth of the national territory and make the greatest contribution to the nation's wealth1; examples of this are five of the country's major hydroelectric dams which are located in and draw their water from indigenous territories. In addition, 67% of the indigenous population are engaged in agriculture, while only 22% of the rest of the non-indigenous population work in this sector.2

Chiapas.-

This State has a population of 3 920 892[3] and is currently on one of the lowest rungs of the ladder so far as the health structure is concerned. It possesses great petroleum wealth, accounting for 21% of national petroleum production (Mexico is the fifth producer of petroleum in the world), at the same time Chiapas generates 55% of the national electricity output, plus that which is exported to Central America, produces 47% of the nation's gas, and is a producer of timber and agricultural produce. However, it is the state with the highest poverty and marginalization figures, particularly in those administrative areas with the highest indigenous populations. Approximately 30% of the total population are from the following ethnic groups: Tojolabales, Mames, Tzotziles, Tzeltales, Lacandones, Zoques and Choles, all of them of Maya stock, all of them with their own language, culture and religion, this native population is mainly concentrated in two regions: Altos and Selva.

Structure of the health services in Chiapas

1 CDI National Commission for the Development of the indigenous peoples. cdi.gob.mx
2 Idem
3 Population census. National institute of Statistics, Geography and Informatics (INEGI) 2000.

The health infrastructure consists of 1,147 primary-level medical units and 38 second-level hospitals. There is a total of 1443 surgeries (i.e. roughly one per 2716 population.),and 2229 hospital beds (equivalent to one bed per 1759 population, far from the global indicator). In this case, in the same way as for the distribution of doctors, approximately 45% of units are concentrated in regions such as the centre and the coast[4].

One important indicator, given the degree of dispersal of the population, is the proportion of communities per local authority and primary medical unit; for example, the municipal authority of Palenque has within its boundaries 679 centres with a population of less than 5000 pop. and has 265 medical units; Ocosingo6 has 883 localities with a population of less than 5000 and 36 medical units, i.e. 25 localities per unit; where the population's conditions of access and mobility govern actual coverage, so that many localities remain virtually without any health services.

The Zapatista Autonomous Health Care System (SSAZ)

Historical background

Health care has existed since the times of the ancient Maya peoples. Around the year 300 A.D., they had attained a significant level of development, expressed in the construction of ceremonial sites, the development of a form of writing based on hieroglyphics, development of medicine, mathematics, astronomy, the plastic arts, and a series of agricultural innovations.

Between 600 and 900 A.D. these civilizations reached their greatest splendour in the Mayan world. Internal problems began, there was a population explosion, conflicts broke out between nobles and the military, and there were internal revolutions, all of which gave rise to a period of decline and to major migrations

4 Chiapas statistical yearbook 2005, health. data up to December 2004. www.finanzaschiapas.gob.mx.
5 Data from the Chiapas health institute, health jurisdictions, 2000.
6 Ocosingo is one of the country's largest municipal areas and, together with Palenque, is the largest in the North and Selva regions of the State of Chiapas.

towards Yucatan. By the year 1200 AD, collapse was inevitable and the cities were abandoned.[7]

This exodus left small indigenous populations which established themselves in other parts of Chiapas. It is these groups that survived and each passing generation reproduced a series of health care practices, through such personages as the *curandero* [healer] , *hierbero* [herb gatherer], *pulsador* [pulse taker], *Ilol* [physician], *partera* [midwife].

In more recent times, during the nineteen-fifties and nineteen-seventies, the indigenous population of Chiapas was still enduring the most unjust conditions, even though major changes had taken place in the post-revolutionary period, in relation to land tenure, in the case of Chiapas this had not occurred; the Indians were bonded serfs, trapped in a work cycle designed to keep them indebted for life, without many options and finding refuge in the Selva Lacandona jungle of Eastern Chiapas, thus occupying that area.

