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Sexual and reproductive behaviors of the indigenous women: findings from Mexico

Jorge Adán Romero ZEPEDA[1], Arun Kumar ACHARYA[2], Jose Maria INFANTE[3]

Abstract

At the time of designing family planning programs focused on the indigenous population, it should be considered their historical situation of cultural marginality. Historically, in Mexico there is a confrontation between indigenous and no indigenous population, so there is a clear lack of confidence (and in part well founded) of these groups to accept any government programs. The indigenous are convinced that health care programs are not going to respect their culture. As indigenous usually live in poverty and extreme poverty, poor education and cultural and geographical isolation, therefore they have poor knowledge of reproductive health, gender equity, physiology or sexuality. It is recognized the need to address indigenous peoples as distinct groups that require special care programs. In this study we have analyzed the sexual and reproductive behaviors of the indigenous women in Mexico. Also we have calculated an Indicator of Risk to HIV Infection (RHIV) among indigenous women. Result indicates that majority of women have sexual and reproductive health problem as well as our indicator majority of indigenous women are in high risk to HIV infection in Mexico.

Keywords*: indigenous women; sexual and reproductive behaviors; family planning program; risk to HIV infection; Mexico.*

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Introduction

At the time of designing family planning programs focused on the indigenous population, it should be considered their historical situation of cultural marginality. The indigenous in Mexico have been treated in the past by Mexican government institutions with racism, human rights abuse and even persecution, and so that is why this population often deliberately rejects the state services (Garcia, 1999). In the prevailing discourse on reproductive health for indigenous, there is a dominated vision in which lack impact of sexual health programs caused by a lack of individual responsibility as well as backwardness in sex education, or not to prevent early pregnancies, or the spread of sexually transmitted diseases, or by gender violence (Tinoco, 2009). Moreover, in the operation of government programs, there is no dialogue between partners with the same symbolic capital, but it is common for physicians, nurses, social workers and other staff to treat the indigenous with racism and discrimination, understanding their uniqueness as weakness or ignorance. In fact, the call for family planning programs in the indigenous population tends to be coercive or conditioning dyes to obtain benefits from government programs (Tinoco, 2009).

Historically, there is a confrontation between indigenous and no indigenous population, so there is a clear lack of confidence (and in part well founded) of these groups to accept any government programs. There is a well established structural violence against indigenous people to reduce their population, now becoming the way of mass sterilization programs. In this sense Barroso (2004) cited that; this people have expressed opposition to family planning programs, not because they are not interested in controlling their reproductive health, but because they have many negative experiences of the implementation of these kinds of programs. The indigenous are convinced that health care programs are not going to respect their culture. Some examples have been the case for mass sterilization of men in exchange for false promises of food pantries and monthly pensions. Another case that even have shocked the international community was that of the indigenous Amuzga women from the state of Guerrero, who 20 of them every Saturday were recruited to be sterilized in clinics, in order the Social Security could meet the goals of institutional control birth.

The Human Rights Commission said that its investigation has found that in several rural clinics of public health institutions engage in the practice of forcing indigenous women to use the intrauterine device (IUD), under threat that if they do not do so, they lose health coverage. Similarly, community health brigades shakedown the indigenous male population to practice the definitive method to family planning (vasectomy), making them false promises that they will receive tangible property and financial resources. Other practices registered as reproductive rights abuses to indigenous in health facilities, has been to place in women

the IUD (intra-uterine device) at the time they are screening tests, in a clandestine manner without their consent (Soberanes, 2002).

Soberanes (2002) stated that; it is noteworthy that the indigenous often with little or no knowledge of Spanish, claim that they neither understand health personal who work in clinics and hospitals, printed information, nor documents they have to fill, so in many cases they access to be subjects of contraceptive practices without real inform consent (sometimes even health personnel falsified their signature). In this regard, there is a need for translators in clinics to inform them on their own language the diagnosis, treatment and possible side effects of family planning methods. In turn, it is necessary to verify if they have sufficiently understanding of the information provided, so they can choose freely and informed the method that suits better to their needs (or at the time they could have the capability to reject the family planning knowing that this action does not involves any type of sanction).