During the nineteen-seventies and nineteen-eighties, there was a series of campaigns and protests, involving peasant organizations, cooperatives, associations, etcetera, which achieved great strength in calling for attention to the problems of the peasantry, particularly indigenous groups, notably **land, trade, education and health**.[8]

Against this background various social actors (the Catholic Church, NGOs, the universities, INI[9]) intervened in different areas, in which, where health is concerned, allopathic medicine was introduced, accompanied by methodologies aimed at transfer of knowledge so that the community could practise auto-medication. Initially this consisted of small first-aid courses and courses on care of certain diseases such as malaria, dengue, and parasite-borne diseases. On this foundation, the movement grew into an autonomous health-care structure.

7 Ciesas (*Centro de Investigaciones y Estudios Superiores en Antropología Social*) [Mexican Centre for Research and Advanced Social Anthropology Studies]
8 First Indigenous Congress, 1974.
9 Instituto Nacional Indigenista [National Institute of Indigenous Affairs].

Thus, when the Zapatista movement (EZLN) took up arms on 1 January 1994, it already had in its rear a large number of health promoters, henceforth responsible for providing the population with medical care and assistance. They were responsible for providing health care during a tactical retreat by the EZLN when it kept control of a huge geographical area for a whole year.

A year later, when negotiations were broken off, the EZLN publicly declared its decision to build its autonomy, which had been refused in the discussions. This gave rise to the definition of autonomous local communities and the task of establishing them. This was the first attempt to put a distance between the political and military structure and civil society - which forms the basis of the movement's support, leaving it to the different regions autonomously to determine their structures (representatives, fields of work, funding strategies). In this way, a number of autonomous municipalities took shape and made public their work and inauguration. For its part, the State Government declared them illegal and set out to dismantle them,10 although it failed to do so because of the reaction of society and the population's ability to react.

Autonomy project

The Indian communities in Chiapas have been fighting for their autonomy throughout history, and have at the same time been resisting outside domination, as can be seen in the legend of the Chiapas Indians who, instead of accepting slavery, decided on collective sacrifice along the cliffs of the Sumidero Canyon.

The EZLN autonomy project consists of a series of basic demands: land, work, health, education, food, housing, autonomy, justice and freedom and peace.
It sprang out of the community itself, through a programme of consultation and agreements that took shape little by little,11 incorporating elements of the historic struggle of the indigenous peoples, including their resistance, taking the shape of a project for armed struggle with the founding of the EZLN on 11

10 In 1998, the interim governor of the State, who was already acting as interim for another interim governor, Roberto Albores Guillén, declared them to be illegal and sent the police to dismantle them. A large number of people were imprisoned, although they were later released.
11 In fact, the outcome of the first indigenous Congress, in 1974, include the demands for land, health and education.

November 1983. One year after the armed uprising, in 1995 the foundations were laid for to autonomous struggle to continue through civil society.

As time has gone by, the Zapatista movement's decision to commit itself to continuing the struggle via political channels became apparent. In 1995, regional political bodies came into being, offering a channel for interaction with civil society as a whole, defined as "Aguascalientes". Later, in 2003, the same bodies were renamed "Caracoles" (snails), and included committees on good governance made up of representatives of the autonomous regions and municipalities who sat on them in rotation for short periods.

Health Policy-

The Autonomous Zapatista Health System forms part of the EZLN's project for autonomy, in which it interacts with other demands. Although there are few documents in which its actors explain it, in practice it is possible to observe a gradual building up, reflected in the network of services that has taken shape.

In the Declaration of Moisés Gandhi[12], certain ideas are grouped around the health concept and health policy to be followed, framed as follows: "The wellbeing of the people and the individual, which contains the capacity and motivation for every type of activity, whether social or political" and adds "Health is to live without humiliation, enabling us to develop as men and women", "it is to be able to fight for a new country where the poor, and in particular the indigenous people, can decide on matters independently."

Health is described as being "a right of all men and women", linked directly to living conditions, housing, nutrition, labour, justice, education (EZLN demands). It is also defined as a project that must be in the hands of the people, who have to play an active part in defining policies, planning, education and evaluation.