Many research in Mexico for example (Soberanes, 2002) citied that; vast majority of indigenous people in Mexico live in extreme poverty, with no schooling, lack of elementary basic necessities, unemployment, malnutrition, racial discrimination and/or cultural and historical violence to their human rights. That is why they are in a position of disadvantage and vulnerability to the rest of the society and it has a great impact on the sexual and reproductive health status of indigenous women. Thus*, considering the above discussion, the main objectives of this paper is to analyze the sexual and reproductive behaviors of the indigenous women in Mexico.*

Methodology

For the present study we have utilized the National Reproductive Health Survey 2003 (ENSAR) conducted by the National Autonomous University of Mexico (UNAM). In this survey 20925 indigenous and non-indigenous women were interviewed with a semi-structured questionnaire. The main objective of this survey was to have complete information regarding the reproductive health status information Mexican women.

To understand the risk behaviors to HIV/AIDS among the indigenous women, here we have calculated an indicator "Risk to HIV Infection" (RHIV). To get this indicator we have considered three indexes, i.e. Index of knowledge on HIV/AIDS (IKOHIV), Index of knowledge of any methods to avoid of HIV infection (IKOAMHIV) and Index of current method use to avoid HIV infection (ICMTAHIV).

1. IKOHIV = (Total number of indigenous women have knowledge on HIV/AIDS / Total number of Indigenous women) * 100
2. IKOAMHIV = (Total number of indigenous women have knowledge of any methods to avoid of HIV infection / Total number of Indigenous women) = 100
3. ICMTAHIV â (Total number of indigenous women currently using to avoid HIV infection / Total number of Indigenous women) * 100

To calculate the indicator RHIV we have use the following formula:

RHIV = (KOHIV + KOAMHIV + CMTAHIV)/3

We have interpreted RHIV result in three different risk levels:

1. Low Risk to HIV Infection (RHIV) â More than 80 percent indigenous women have complete knowledge to avoid HIV infection.
2. Medium Risk to HIV Infection (RHIV) â Between 50 to 79.99 percent indigenous women have complete knowledge to avoid HIV infection.
3. High Risk to HIV Infection (RHIV) â Less than 50 percent indigenous women have complete knowledge to avoid HIV infection.

Indigenous population in Mexico

The data given by INEGI, 2010, the total population of Mexico in 2010 was 112,322,757, which includes 10 per cent of indigenous people. Studies indicate that if something characterizes the indigenous groups in Mexico is their poverty. Among the poor, indigenous people are often the poorest of all, and this situation has no signs of overcoming centuries; however, the economic dynamics tend to their growing social exclusion: 70 percent of these populations have high and very high levels marginalization, 4 of every 10 children has some degree of malnutrition, and pandemics are prevalent in this population. The backlog of health care coverage for this population seems to have settled permanently (Barroso, 2004).

On the other hand, indigenous population also is characterized by high infant and maternal mortality, high death rates for gastrointestinal illnesses and respiratory tract, high mortality from violence, and they are also strongly ejectors of labor force to the United States (Barroso, 2004). As indigenous usually live in poverty and extreme poverty, poor education and cultural and geographical isolation, therefore they have poor knowledge of reproductive health, gender equity, physiology or sexuality. Many traditional practices are harmful and likely to increase unwanted fertility, to begin sexuality and fertility at a young age and to generate mortality and morbidity in newborns and mothers. It is important to note that most of the indigenous cultures in Mexico have a lot of pressure on girls to prove their fertility (García, 1999).

Indigenous women and their demographic-economic characteristics

The data indicated that 2087 women belong to different indigenous groups, in whom 90 percent women responded that they are bilingual which mean they can speak their own native language and Spanish. We also seen from our analysis that only 10 per cent are unilingual which mean they can only speak their native language (see table 1). In his study Vazquez (2009) indicates that not speaking Spanish make indigenous women severely disabled to access any government program.

These women are unaware of contraceptive use and most of them do not control their fertility. The geographical conditions of high dispersion and strongly patriarchal cultural context remain as an obstacle to the adoption and distribution of contraceptives in this population. In the indigenous population, the adoption of family planning depends heavily on the public health institutions witch could provide advisory service to inform them about contraception and their appropriate use.

On the other hand, level of education indigenous women, we have seen that one out of five (20 percent) indigenous women is illiterate, whereas 50 percent women have primary level education. Looking into higher education, only 16.8 percent indigenous women in Mexico have studied up to secondary level, whereas 11.7 percent and 0.2 percent were educated up to high school and graduate level (see table 1).

Whereas, it is notorious how there has been a decrease in the gap between literacy among male and women, as if in 1970 the female literacy population over fifteen years old was 62.6 percent and 70.4 percent for male, in 2005 was 93 percent for men and 90 percent for women. In the case of the indigenous population we can observe wider gap percentages between genders and literacy rate, as the indigenous literate population aged 15 in 1990 was 59 percent, 66.2 percent in 2000 and 68.3 percent in 2005, being the percentage by gender gap of 22.1 percent, 19.3 percent and 16.4 percent, according to the respective years (CONAPO, 2009).

To understand the work participation of indigenous women we have studied the remuneration activities of women during the last week at the time of interview. Analysis indicates that, approximately 4 out of 5 indigenous women in Mexico were occupied in different labor activities without receiving financial reward for it. A little over 1 in 10 indigenous women held productive activities only as auxiliary of men, and less than 1 in 10 indigenous women engage in gainful activity independently of their husbands (see table 1). Looking into above finding we can say that the perception of family roles and gender stereotypes are a clear indicator of gender inequalities. In one study Instituto de Mujeres, Mexico stated that, in 2006, 68.1 percent total Mexican women of over fifteen years old felt that

men should take responsibility of all household expenses, while 85.7 percent of indigenous women agreed with this statement. In the same year, 38.3 percent of women in general population believed that a wife must obey her husband in whatever he ordered, while 74.5 percent of indigenous women felt the same. Around 4.0 percent women thought that husband has right of wife beating and 11.0 percent thought that husband has right to force women to have sex, while it is 12 and 20 percent in the case of indigenous women (CONAPO, 2009).

Table 1: Demographic-economic characteristics of indigenous women in Mexico

Characteristics	Percent
Language	
Bilingual	90.0
Unilingual	10.0
Level of education	
Illiterate	20.9
Up to primary	50.4
Up to secondary	16.8
Up to high school	11.7
Up to graduate	0.2
Economic Activities	
Sold agricultural product	9.7
Helped in family business	2.2
Domestic servant	1.1
Worked in Agricultural farm	9.9
Unemployed	77.2

Early pregnancy and fertility level

Biological, cultural and socioeconomic conditions determine together the ability to conceive a child, as well as number of children a woman wishes to have (Population Reference Bureau, 2011). But, the risk of teenage pregnancy is one of the major factors of large family. In Mexico, it is one of the evident features that majority of male and female enter to their nuptial life at very early age. From the analysis we can see that around 2 percent indigenous women experienced their first pregnancy at the age of 13 years or less, whereas, 15 percent women had pregnancy at the age of 14 and 15. The data indicates that 76 percent indigenous women had their fist pregnancy in between 16 to 25. This shows that 3 out of 4 indigenous women in Mexico experienced their first pregnancy around at an age of 16 years (see table 2). In a study, Instituto de Mujeres, Mexico citied that;

reproductive life among the indigenous women is begins early than the non indigenous. They stated that indigenous people have their first sex encounter at the age of 16.7 years and the first union (marriage) at 17.8 years and their first child at the age of 19.0 years, while the non indigenous people have their first sex encounter at the age of 17.8 years, the first union (marriage) at the age of 19.5 years, and their first child at 20.5 years (CONAPO, 2009).

Table 2: Age of pregnancy of indigenous women in Mexico

Age of pregnancy	**Percent**
Less than 13 years	2.0
14 to 15 years	15.1
16 to 18 years	38.8
19 to 25 years	37.5
26 and more years	6.6

As shown in the above figure, approximately little more than fifty percent indigenous women had their first child at underage. It is noteworthy that a considerable percentage of indigenous people (2 percent) became mother while they were still in childhood (13 years old or less), which tells us, among other things, high-risk pregnancies.

Fertility rate among indigenous

At country level, one can speak of accomplishments over the past 35 years of family planning, but there are still population subgroups where there are long lags, as it is the case with the indigenous people living in high and very high marginalization. The unmet need for contraception on indigenous women is 16.2 percent without coverage, ranking within the most vulnerable groups with residents of rural areas (15.8 percent), and people with no schooling (15.8 percent), young women aged 20 and 24 years of age (16.8 percent) and teens (24.4 percent) (CONAPO, 2009). It is necessary to highlights that fertility level in the indigenous population is going down and filling gaps with respect to the population that is not vulnerable, as if in 1995 the indigenous women used to have 1.5 more children than non-indigenous women, in 2005 the difference reduced to 0.8 more children on average. However, still the government must make great efforts to make the indigenous population enjoys the same opportunities as the rest of the population and can exercise their right to access information and services for family planning and sexual and reproductive health (Romo, 2009).