Depending on the way the autonomous communes grow and evolve, they will make a major contribution, as in the case of the Autonomous Commune of

12 February 1997, Autonomous Region of Moisés Gandhi.

Ricardo Flores Magón,[13] which defines "Authentic Health"[14] as "a dignified existence, decent housing, land, justice, food, education and work", and sets it on the horizon as "the objective, not only of health projects but of the struggle as a whole". Lastly, it defines its health policy as "Marked by respect, free of charge, a source of sound advice and observant of culture, disciplined and imbued with a sense of companionship."

In practical terms, and in the light of the above, health may be characterized as follows

- The entire population is entitled to health care, regardless of whether they belong to the Zapatista movement, of their religion or membership of any political party;
- Persons are to be treated with respect for their dignity, culture and beliefs and using their own language;
- Patients are not to be reprimanded, they must be informed and given recommendations for their health;
- No-one may be obliged to plan or forcibly participate in a health programme. Participation shall be voluntary;
- Health care is provided free of charge. However, because of the absence of a regular source of income to pay for medicines, [15, 16] a charge is made for these in order to renew the stock of medicines.

There are a number of major differences in comparison with the National Health System:

- Participation in the national system is not voluntary but linked to other economic benefits for education and health; [16]
- The main complaints made by the population regarding the government's health services concern the poor way patients are treated, the lack of

13 This municipality was one of the first to organize itself autonomously and also the first to be attacked, in 1998, by the State Government. It subsequently re-organized itself.
14 True Health. Ricardo Flores Magón autonomous municipality, 2002
15 The movement has been in resistance since 2005.
16 Under the condition of "co-responsibility", the Federal Government's" Opportunities" programme, which addresses health, food and education makes the provision of financial support for education and food for families conditional on attendance at health facilities, whose staff are responsible for pressuring people to participate in programmes such as family planning, screening for cervical cancer, basic sanitation, etc, under threat of the withdrawal of financial support in case of refusal.

equipment and drugs, the constant absence of staff and the excessive waiting times;

- Care is not free of charge and cost recovery is practised. Recently, in 2001, popular insurance was introduced, a system under which an annual payment has to be made and which in fact constitutes a new form of exclusion.

Structure of the Zapatista Autonomous Health Services.-

The structure of the autonomous health services is part and parcel of the political structure of the Zapatista movement; it has three levels, with the *Caracoles* (snails) maintaining political links with the Clandestine Indigenous Revolutionary Committee (CCRI), a body which was the only one to represent the Zapatista movement during the period when it was clandestine and when it was engaged in negotiations. Nowadays the insurgent group, including Sub-commandant Marcos, is under its orders.

Caracol: There are five of these and they were established in 2003;

- They constitute a political and territorial body covering several autonomous municipalities and regions. The supreme governing body is the Board of Good Governance (JBG), which is appointed by the autonomous councils. There is a health committee or office within the Board. Its role is to support and coordinate the smooth running of the autonomous municipalities, seeking to ensure their equitable development.[17]

Autonomous municipalities

- Within each municipal council there is a health coordinating committee, comprising representatives of health outreach workers, of the local health committees and of the different communities living in the municipality.

Community representatives (local health committees)

- These are the foundation of the structure, and are made up of health workers (health outreach workers, vaccinators, reproductive health outreach workers) and people from the community. Each community participating in the health programme is required to have one.

17 Declaration of Caracoles and Boards of Good Governance, EZLN, August 2003. www.ezln.org

The structure of the autonomous health service is built from the bottom up, and its foundation is small health networks formed by the community health homes, which are built by the communities themselves and served by staff also from the communities, who have been trained as health outreach workers, vaccinators or reproductive health outreach workers. Above these come the medical referral units, which are defined as autonomous regional clinics; they are assisted by medical staff and in some cases university physicians or physicians under contract. Their role is to find solutions when possible or to refer patients to a second level, which does not yet exist under the autonomous health service. Consequently, patients are referred to the National Health System, a step which forms an interface with the System.