The proportion of indigenous people with regard to the general population in Mexico has tended to decrease from the second half of the twentieth century. The reason for this decrease in percentage of indigenous people is mainly due to urban

and international migration, which causes the loss of linguistic and cultural tradition. Far from their home communities indigenous lose their ethnic identity and their language. Into modern contexts, their indigenous traditions far from being useful are grounds for discrimination (Vazquez, 2009).

In the year 1982 the average of native children per woman was 6.3 percent and in 2003 fell to 2.7 percent. This indicates that the reproductive differences between indigenous and non-indigenous are shrinking. The demographic transition in the indigenous population began late with respect to the general population (approximately 10 years later), resulting in a still higher fertility rate (Vazquez, 2009). According to the National Reproductive Health Survey-2003, only about 1 in 4 indigenous women had 1 to 2 children. In contrast, slightly less than 1 in 2 women have 6 or more indigenous children (see table 3). This indicates that though Governmental Program on family planning has not impact to the indigenous population.

Table 3: Number of children born in indigenous women in Mexico

Number of children	Percentage of women
1-2	24.5
3-5	29.9
6 and more children	45.6

Infant and Child mortality

Although indigenous people in rural areas are in a condition of isolation, and therefore are hardly beneficiaries of family planning, while the non-indigenous are much better than in the past, not only with a lower fertility rate, but also by a decrease of early childbearing, greater spacing births each other, and less child mortality and maternal morbidity. The situation has improved, but there are still lags that force us to redouble our efforts to improve reproductive health conditions of the indigenous population (Loggia, 2009).

The information obtained from the analysis (see table 4) that 93 percent of women have experienced 1 to 2 male child death in their reproductive life, while 7 percent women said they have experienced 3 to 4 male child death. On the other hand, nearly 98 percent of women have experienced 1 to 2 girl child death and 2 per cent women have faced 3 to 4 girl child death in their reproductive life. By this comparison of childhood deaths by gender, we can see a probability of around 5 percent higher in female newborns that die in comparison to men, a percentage that could be due to cultural reasons (infanticide, neglect etc.) that purely biological.

Table 4: Percentage of indigenous women experienced male and female child death

Percentage of male child death	Percentage of female child death
93.0	98.0
7.0	2.0

Current contraceptive use

It is very much noticeable the lacking behind of current contraception use by indigenous people in Mexico compare to non-indigenous population. Data indicates that currently 75 percent of non indigenous women of childbearing age currently using any method of contraception, while it is only 50 percent in the case of indigenous women, as unmet demand in native people are twice that of the rest of the population. The reason for this lag is given not only by the geographic dispersion status and economic marginalization of this population, but highly unequal gender relations that limit indigenous women decision-making power in the domestic sphere and the reproduction life (Loggia, 2009).

Our analysis on the data given by the National Reproductive Health Survey of 2003 shows that approximately only 1 out of 4 contraceptive methods practiced by the indigenous population involves male responsibility, while nearly 3 in 4 cases the use of contraceptive methods is exclusively for women. Similarly, one can observe that roughly 15 percent of the indigenous population practice traditional methods of family planning with little effectiveness (rhythm, withdrawal and tea) (see table 5).

Table 5: Current contraception use by the indigenous women in Mexico

Current contraception use	Percentage women
Female operation	39.0
Male operation	0.7
Intrauterine device	17.8
Monthly Injection	12.9
Bi-monthly injection	3.2
Quarterly injection	0.1
Condom	4.3
Rhythm	7.4
Withdrawal	7.1
Pills	6.6
Total abstinence	0.1
Herbal teas	0.7
Others	0.1

High risk sexual behavior

There are many conditions that lead the indigenous to make high-risk sexual practices, such as gender hierarchical relationships in witch women do not decide about sexual practices and therefore can not suggest condom use (to prevent sexually transmitted infections) or any type of contraception (even unwanted pregnancies); important socio-cultural barriers usually interpreted sexually transmitted disease as divine punishment for sexual behavior changes, and therefore must resign themselves to the disease as a way to overcome their lack of moral; native girls and women often choose prostitution as a strategy for economic survival; men in urban and international migration are exposed to sex without control, and poverty make them living in overcrowded situation, so they usually falls in incest and promiscuity (Yáñez, 2003).

On the other hand, we have seen from the analysis that majority (51.1 percent) of indigenous women had their first sexual relationship at an age of 11 to 18 years. There were women who also start their sexual life at a less than 10 years. This shows that how this population vulnerable towards the unwanted pregnancy as well as proximate to sever health consequences like sexually transmitted diseases (see table 6).

Table 6: Age of first sexual relationship of indigenous women in Mexico

Age of first sexual relation	Percentage of indigenous women
10 years and Less	0.1
11 to 18 years	51.1
19 to 25 years	21.2
26 years and more	27.6

The above table indicates that how early age indigenous women enter their sexual life, but when we analyzed with whom they started this relation, we observed some astonishing results. Result indicates that 1 out of 4 indigenous women had their first sexual relation with their boy friend, whereas 3 out of 4 women had their first sexual encounter with their husband (see figure 1). Some indigenous women said they had also first sexual relation with some familiar and friends. It can be conclude that majority of indigenous women were virgin till their marriage. For indigenous community it is very important to preserve their virginity as it is symbol of purity.

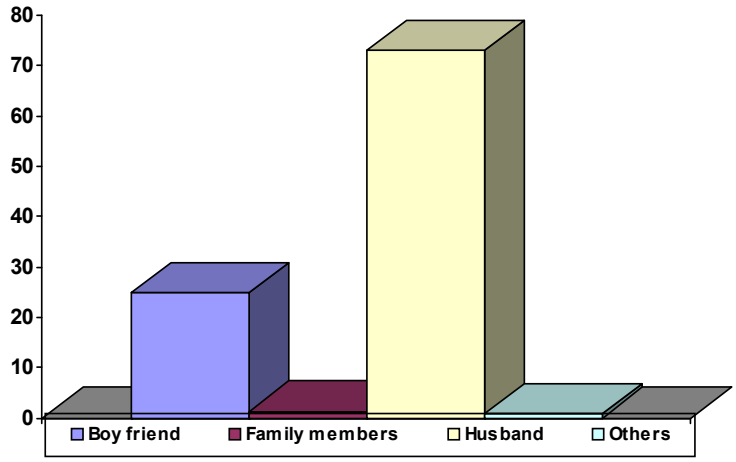

Figure 1: Persons with whom indigenous women had first sexual encounter in Mexico

Age of beginning of sexual relation is an important variable to know the sexual risk behaviors of indigenous women, but the another variables such as use contraception use in the sexual relation also indicates how much indigenous women might be vulnerable towards the unwanted pregnancy as well as sexual transmitted diseases. Taking into consideration the above interrogation we have analyzed the contraception use in their first sexual relation. Data shows that 96 percent of women didn't use any kind of contraception in their first sexual encounter (see table 7).

Table 7: Indigenous women use any kind of contraception in their first sexual encounter

Contraception use during 1st sexual encounter	**Percentage of women**
No	96.0
Yes	4.0

On the other hand, when we analyzed why they didn't use contraception in the first sexual encounter, we observed that 6 out of 10 indigenous women were totally unknown about any kind of available contraception methods, which indicates that how Mexican family planning program has not reached to the indigenous community. This can be says that native people has totally ignored by the governmental programs, as a result we have higher fertility rate in this sector of population. In the figure 2, we have analyzed why indigenous women didn't use any kind of contraception in their first sexual encounter. Some indigenous women indicate that they didn't use because they were known where it is available, also some women though they wanted to use but their boy friend rejected and in some cases they wanted to get pregnant, thus didn't use contraception. Whilst some

didn't use because they were thinking that it may causes any kind of health problem.