A noteworthy feature of this system is the Guadalupana Autonomous Clinic, located in the Altos region in the Oventic *Caracol*. This clinic has developed its care capacity up to an intermediate level, between the first and second levels. It provides regular basic surgery, dental, gynaecological and eye clinics; a laboratory, an herbal workshop and 8-10 beds for admissions. Most of its users are from the indigenous population. Its existence provides an important referral point for virtually all the autonomous areas, and it is has a very high patient turnover.

The nature of the population's participation is apparent from the manner of appointing their representatives; both the health outreach workers and the health committees are appointed by the community assemblies. In turn, the local committees appoint representatives to the municipal health coordinating committee, from which representatives to the *Caracol* are appointed. The community assembly is responsible for punishing shortcomings, and may even suspend health workers from their position.

Activity covers both treatment and prevention. As a rule, patients are treated as outpatients, some of them being referred to more specific programmes such as reproductive health, dental health, checking weight and size of children under five years old, antenatal examination, hypertension and diabetes.

In recent years closer links have been developed with and support provided to midwives, who are responsible for 90% of birth-care in most rural communities.

As far as preventive action is concerned, we should mention the immunization programme, which has gradually achieved wide coverage. Another significant action has been the community sanitation campaigns, which focus on refuse management, water management and latrine building. The health outreach workers are responsible for health promotion in the community sphere.

In this respect, we cannot fail to mention the participation of civil society, represented by national and international NGOs, universities, religious groups and individuals, who have played an important role both in providing support and through their methodological contribution.[18]

These external actors generally occupy a sphere that depends on the nature of their collaboration, either locally as social workers and/or advisers to the local health committee or as advisers to the health committee at the level of the *Caracol.*

This form of organization operates from the bottom to the top, and from top to bottom, with as its motto "order by obeying".

As regards financing for the autonomous health service, we should point out that it has received considerable support from the national and international community of sympathizers as well as from individuals, independent groups and autonomous governments in other countries. Considerable funding also comes from the local level, generally in the form of material and human resources.

Where medicines are concerned, for a number of years the rule was to provide them free of charge. However, because of the unreliable and irregular nature of the support received the very existence of health care services was under

18 Health and Community Development AC, proposal for a community health network. Internal document

threat. Consequently, an agreement was made to charge for medicines in order to be able to replace them and maintain a constant stock.

Interaction with the National Health System (SNS)

The declaration of resistance[19] might suggest that interaction between SSAZ and the National Health System is impossible. However, this is not the case. There are several examples of such interaction:

- Referral of patients to a second level is to SNS establishments;
- The vaccine used for immunization by SSAZ is supplied by SNS;
- During some epidemiological emergencies, coordination was assured by intermediaries.

This may be explained by the fact that the Declaration of Resistance has both a political thrust, in refusing to recognize a Government that failed to respect an agreement,[20] and a practical one in that it accepts financial resources (funding), medical equipment and medicines. If a patient needs treatment which is beyond a clinic's resources, it will seek assistance. Similarly, it will not force decisions on patients. The same applies to immunization of a population.

Outcomes

Qualitative

This is a model which is:

- Sensitive; it is run by and for the community, and responds directly to abuses such as maltreatment, discrimination and authoritarian behaviour.
- Inspired by a sense of relevance and identity.
- Participatory, allowing the development of skills and capacities, with room from the local level upwards for evaluation of the progress of health work.
- Welcoming towards participation by other actors, such as universities as the Autonomous Metropolitan University located in Mexico City, which since 1995 has incorporated into the autonomous project physicians,

19 Second declaration of the Selva Lacandona, June 1994, www.ezln.org/documentos inviting the population to reject any help and/or support from the government, including health and education.
20 The San Andrés agreements between EZLN and the Federal Government, relating to indigenous rights and autonomy, signed in 1995 and not complied with.

dentists and nurses performing their social service who work for one year in an autonomous clinic. During this period, more than 100 persons performing their social service participated in volunteer work.