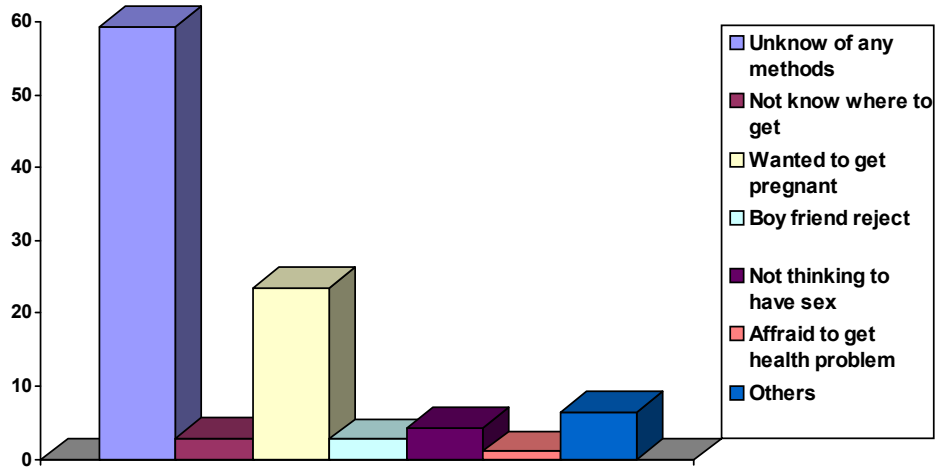

Figure 2: Reasons to not use any contraception at first sexual encounter

Reproductive morbidity

While Mexico has almost completed its epidemiological transition (deaths from chronic degenerative diseases rather than deaths from infectious and parasitic diseases), the indigenous population is at a stage prior to the rest of the population because mortality varies substantially on gender and age, as indigenous women on reproductive age die mainly from complications of childbirth (1537 deaths per million inhabitants in 1999), while indigenous newborns are affected by infectious and parasitic diseases. Importantly, maternal mortality is a clear indicator of gender inequality, as it is the result of a liability in the exercise of sexual and reproductive rights (CONAPO, 2009).

Thus, looking into this discussion and the sexual behaviors of the indigenous women, here we have analyzed the reproductive morbidity of indigenous women, it is seen that 15 percent indigenous women had any kind of reproductive health problem and 94 percent of them believe that they have infected by the their partner. While analyzing the kind of health problem, nearly 50 percent women said that they had white and yellowish color vaginal discharge, 39 percent told it had a very bad smell and nearly 50 percent indicates they were feeling itching and irritation in their vagina (see figure 3).

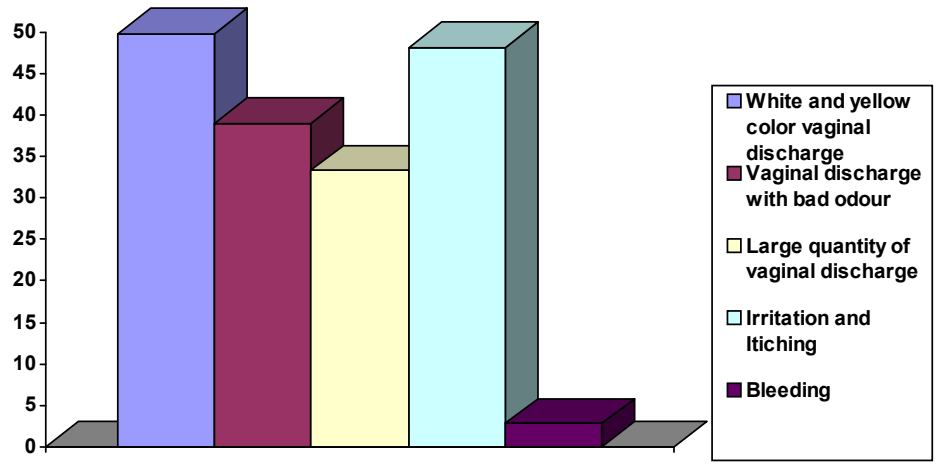

Figure 3: Indigenous currently having reproductive health diseases

Indicator of Risk to HIV Infection among indigenous women

As indicated in most of the studies (Acharya and Clark, 2010, CONASIDA, 2010), over the year, the HIV/AIDS pandemic in Mexico is spreading rapidly. This pandemic immensely affect negatively on women's health. Consejo Nacional para la Prevención y Control del Sida (CONASIDA) (2010) indicates that in Mexico currently 144,127 persons living with HIV. From the analysis on knowledge on HIV/AIDS as well as their mode of transmission among the indigenous women, we can observed that 75.5 percent of indigenous women are aware of this disease through radio, television, hospital as well as from their partner and parents. Nearly 80 percent of indigenous women believe that AIDS transmitted through sexual contact, while some also said that this pandemic spread through the use of needle, through blood. Some women indicates others reasons such as through physical contact, insects, saliva, having sex with prostitute and homosexual persons and use of public toilet, whereas, 18.3 percent said they are unaware of mode how the AIDS transmitted.