From the quantitative standpoint:

- Coverage - there are currently some 200 community health houses and 25 autonomous regional clinics, some of which have already been in operation for 10 years and a dental clinic. These provide a large amount of data on patient care, immunization, pregnancy monitoring and follow-up of the chronically ill. If we bear in mind that almost all the medical facilities have been build in places where none existed before, it is easy to appreciate the significance of achieving this objective thanks to an effort by the community.

- So far as specific problems, such as maternal mortality are concerned, some isolated data are available. For example, in two autonomous clinics located in the Selva region, where maternal mortality rates were historically high,[21] it has been possible to eliminate maternal deaths for periods of more than seven years.[22] In practical terms, they have shown the feasibility of the association between physician and health outreach worker and midwife for childbirth, and have laid the foundations for cooperation whereby it is possible to bring together practice and knowledge to preserve women's lives.

- This is a model which has proved able to have an impact on what one can call the primary level of health care, acting within an organized health structure and as part of a political project. Seen from that viewpoint, it has been able to insert into the scenario a methodology that the National Health Service has been unable or unwilling to develop. Apart from this experience, some of its parts have been reshaped, particularly as regards persons trained as health outreach workers, many

21 Chiapas Health Institute, Jurisdictions, maternal mortality 2005. The VI Selva Jurisdiction, whose headquarters are in Palenque, reported 42 maternal deaths in 2001-2005, and the IX Jurisdiction, whose headquarters are in Ocosingo, reported 36 maternal deaths during 2000'2004; both these Jurisdictions cover the Norte and Selva de Chiapas regions.
22 Health and Community Development AC, reports by physicians performing their social service, 1995-2001.

of whom have been contracted by the different departments of the Chiapas Institute of Health, for example N° IX Ocosingo Jurisdiction currently employs more than 450 health outreach workers who were trained in previous years under the nascent community model.

Impact

The foundation of the *Caracoles* in the old Aguascalientes made a number of contributions to reorganizing power peacefully and within the framework of the Constitution. [23] As a result, this new power base saw the creation of a different approach to health care which has now developed its own sphere of action in the form of a local health system based on a project to achieve autonomy.

Meanwhile, other parallel lines of action have developed, such as education, food and agricultural ecology and it has been possible to address a number of health-related problems. In this respect, the autonomous education project, housing support, food assistance for the population during emergencies and the agricultural ecology projects have been important.

They have offered the Autonomous Metropolitan University scope for working and learning in which graduates have discovered a different way of practising medicine, with a social purpose and a commitment to the population.

One problem among others

We cannot ignore a contradiction that has become visible in this process, where the health care model has marginalized traditional practices; except for the *parteras* (midwives), interaction with other agents such as *hueseros, curanderos, iloles,* and *hierberos,* has been very limited. Whereas autonomy has pushed forward and incorporated other practices, it has left aside the indigenous system, which historically has been a key element in the survival of the community and a fundamental element of identity. In actual fact this explains why the midwives still act as lead actors even when there are often medical personnel, since pregnant women prefer to be cared for by the midwife.

23 The Zapatista caracoles, Networks of resistance and autonomy, Pablo Gonzalez Casanova, www.memoria.com.mx/177/gonzalez.htm

We should not be surprised that the model has come closer to Western medical practice since the chief care need is in response to infectious or contagious conditions, some of them involving the risk of complications and death.
The paradox is the failure to develop the model on the basis of indigenous practices. Its strength lies in being able to do so within an institutional framework that has no room for it, moreover in the midst of a conflict. The challenge may be to consolidate our achievements and find tools for interaction to help push forward traditional practice. The result, a health care model with two alternative sets of practice, based on and serving the community.

It is important to mention that men and women traditional health workers still enjoy recognition by the new health actors, and for the moment are not in conflict with them.

We are now moving to the next stage and rebuilding our links with traditional health workers, who were perhaps initially neglected because of the need to respond to the emergency and perhaps also because of our ignorance of the achievements of the model they have developed.