On the other hand, indigenous women who have heard of AIDS were asked, if a person can do anything to avoid becoming infected. Those who reported that something could be done were asked what a person could do to avoid. Data Indicates that 3 women out of 4 indicates some knowledge to avoid HIV infection, whereas one out of four didn't know any method to avoid the infection. Among the women who responded who knows way to avoid HIV infection, majority of them said; condom is the only way to avoid the AIDS infection, while nearly 14 percent indicates having sex with only partner is an important way to prevent the AIDS. Some indigenous women indicates abstaining from sex and avoiding sex

with commercial sex workers and homosexual are the ways to prevent AIDS transmission, whereas women also citied others modes of preventions such as; avoiding blood transfusions, avoid of touching a person having this diseases.

To understand the risk behaviors to HIV/AIDS infection among the indigenous women, here we have calculated an indicator "Risk to HIV Infection" (RHIV). To get this indicator we have considered three indexes, i.e. Index of knowledge on HIV/AIDS (IKOHIV), Index of knowledge of any methods to avoid of HIV infection (IKOAMHIV) and Index of current method use to avoid HIV infection (ICMTAHIV).

IKOHIV = (1573/2083) * 100 = 75.5
IKOAMHIV = (1249/2083) * 100 = 59.96
ICMTAHIV = (66/2083) * 100 = 3.16

Taking into consideration the above indexes, we have calculated the indicator Risk to HIV Infection

RHIV = (75.5+ 59.96 + 3.16)/3 = 46.20

If we interpret the above results, it is indicate that; 46.20 percent indigenous women have complete knowledge to avoid to HIV infection. On the contrary, result shows that indigenous population in Mexico is in high risk to HIV/AIDS infection. The lack of knowledge on HIV/AIDS, its mode of transmission and way to avoid infection among the indigenous women is one of the major challenges to avoid the spread of AIDS in Mexico. The indicator Risk to HIV Infection underline that majority of women have heard about HIV/AIDS, but many of them do not know even a single way to avoid the infection as well as very less percentage currently practicing any method to avoid the diseases. Thus, it is clear that HIV/AIDS commission need to strengthen their program, so that indigenous people can educate properly.

Conclusion

Although Mexico has made significant progress in recent decades in family planning, there are still minority groups, particularly the indigenous population, who still cannot realize their right to control voluntary and informed manner the number of children they have within the family.

Sexual and reproductive behavior of the indigenous population remains a major challenge for academic reflection, as though there is a tendency in the reduction of the gap between indigenous and non-indigenous people in regard to reproductive health, there are historical factors in the culture of indigenous peoples

that prevent the solution to their problems successfully, unless specific action is taken.

The main reason of why indigenous people are not getting adequate medical care is the historic racial discrimination, which is still present in the national programs in Mexico. In general, the national projects are created thinking in the Mexican urban middle class citizen (which is usually identified with modernity); completely ignoring the specific material and cultural needs of indigenous peoples (who are usually identified with the tradition). Thus, family planning programs often ignore the self-management capacity of indigenous peoples, their interactions with the environment, and the customs that they have with regard to health.

On the other hand, unsatisfactory family planning is outcome of economic vulnerability of indigenous people. Within the marginal population of Mexico, indigenous people are often the most marginalized in such as; high level of geographic dispersion, lack of coverage by health facilities, low income, low educational levels, and deprivation of all kinds of public infrastructure (electricity, water, drainage, transportation, etc.). The poverty of indigenous people it is not only causes severe problems in reproductive health, but also in health care in general. Unfortunately, the lack of opportunities for these groups to develop economically seems to have no solution in either the short or medium term.

In addition to this, as it cited earlier, indigenous peoples historically have strong gender discrimination (sexism), which prevents women to take their own decision on their reproductive health. While indigenous are the poorest in the group of the poor people in Mexico, indigenous women are even poorer than indigenous men. Levels of marginalization of indigenous women are alarming, and lack of gainful activity and little education (and even official language proficiency in the country) makes them highly prone to lack any kind of health care, including sexual and reproductive care. The lack of self-determination of indigenous women within the family does have high levels of morbidity and mortality, frequently exposed to high-risk births, lack of access to contraception, difficulties to avoid reproductive diseases, or difficulties to have the desired number of children.

That is why it becomes a priority to learn from each ethnic group in Mexico on their ancient healing practices, their view of world of health, and their notion of body welfare. In turn, it should be analyze family planning programs so that they take into account the need for women empowerment in the indigenous population.

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